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Loxley Chase Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 March 2016 was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected in 2015, and at that time was meeting the regulations we inspected.

Loxley Chase is a three-storey converted building providing single en-suite accommodation for up to 30 people. There is a lift giving access to all floors. The home has a large lounge as well as a smaller snug area, a dining room and a separate room for activities and social events. It is situated close to shops and amenities and it is on a bus route providing access to Middlesbrough town centre. At the time of our inspection 29 people were using the service, many of whom were living with dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safely supported to access their medicines. Accurate records were kept of administration, and medicines were securely and safely stored. We made a recommendation that the service consult national guidance when recording the use of covert medicines.

Risks to people arising from their health and support needs or the premises were assessed, and plans were in place to minimise them. Risk assessments were regularly reviewed to ensure they met people's current needs. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use.

Staff understood safeguarding issues, and felt confident to raise any concerns they had in order to keep people safe.

The service monitored people's levels of dependency and used this to asses staffing levels. A number of recruitment checks were carried out before staff were employed to ensure they were suitable.

Staff received training to ensure that they could appropriately support people, and the service used the Care Certificate as the framework for its training. The Gold Standard Framework training was used in End of Life training.

Staff received support through regular supervisions and appraisals. Staff felt confident to raise any issues or support needs they had during supervisions and appraisals.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people's rights were protected. Care plans contained evidence of mental capacity

assessments and best interest decisions.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they had a choice of food at the service, and that they enjoyed it.

The service worked with external professionals to support and maintain people's health. Staff knew how to make referrals to external professionals where additional support was needed. Care plans contained evidence of the involvement of GPs, district nurses and other professionals.

Staff treated people with dignity, respect and kindness. People and their relatives spoke highly of the care they received.

Procedures were in place to support people to access advocacy services should the need arise.

Care was planned and delivered in way that responded to people's assessed needs. Plans contained detailed information on people's personal preferences, and people and their relatives said care reflected those preferences. Care plans were regularly reviewed to ensure they met people's current needs.

People had access to a wide range of activities, which they enjoyed. The activities co-ordinator ensured that everyone at the service could access at least some of the activities, including people living with dementia.

The service had a clear complaints policy that was applied when issues arose. People and their relatives knew how to raise any issues they had.

Staff were able to describe the culture and values of the service, and felt supported by the registered manager in delivering them.

The registered manager and registered provider were a visible presence at the service, and were actively involved in monitoring standards and promoting good practice. Feedback was sought from people, relatives, external professionals and staff to do assist in this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were safely and securely stored, and their use was accurately recorded. We made a recommendation about recording the use of covert medicines.

Risks to people were assessed and minimised, and assessments were used to plan and deliver safe care.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The service monitored staffing levels, and carried out pre-employment checks to minimise the risk of inappropriate staff being employed.

Is the service effective?

Good

The service was effective.

Staff received training to ensure that they could appropriately support people, and were supported through supervisions and appraisals.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people's rights were protected.

People were supported to maintain a healthy diet, and had a wide range of choice.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

Staff encouraged people to maintain their independence, which

was appreciated by people and their relatives.

People and their relatives spoke highly of the care they received.

The service provided people with information on advocacy services.

Is the service responsive?

Good

The service was responsive.

Care planning and delivery responded to people's needs and preferences. People and their relatives said they received the care they wanted.

People had access to a wide range of activities, which were tailored to their needs and preferences.

The service had a clear complaints policy, and people and their relatives knew how to raise issues.

Is the service well-led?

Good

The service was well-led.

Staff were able to describe the culture and values of the service, and felt supported by the registered manager and registered provider in delivering them.

The registered manager and registered provider carried out regular checks to monitor and improve the quality of the service, and were a visible and active presence at the service.

The manager understood their responsibilities in making notifications to the Commission.

Loxley Chase 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.

This inspection took place on 23 March 2016 and was unannounced. This meant that the registered provider did not know we would be visiting. The service was last inspected in 2015, and at that time was meeting the regulations we inspected. At the time of our inspection 29 people were using the service.

The inspection team consisted of one adult social care inspector and two specialist advisor nurses.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was not asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the service provided at the service.

During the inspection we spoke with four people who lived at the service and three relatives. We looked at six care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with 10 members of staff, including the registered manager, the registered provider, senior carers, the activities co-ordinator and cook. We looked at three staff files, including recruitment records.

We also completed observations around the service, in communal areas and in people's rooms with their permission.

Good

Is the service safe?

Our findings

People said they felt safe at the service. One said, "I feel safe living here." Another said, "I feel very safe." A relative told us, "I think [named person] is safe living here."

Risks to people were assessed and plans were put in place to minimise them. People were assessed in areas such as falls, nutrition, bed rails and moving and handling. Where particular risks arose, these were also assessed. For example, one person had behaviours that challenge and a risk assessment was in place for this. Risk assessments were reviewed on a monthly basis to ensure they reflected people's current needs.

Risks to people arising from the premises were assessed and monitored. Fire and general premises risk assessments had been carried out. Some remedial action was suggested on a fire risk assessment completed in May 2014, and it was not clear from the documentation whether this had been completed. It was also not clear whether remedial actions identified in an electrical installation report from December 2015 had been completed. We asked the registered provider about this and were told that all of the actions had been completed. The registered provider spoke with maintenance staff during the inspection about the importance of properly documenting the completion of remedial work. Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. Records confirmed that monthly checks were carried out of emergency lighting, fire doors, water temperatures and window restrictors.

People were supported to access their medicines when they needed them. Medicines were stored securely and safely, and where necessary in a refrigerator at the appropriate temperature. A secure trolley was used for administration of medicines around the service. A secure cupboard was used to store controlled drugs, and stocks were accurately recorded. Controlled drugs are medicines that are liable to misuse and abuse. We noted that the cupboard was full and asked the registered provider if they thought the size was sufficient for the amount of controlled drugs being stored. They said they were considering purchasing a larger secure cupboard.

Medicine administration records (MARs) were used to record the medicines a person had been prescribed and recording when they had been administered. These had been accurately completed by staff. One person's medicines were administered by the district nurse on a daily basis, and these visits were accurately recorded. A record was kept of the signatures of staff trained to administer medicines, to assist the deputy manager in monitoring medicine administration. The deputy manager carried out a weekly review of medicine administration, and we saw that this was effective and identifying any issues arising and remedying them.

One person received their medicines 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. This had been authorised by the person's GP, but there was no evidence that a best interest meeting had taken place involving the GP, staff from the service and the person's family to consider whether covert administration was in the best interests of the person. We recommend that the service reviews and adopts the National Institute for Health and Care Excellence (NICE) guidelines on covert

medicines.

The service was clean and tidy, and bathrooms and communal areas were well maintained. Where people were supported to move around the building this was done at a safe and steady pace, and staff knew how to use mobility equipment to assist in this. Throughout the inspection we observed staff washing their hands and using personal protective equipment where necessary, to assist with infection control.

A record was kept of accidents that occurred at the service, which included details of when and where they happened and any injuries sustained. The registered manager said they reviewed this for any trends, and would take any necessary remedial action needed.

Staff understood safeguarding issues and knew the procedures to follow if they had any concerns. There were safeguarding policies in place and staff were familiar with them. Staff also received safeguarding training. One member of staff said, "I have done safeguarding training", and went on to describe the types of abuse they looked out for before stating, "I would go straight to senior carers if I had any concerns." Another said they would report any concerns they had to the registered manager. There service had a whistleblowing policy, and staff were familiar with this. Whistleblowing is where an employee reports misconduct by another employee of their employer. One member of staff said, "I would whistle blow if I saw any problems."

Staffing levels were based upon people's levels of dependency. A monthly assessment of people's needs was carried out, covering areas such as mobility, speech and communication, memory and continence. The registered provider said they then used this to ensure that sufficient numbers of staff were employed. They said, "We always take on a 30 hour post over and above what we need so we are not left short if staff leave or are on holiday." There was a low turnover of staff, and most had been working at the service for a number of years. The registered provider operated another service a short distance from Loxley Chase, and said staff from there could cover at Loxley Chase in case of emergency. At the time of the inspection, staffing levels between 8am and 8pm were two senior carers and three care assistants. Staffing levels between 8pm and 8am were two senior carers.

During the inspection we saw that staff had time to support people in an unhurried way, and that people did not have to wait long for assistance to be given. One person told us, "Now and again it's busy and a bit short but if I mention it to staff it's usually because someone has phoned in sick." A relative said, "I think staffing is really good. There always seems to be five staff around." A member of staff we spoke with said, "I think there are enough staff here. When you get the odd time that staff phone in sick it can be difficult but they get staff in from the other service. We don't have to rush people."

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Interview notes in staff files showed that applicants were asked questions to test their knowledge of areas such as the importance of people's rights and choices, confidentiality and any training needs they had. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. Before applicants were offered a position they undertook a 'tester day' so that the registered manager could assess their suitability for the post. The registered provider told us, "Applicants do a taster day and work under the supervision of staff and the registered manager. We have rejected 10 people off the back of that. Sometimes we get them in and don't find they're suitable."

New staff undertook an eight week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

Good

Is the service effective?

Our findings

Staff received the training they needed to support people effectively. Annual mandatory training was undertaken in fire safety, first aid, moving and handling, infection control and health and safety. Mandatory training is training that the provider thinks is necessary to support people safely. Additional training was provided in areas including complaints, catheter care, diabetes care and stroke awareness. A training matrix was used to plan and monitor staff training. This showed that all staff had completed necessary training in 2015, and that a training plan was in place for 2016. All training was classroom based, and staff were paid to attend training sessions.

The service was in the process of adopting the Care Certificate as the basis of its training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. All new staff were enrolled on the Care Certificate, and the registered provider was in the process of transferring serving staff onto it. The service also used the Gold Standard Framework for training in end of life care. The Gold Standard Framework is a systematic, evidence-based approach to optimising care for people approaching the end of life. The registered provider said, "We're on the Gold Standard Framework and staff are going really well on it. We meet monthly to discuss it."

Staff spoke positively about the training they received, and said they would be confident to request any additional training they wanted. One said, "The training is really good. We always have it. It goes up on a board and [the registered manager] organises it. We have to come to do it, and we get paid. If I ever wanted specialist training I would ask." Another member of staff said, "The training is okay. [The registered manager] makes sure it is up to date."

Staff were supported through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. A staff supervision plan showed that all staff had received an annual appraisal in December 2015, and plans were in place to undertake quarterly supervisions in 2016. Records confirmed that supervisions and appraisals were used to discuss knowledge and training and any support needs the member of staff had. One member of staff told us, "We sit down and [the registered manager] asks if everything is okay and how things are going. We can speak about anything on our mind."

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. At the time of the inspection, nine people were subject to DoLS authorisations and a further 12 people had applications for DoLS re-authorisation pending. The registered manager maintained a matrix of people's DoLS status, which allowed them to monitor the status of authorisations and progress of applications. The registered manager said, "We are in the process of updating some and have had the social worker and best interest assessor in." Where appropriate, DNACPR decisions were recorded in people's files and contained evidence of authorisation by their GP.

Staff had a working knowledge of the principles of the MCA. One said they would never make assumptions about a person's capacity or ability to consent solely on the basis of their behaviour. They said, "If someone was confused it could be that they have a water infection or something else that confused them. We ask people for permission. If people can't give it it's recorded in the care plan." Another said, "I have done training on the MCA. You can't take control. You have to let people have control instead of taking it away. You never assume that people can't make decisions, even if they seem confused. They might just be having a bad day. You talk to people to get permission and always explain what you are doing." During the inspection, we saw staff asking people for permission to support them. Where people were living with dementia and could not communicate their preferences, we saw staff consult care plans and look for non-verbal indicators of people's choices.

People were supported to maintain a healthy diet. People were regularly weighed and food and fluid charts were used to monitor their nutritional health. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team. There was a clear record in the kitchen of people's specialist dietary needs (for example, pureed food and fortified food) and meals were plated up by the cook to ensure that people received the appropriate meal.

Menus were available in the dining room, and a visual menu was displayed on the wall. The cook said the menu was provided centrally from the registered provider, but that people could choose anything they wanted to eat. The cook was familiar with people's dietary preferences - including any cultural preferences they had – and said these were catered for. One person who used the service told us, "We get a choice at breakfast, it's not set. People can have whatever they want, like cereal, toast or a full fried breakfast. Someone got fed up with fish, once, so they got chicken curry instead. As that person said, just ask and they'll do it for you." Another person said, "I'm on a liquid diet and it's very good. They always give me a choice of what I want." A relative told us, "The food is excellent." Another relative said, "it's really good food."

We observed at lunchtime, and saw that most people chose to eat in either the dining room or the adjacent lounge. Staff were attentive to people as they ate and discreetly monitored and discussed how much people were eating. Some people's relatives attended to eat lunch with them, which created a convivial atmosphere. Where people needed support with eating, this was done discreetly and patiently. Staff encouraged people to do as much for themselves as they could before offering to help.

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the district nurse, dieticians, speech and language therapist and services for people with behaviours that challenge. We spoke with two district nurses who were visiting the service during our inspection. They said staff were responsive to people's needs, were helpful during their visits and provided all of the information they (the district nurses) needed. One person told us that after an accident, the service worked with their GP and other agencies and "took care of it." A relative we spoke with said, "[A named person] had sepsis recently and they were really on the ball with it here. They always get the GP if there is any change."

Good

Is the service caring?

Our findings

People said care was delivered with dignity and respect. One said, "Staff are great at dignity and respect." Another said, "They (staff) are always very respectful." A relative told us, "It is lovely to see how staff relate to people, very respectful. I am very impressed with the ethos here." Another relative said, "They (staff) are always very respectful when speaking with people."

Throughout the inspection we saw that staff treated people with respect and took steps to maintain their dignity. When people indicated that they needed assistance, staff approached them and discreetly asked how they could help. This helped to maintain people's confidentiality. Staff asked people for permission before offering help, and tailored their communication style to suit the person they were talking to. For example, we saw staff asking one person who was living with dementia and who had difficulty in communicating if they would like a drink by holding up a cup to demonstrate what they were talking about. Staff knocked on people's doors before entering, and where they needed to discuss people's support needs with other staff did so away from communal areas.

Staff encouraged people to maintain their independence. Where support was requested, staff asked how much help people wanted and what they wanted to do – if anything – for themselves. One person said, "They help me with things I need help with but are keen on keeping people independent." A relative told us, "They are very good at maintaining people's independence."

Throughout the inspection we observed staff interacting with people with care and kindness. As staff moved around the service they made an effort to stop and talk with people and their relatives. People were looking forward to a forthcoming Easter party, and were joking with staff about this. Staff clearly knew people well, which meant they could have conversations with people that the person enjoyed. For example, we saw one member of staff talking to a person and their visiting relative about a recent family holiday.

People and their relatives spoke positively about the care and support they received from staff. One person said, "They (staff) are great…it is lovely here." Another person said, "I have a good key worker and staff make the time to talk to you… it's very friendly, the staff are all very friendly." Another person spoke positively about a named member of staff, and described the help they received to arrange and collect books from the library.

Relatives told us they were free to visit whenever they wanted to, and always felt welcome and involved when they did. A relative told us, "It's lovely here…I have high praise for them (for staff)]." Another relative said, "I think staff make the best of what can be a very hard job. It is a very nice atmosphere here, and you can feel it when you walk in. You sense that staff like working here and enjoy it. You can tell staff love their job."

Nobody at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. Staff were able to tell us how they would arrange an advocate should one be needed.

Plans were in place to begin End of Life care for some people at the service, using the Gold Standard Framework. Their care records contained details of the discussions that had taken place regarding this, though care plans had not yet been produced. We asked the registered provider about this and they said all relevant information would be used to produce End of Life care plans.

Good

Is the service responsive?

Our findings

Care planning and delivery responded to people's needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

People's care records began with an 'All about me' section. This contained information about the person's life history and things that were important to them, such as particular events or family information. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences.

Each person then had a care plan in place for a number of different areas, including mobility, moving and handling, nutrition, oral health, mental health, night time care and medicines. The care plans were detailed and personalised. For example, one person's care plan contained detailed information on what they liked to wear to bed, how they liked to be showered and their preferences for shaving. Care plans were reviewed on a monthly basis to ensure they reflected people's current needs and preferences. Daily notes were used to assist staff coming onto shift to familiarise themselves with any developments that had occurred that day. These contained detailed and comprehensive updates on people. For example, one person with behaviours that challenge had fallen in January 2016. The daily notes contained detailed information on this, and on a referral to an external professional that had been made to obtain more help for the person.

People had their own 'keyworker', who among other responsibilities was responsible for ensuring that the person could give feedback on their care. People we spoke with were able to identify their key worker and spoke positively about them.

People and their relatives told us that the care delivered reflected their needs and preferences. One person said, "They look after me and my preferences." A relative said us, "The family were involved in care planning. [The registered manager] came out for an assessment and got [the person's] needs and preferences." Another relative said, "We were asked a lot of questions at the assessment. I was happy with that. They asked the right questions. I was asked to fill in a life history. The care reflects [the person's] preferences."

The registered provider employed an activities co-ordinator who worked at all of their services, and who was based at Loxley Chase for a day and a half every week. When they were at the registered provider's other services, care staff were asked to undertaken activities and external entertainers were arranged.

During the inspection we saw people participating in a wide range of activities, including a quiz, exercises and a sing along. The activity co-ordinator also used a flash card game that involved random topics being picked and used as the basis of a group discussion. This was particularly effective at engaging people living with dementia, and the participants obviously enjoyed the activity. The activities co-ordinator said they ran a large number of relatively short activities for people so that everyone could be involved in something they enjoyed.

There were lots of photographs around the service of activities people had participated in, including parties

and visits from entertainers and pet therapists. Staff and people at the service were getting ready for an Easter party, and Easter eggs and other prizes were on display for a raffle that was underway. The day before our inspection we were told that people had enjoyed a cheese and wine afternoon.

People and their relatives told us they had access to activities. One person said, "We get a man who comes in every week with dogs. I play dominos with him. I asked him if he had a chess set once, and he brought one in." Another said, "We have enough to do here. I play Scrabble and dominos. The activities co-ordinator comes in and does quizzes and puts films on the TV and entertainment. There's an Easter party tomorrow." A relative told us, "They do some lovely things, like cakes at birthdays."

There was a clear policy in place for managing complaints. This set out what would constitute a complaint, how it would be investigated and the relevant timeframes for doing so. It also contained information on external bodies people could complain to if they were dissatisfied with the service's response. No complaints had been received since our last inspection. The registered provider said, "Because [the registered manager] is on the shop floor they can deal with anything that comes up." People and their relatives said they knew how to raise any issues they had and were confident they would be addressed. One person said, "If I wasn't happy I would speak to [the registered manager]." Another person said, "If I had any complaints I would go to [the registered provider] and I wouldn't need to go any further." A relative said that when they had raised an issue about a person's room, it had been quickly dealt with. They said, "I just spoke with [the registered provider] and they said [to the registered manager] just buy whatever is needed."

Good

Is the service well-led?

Our findings

A written objective of the service was, 'to provide a high standard of residential care in a safe, secure and pleasant environment.' We asked staff to describe the culture and values of the service. One said, "This is a happy place, comfortable, where people can relax." Another said, "It's warm, friendly and management know the place inside out." The registered provider said, "We provide person centred care, with highly skilled staff. It is a home away from home and is very professional. You can walk in and be part of the team. We're a very open team, with excellent leadership."

The registered manager and registered provider carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager carried out daily, weekly and monthly checks of areas including medication, health and safety, staffing levels, infection control and falls analyses. The registered provider carried out a monthly audit of the service, reviewing people's recorded weights, dependency levels and staff training. The audits were used to pro-actively monitor any impending deadlines. For example, the March 2016 audit of care plan risk assessments identified that two people needed their Malnutrition Universal Screening Tool (MUST) updating.

Feedback was sought from people, their relatives and external professionals through annual questionnaires. This was most recently done in August 2015, when 10 people, 11 relatives and four external professionals responded. The majority of the feedback from all three groups was either good or excellent. Where issues were raised, an action plan was put in place to address it. For example, some people said they did not know who their key worker was. This led to an action plan including reviewing key workers and raising their profile and discussing this with relevant staff at clinical supervisions. Some relatives had asked that more care be taken when ironing people's clothes, and this led to the purchasing of a new steam iron.

The registered manager and registered provider were a visible presence around the service. The registered manager worked some care shifts during the week, which they said they valued as it helped them to monitor things "from the shop floor" and support staff. The registered provider was based at the service, and supported the registered manager when they worked care shifts. Both the registered manager and registered provider clearly knew people and staff well. One person we spoke with said, "the registered manager is great" before joking, "[the registered manager] keeps staff on their toes." Another person said, "[the registered provider] took me around and helped me to choose my room." A relative told us, "I think the management is excellent. I'm always very confident when I see [the registered manager] on duty. They do the management so well, but also get involved with the nitty gritty."

Staff said they felt involved in the running of the service, and spoke positively about the registered provider and registered manager and the support they offered. One said, "[The registered manager] is lovely. You can go to [the registered manager] with anything and I would be happy to raise any problems. [The registered provider] are lovely." Another said, "[The registered manager] is lovely. A nice, genuine person who is on the floor helping. You can go to them if you need help, and I would be happy to go and get help from [the

registered manager]. Approachable and knows job. [The registered manager] keeps you going. [The registered providers] are lovely and always pop in whenever they can."

Staff meetings took place at which staff could raise any general issues or concerns they had. Where suggestions were made they were acted on. For example, at one staff meeting a carer suggested that a large pictorial menu be installed to assist those who were living with dementia. This resulted in a pictorial menu being installed in the dining room.

Systems were in place to encourage and promote good practice. Some staff acted as "champions" in areas including nutrition and infection control having expressed an interest in those areas, and had received accredited training to share with colleagues. The registered provider said they encouraged the services they operated to share good practice. They said, "We have encouraged interaction between the registered managers of the services. We have a business meeting and an informal meal afterwards, and are always looking for innovative was to do things."

The registered manager was able to discuss the roles and responsibilities of a registered manager, and understood the types of notifications that should be made to the Commission.