

Anchor Trust

Wellington Lodge

Inspection report

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Date of inspection visit:
28 September 2018

Date of publication:
31 October 2018

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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

The inspection took place on 28 September 2018 and was unannounced. The last inspection of this service was on 1 March 2016 and we found the service to be good in all areas. The service is run by Anchor Trust.

Wellington Lodge is a care home located in the Cheetham Hill area of Manchester. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and support for up to 33 people some of whom are living with dementia. On the day of inspection, 32 people were living at the home.

The service is divided into two floors, the ground and the first floor. There is access to each floor via a passenger lift and two stairwells.

At this inspection we found the evidence continued to support the overall rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. At this inspection we found the service remained good overall.

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a deputy manager, both managers assisted with the inspection.

People felt safe living at Wellington Lodge and were aware of how to raise any concerns they had. Staff members were aware of their responsibilities in relation to protecting vulnerable adults from abuse and were confident the registered or deputy manager would act on any concerns they had. All staff had received safeguarding training.

Staff members were recruited safely and received a robust induction to introduce them to their role.

Premises safety was well managed. Regular external checks took place of equipment such as the firefighting systems, the passenger lift, moving and handling equipment and electrical and gas safety. Internal checks on premises safety were completed weekly or monthly and clearly documented.

People had appropriate risk assessments in place to support them. Risk assessments were reviewed regularly or when needs changed.

Accidents and incidents were fully documented and lessons learned were shared to prevent future occurrences.

Medicines were safely managed. Audits were in place to monitor the safe receipt, storage, administration

and documentation of medicines. Staff received training to enable them to administer medicines safely.

Staff received training suitable for their job role. The provider supported staff to complete diplomas in health and social care to expand their knowledge. We saw all staff received an induction and were given the opportunity to shadow more experienced members of staff.

The service was working in line with the Mental Capacity Act 2005. People received appropriate capacity assessments and decisions were made in people's best interests. People were only deprived of their liberty where applications had been made to do so.

People were supported to eat a healthy and nutritious diet. People were very complimentary of the food and meal times were a sociable event.

People received input from primary care services such as a GP or dentist. People told us they could see a GP when they felt unwell and the home had regular weekly visits from the district nurses and a practitioner who assisted in monitoring people's weights and skin integrity.

We observed caring and dignified interactions between staff members and people living at the home. People told us they felt cared for and staff always ensured their privacy and dignity.

Care plans captured people's support needs and were person centred. People told us they had been able to contribute to their care plan and we saw people's choices, likes and dislikes were clearly recorded. Care plans were regularly reviewed to ensure they were current.

Activities were varied and clearly enjoyed by everyone. We observed staff actively engaging people in activities and the homes Twitter page highlighted some of the work the service provides in relation to activities.

People were supported to remain at the home at the end of their life. The service had developed memory books to allow people, staff and visitors to record their favourite memories of people.

The provider had developed audits and tools to monitor the service. Audits worked to highlight areas for improvements and action plans were then developed to ensure the improvements were made in a timely manner.

People and staff members told us they felt well supported by the registered and deputy manager. We observed both managers to be visible across the home throughout the inspection and offering support to people, staff and relatives. The registered manager felt well supported by the district manager.

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 remains safe.	Good ●
Is the service effective? The service remains effective.	Good ●
Is the service caring? The service remains caring.	Good ●
Is the service responsive? The service remains responsive.	Good ●
Is the service well-led? The service remains well-led.	Good ●

Wellington Lodge

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 was unannounced and was undertaken on 28 September 2018. The inspection team consisted of one inspector.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Wellington Lodge, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

We contacted Manchester local authority, and Healthwatch (Manchester) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with five people who lived at the home. We spoke with six members of staff including one team leader, three care assistants, a house keeper, the cook, the registered manager and deputy manager. We also spoke with a health professional who visited the home regularly.

We looked at training and supervision records for the staff team, one month of staff rotas and the staff files for three staff including their recruitment records. We looked at four medicines administration records in the medicines treatment room and three people's care files. We also looked at records of staff meetings, quality

monitoring records, medicines adults, fire safety records and health and safety records relating to legionella, maintenance of the home and servicing of equipment.

Is the service safe?

Our findings

At our previous inspection we found that the service was safe. At this inspection the service continued to be good in this area.

We asked people living at Wellington Lodge if they felt safe. One person said, "Oh aye, I am safe here, we are well looked after here." Another person said, "Oh yes, of course it's safe, I wouldn't be here if it wasn't."

Staff we spoke with could clearly describe their responsibilities under the safeguarding of vulnerable adults. All staff said they would report any concerns they had immediately to the registered or deputy manager and were confident their concerns would be acted upon. Staff had received both eLearning and face to face training in safeguarding vulnerable adults from abuse which was evidenced by training certificates. Additionally, people we spoke with told us they would tell the staff or their families if they had any concerns. The service had a safeguarding policy in place. This meant the service was working to protect people from abuse and empowering the staff to report concerns. Furthermore, a whistle blowing policy was in place and staff confirmed they were aware of and understood the policy.

We looked at three staff files. These included a fully completed application form, proof of identity and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies unsuitable people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We observed that staffing levels at Wellington Lodge were sufficient and regularly reviewed using a dependency tool. People's dependency levels were reviewed at six monthly intervals unless there had been a noticeable change in which they were reviewed more often. Dependency levels were rated at high, medium or low and staffing levels were worked out from the differing levels of dependency.

We saw there were five care staff on from 8am to 2pm each day and four staff from 2pm to 8pm and three waking night staff overnight. Each shift pattern included a team leader leading the shift. We viewed the rotas over the last month and saw the staffing levels were consistent with additional support from the registered and deputy managers and ancillary staff such as house keepers, kitchen staff and an administrator. Staff told us that staffing levels were okay and the registered manager told us an additional afternoon staff member had been authorised and was currently being recruited.

People living at the home told us there was always staff around and they didn't have to wait long for staff if they had called them via the call bell system. One person told us, "They [staff] are always around when I need them, one had just gone to my room to get me something." Our observations on the day of inspection were that staff presence was visible, particularly in communal areas and call bells were answered in a timely manner.

Risks to people at the home were regularly assessed and reviewed. General environmental and specific risk assessments were completed. Risk assessments were in place for mobility, falls, medicines, continence, skin

integrity and smoking. The service used evidence based standardised risk assessments such as the Malnutrition Universal Screening Tool (MUST) to assess people at risk of malnutrition. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition.

People at risk of falls regularly had their falls risk assessment reviewed and we saw when a fall had occurred, a post falls analysis was completed. This looked at any effects of medicines which may have contributed to the fall, any trip hazards and any previous falls to look at patterns and trends. Where people identified as high risk of falls, equipment was available to manage the risk such as sensor mats in people's bedrooms and additional room checks. This meant the service was responsive in the management of falls to reduce risks to keep people safe.

Accidents and incidents were recorded on an internal computerised system which could be accessed by the management team and team leaders. We saw accidents and incidents were clearly monitored with lessons learned recorded to prevent future occurrences. Actions from the learning were shared amongst the wider team as part of the lessons learned process.

All medicines were stored in a locked medication trolley in a locked treatment room. Both the fridge and room temperatures were recorded daily. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. The team leader on duty was responsible for administering medicines and held the keys for the trolleys at all times.

We observed the team leader administering medication to people during our inspection and found them to be patient with people and answered any questions they had. The team leader ensured each person had taken their medicines as prescribed and could describe people who required their medication to be taken with particular directions such as before breakfast or with food. We saw medication administration records (MAR) were fully completed and people had received their medicines at the right time.

We checked the stocks of medicines for four people which included checking controlled drugs and prescribed creams. Controlled drugs are medicines controlled under the Misuse of Drugs Act. There are special measures in place for the safe storage and administration of controlled drugs and we saw they were being fully adhered to. Cream were clearly recorded for people with body charts in place to identify the location of the cream and stock balances were all correct.

Where identified, people were risk assessed to administer their own medicines. There was no one administering their own medicines on the day of inspection but some people were applying their own creams in line with the prescription. The risk assessment confirmed people's understanding of why they were prescribed the cream, if they were aware of the times and locations of it to be applied and if it was safely stored in their bedrooms. This meant people were able to retain independence where deemed safe to do so.

Team leaders received training in the safe administration of medicines from the pharmacy and via eLearning and received annual competency assessments to ensure their capabilities in administering medicines. Furthermore, workbooks were completed to ensure the team leaders understood what they had learned from the training.

This meant people received their medicines safely and the service had processes in place for the safe receipt, storage, administration and recording of medicines.

Records showed that equipment and services within the home were maintained in accordance with the manufacturers' instructions. This included checks on gas safety, portable appliance testing, electrical safety, fire prevention and detection, inspections of the passenger lift and emergency lighting. The service has a fire risk assessment in place which was regularly reviewed and weekly and monthly internal checks were completed of the fire escape route, the fire alarm system, call points, fire extinguishers, fire door checks and emergency lighting.

The service had a legionella risk assessment in place. Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. The guidance in the risk assessment was being followed with regular checks of water temperatures and six-monthly testing of thermostatic mixing valves (TMV). This meant the service had ensured the premises was safe for the people, staff and visitors.

Each person had a personal emergency evacuation plan (PEEP) in place. A peep gives guidance to staff and others to evacuate people in an emergency. Each peep was rated as green or red. Green for people who could self-evacuate to red which meant people would need assistance due to cognition or mobility concerns. This meant there were procedures in place to support people to leave the building in an emergency.

The service also had a business continuity plan in place. The plan contained details of what action needed to be taken in the event of an emergency or incident occurring such as a fire or utility failures. The plan also contained copies of the peeps.

The home was clean and well maintained. Housekeepers completed daily audits to ensure rooms had been cleaned. The laundry was managed by a laundry assistant. We saw personal protective equipment (PPE) such as gloves and aprons were freely available throughout the home.

Is the service effective?

Our findings

At our previous inspection we found that the service was effective. At this inspection the service continued to be good in this area.

Prior to people's admission to Wellington Lodge, a full assessment of support needs was completed. Care plans and risk assessments were formulated from the assessment and there was recorded information from a host of professionals including social work assessments, occupational and physiotherapy reports. This meant that people received a holistic assessment to ensure the home could meet their needs.

People had access to primary care services including GP's, dentists, chiropodists, opticians as well as wider services such as physiotherapy and audiology. One person told us they could see a GP when they wanted and the service had arranged for the person's relative to go with them to the next appointment. We saw district nurses visited the service at least once a week to review people's dressings and a practitioner visited the service every Tuesday to review people's weights and skin integrity. This meant people had good access to health services and were able to have any concerns with their health addressed in a timely manner.

Staff told us and we saw they received training to enable them to carry out their job role effectively. Training was a mixture of eLearning and face to face training including safeguarding, dementia awareness, health and safety, mental capacity, moving and handling, food safety, fire safety, infection control and equality and diversity. Staff told us they were encouraged to complete diplomas in health and social care and another staff member had been trained to deliver and support staff through the diploma. We saw 97% compliance for all trainings. Staff told us that training was good and relevant to their role. This meant staff had the appropriate skills to support people in their care.

The induction process for new staff included completion of the care certificate. The care certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care over a 12-week period. This included written work as well as practicals and observations. New staff shadowed other more experienced members of staff prior to working independently.

Staff received regular supervision and appraisals. Verbal and written handovers were given at the end of every shift were undertaken. This meant communication between staff and managers was effective.

We observed lunch time and found the food looked and smelt appetising. People were very complimentary of the food and told us, "The food is lovely, they will make you something else if you don't fancy what's on."; "I had egg on toast for breakfast, it was lovely." and "Delicious, I have no complaints." Menus were advertised on a board in the dining area and updated each day. We noted tables were set with cutlery and had condiments available.

We saw people had enough to eat and drink and people told us they were always offered extra portions. Fresh fruit, biscuits and drinks were always available and people had access to jugs of water in their

bedroom and there were regular checks completed to ensure the jugs were replenished.

We spoke with the cook who could describe people's diets. The cook told us they met with people when they moved into the home to find out likes and dislikes and if they had any special diets or requests. The cook was aware of who required a soft diet or who may need their fluids thickened. Thickening of fluids was completed by staff who had received training from the thickening agent provider and this was clearly recorded in the person's care plan. Additionally, the cook also was able to review people with the speech and language therapist (SALT) to ensure they were involved in any changes to people's diets.

We observed staff supporting people into the dining room and offer encouragement to eat and drink. The atmosphere was calm and meal times were a sociable occasion with friendly chats and people sat with people they were comfortable with.

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).

People had their capacity regularly assessed. The majority of the assessments were based upon people's understanding of the decision to remain in the care home or consent to care. We saw where people were unable to consent or make decisions, a decision had been made in their best interests and included, where possible the views of the person and their representatives. DoLS referrals were made to the local authority for review and any restrictions from the outcomes of the referrals were captured in people's care plans.

Staff members were spoken with and were aware of who had DoLS in place and any restrictions placed upon them.

This meant the service was working in line with the MCA.

Wellington Lodge is a purpose built two storey care home that was well decorated. The rooms within the home were referred to as flats and some people chose to have their own keys on a lanyard and were able to open and lock their flat as they pleased. Staff were still able to access the flats in an emergency. Each flat had an en-suite bathroom, bed, wardrobe, drawers and side table and room for a comfortable chair and television and associated equipment. We were given permission to view one person's flat and they showed us their own art work that had been placed around the flat for others to see. Flats also had a mail box on each door so people could receive their mail directly to their bedroom if appropriate.

People were given information in a way they could understand. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. In the communication care plan, methods to communicate with people were clearly described. Large signage was used to highlight areas of the home such as the bathroom and communal areas. This meant the service was working to meet the standards of AIS.

People had their photos on their front doors, this helped people living with dementia to identify their flat.

There were also memory boxes placed outside each person bedroom. A memory box houses meaningful objects and photographs to help people with dementia express aspects of their life that has been the most important to them.

There was a passenger lift to the first floor as well as two stair wells. On the ground floor, there was a large dining area and a large lounge area and on the first floor, a large lounge had been turned in a cinema / quiet room complete with projector and traditional cinema seating. There was also a hair salon and laundry room.

The home is surrounded by gardens and a sheltered seating area and smoking shelter for those people who wished to smoke.

Is the service caring?

Our findings

At our previous inspection we found that the service was caring. At this inspection the service continued to be good in this area.

During our inspection of Wellington Lodge, we spent time talking with people and observing interactions within the home. The environment was friendly and relaxed with an air of calmness. People freely moved within the home from communal areas to their flats and even sat near the reception area, chatting to visitors as they arrived.

Interactions between staff and people living at the home were kind and dignified and we observed friendly joking with people throughout the visit.

People told us they felt well cared for at Wellington Lodge. Some of the comments included, "Yes, I am, well cared for, you won't get any better."; "Oh yes, she's [staff member] is my favourite, she bought me a pint."; "The staff are lovely, they will do anything for you" and "I am cared for, I don't want for anything."

We observed staff knew people well. Staff were patient with people and we observed one staff member providing reassurance to a person who was becoming anxious.

We observed the call bells were answered in a timely manner and people were assisted with their care and support needs promptly.

Music was played in the communal lounge while waiting for the evening meal and staff joined in to the old music of Vera Lynn and people joyfully joined in,

People told us they were encouraged to do as much as they could for themselves and this gave them opportunity to retain their independence. This included being consulted about their care and support needs and one person we spoke with said, "I had input into my care plan, I know what's in it. The staff asked me and I said I wanted to do as much as possible. I set the tables and clean out the budgies. They know me and I know them."

We observed staff knocking on doors and gaining permission to enter and people we spoke with confirmed this always happened. Personal care was delivered in people's flats or communal bathrooms to ensure privacy. We saw information in care files confirming how people liked to be known as, this could include nick names and other names. This meant people were treated with privacy and dignity.

Records showed that staff had received training in respecting people's equality and diversity. The provider had developed a lesbian, bisexual, gay and transsexual plus(LGBT+) group to provide support and guidance to people from the LGBT community. Posters were displayed in the communal parts of the premises and staff were clear on their responsibilities to provide information and support to anyone who identified as LGBT. Nationally, the provider was working to become more inclusive and supportive to people from the

LGBT community. Additionally, staff told us they would not tolerate any discrimination to the people they supported and they would raise concerns with the management immediately. This meant people were being supported to be who they wanted to be and were free from discrimination.

People care files and other personal related documented were stored securely in a locked cupboard. Staff personnel files and premises related records were stored securely in the registered managers office. This meant that the service was working to ensure people's personal information was kept safe and secure.

Is the service responsive?

Our findings

At our previous inspection we found that the service was responsive. At this inspection the service continued to be good in this area.

People told us there was always lots for them to do and join in with at Wellington Lodge. Three people we spoke with said they loved their trips to the local Irish centre where they played bingo, had a dance and a pint. Other people spoke fondly of donkeys visiting the home and more recently owls and one person said the animals reminded them of growing up. Two staff members had been trained in 'Oomph' exercise and we observed a fun and lively arm chair exercise session during our visit. Oomph is a variety of person centred exercises for older people to do to assist them to keep healthy. Our observations were people enjoyed the exercises and were engaged by enthusiastic staff regardless of their ability. One person told us they were encouraged to maintain their hobbies which were drawing and arts. The person proudly showed off the work they had completed and staff had supported the person to display their work in a folder.

The home had its own Twitter social media page which confirmed some of the activities people spoke about. This include arts and crafts, baking, gardening, dancing, church services, afternoon tea, table top games, mocktail making, needlework and a performer visited the home once or twice a monthly to provide an afternoon of song and dance. The addition of the new cinema had been welcomed with cinema style seating and a projector screen. One person told us, "I enjoy watching old films on the screen, the mayor opened it up for us." Another person said, "It's a quiet room with a large screen, I enjoy it."

People told us they could get their hair attended to by the hairdresser who made the visit to the salon a pampering session and more recently, people had been able to have their nails painted at the nail salon.

We reviewed the care plans of three people. Each care plan was fully completed and regularly reviewed with people's needs, choices and wishes captured throughout. Each care plan described what actions staff needed to take to support each person in detail. This included what the person could do for themselves. Care plans confirmed the support people required with mobility, nutritional support, falls, continence, skin integrity, communication, sleep and rest, personal care, emotional and psychological support, beliefs and religion and cultural needs.

Each care plan confirmed what help people needed with any cognitive impairments such as dementia. For example, in the mobility care plan, it confirmed people's understanding of the help they needed to mobilise and any equipment required. In the emotional and psychological care plan, we saw information advising one person became particularly disorientated and it could be a sign of a urinary tract infection (UTI) and gave signs of what staff should look for. This information was also corroborated in the continence care plan. This meant care plans gave information to staff to support people in a person-centred way and considered the support needed to adhere to each care plan while supporting people with cognitive impairments.

We saw good examples that people had been involved in their care plans which included information, for example; one person liked a small glass of whisky before bed and another person enjoyed a glass of wine

with their evening meal. In the sleep and rest care plan, people had agreed to receive checks while in their flats and at what frequency they would like the checks to be. Most checks were two hourly but for those who wished a longer frequency, the care plan documented if the person could use their call bell adequately to summon help if required.

Peoples life histories were recorded within each person's care file in a 'My life story' document. Information included details of people's family history, employment history, any hobbies and memorable events. We also saw some of this information captured in people's memory boxes outside each flat. Staff told us they would use this information for one to one time with people, to promote conversation and memories.

We saw information to peoples wishes at the end of their life. End of life care relates to people who are approaching death; it should ensure that people live in as much comfort as possible until they die and can make choices about their care. The service had completed the six steps framework for supporting people at the end of their life. Six steps aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care.

We saw from care plans that discussion had taken place regarding people's future wishes so that staff would be able to meet people's needs and preferences when the time came. We found do not attempt cardio pulmonary resuscitation (DNACPR) instruction were in place for some people and this information was recorded in the front of each person's care file and a separate list kept in the registered managers office.

Staff members we spoke with confirmed they were aware of who had a DNACPR in place and told us they felt well supported when caring for people at the end of their life. One staff member told us, "[Registered manager] is very supportive, people become part of our family and when they pass away, [registered manager] rings us to check we are ok."

In the reception area, a memorial photo was placed on a table of a person who had recently passed away. A message of condolence was written and we were told, each person who passed away were remembered in this way. Additionally, a book of remembrance was available for people, staff, relatives and friends to record their memories of the deceased person. We saw the book was regularly completed and one person told us, they read it and it helped them to reminisce.

The service had a complaints policy in place. People told us they would make any complaints to the registered or deputy manager, the staff team or their family. We saw the service had received five complaints within the last 12 months and each complaint had been responded to in a timely manner. This meant the service was responsive in acting on complaints to reduce the opportunity of it escalating.

Is the service well-led?

Our findings

At our previous inspection we found that the service was well-led. At this inspection the service continued to be good in this area.

The registered manager and deputy manager were available throughout our inspection. We observed that they both interacted with people, professionals and visitors during our visit to Wellington Lodge. We noted the registered manager was particularly supportive to a family member who was visiting after the death of their relative. The registered manager offered condolences and support to the family member while they reflected on the person's life in a kind and dignified manner.

We asked people who lived at Wellington Lodge about the management of the home. All people we spoke with said the registered and deputy manager were visible in the home and were approachable and friendly. Comments included, "[Registered manager] and [deputy manager] are really nice, they are always around."; "Oh yes, they are, always chatty and helping out." and "Yes they are lovely girls."

A visiting professional told us the management were approachable and responsive. They said they found the home was well managed and the registered manager will ask for the professional's assistance and advice to support people.

The staff members we spoke with were also complimentary of the registered and deputy manager. Comments included, "If we need any support, they are always there."; "We have a good manager." and "I can go to [registered manager] and she will act on what I tell her."

We viewed many compliment cards thanking the service for their care provided to a relative or friends. Comments included, 'You were amazing with [name]. I couldn't have wished for a better place for her to spend her final weeks' and 'Thank you for the wonderful care you provided for [name].'

The service gained feedback from people and their relatives to monitor and improve. The most recent survey results received 11 responses from people living at the home and seven from family members. The results showed 100% of people were happy living at the home, have a say in how their care is provided, they were treated with dignity and respect, the home was clean and the service was good at keeping families informed. 86% of responses said the staff had the time to sit and talk to them and this was observed throughout the inspection. There were no negative responses.

People were also encouraged to share their feedback via the carehome.co.uk website and information on how to use this facility was displayed in the reception area of the home. We viewed the website and saw there had been nine reviews in the last 12 months, all of which were positive, with the home having an overall rating of 9.9.

A district manager visited the home on a monthly basis for manager support visits. The district manager reviewed information relating to the service such as staff training, premises safety, the meal time experience

and medication management. We saw the audit had identified where six staff members had not completed a fire drill in the previous six months. Also, only 66% of staff members had received face to face safeguarding training, however they had attended the eLearning safeguarding training. This information was fed into an action plan for the registered manager to meet. All actions were met in a timely manner.

An excellent tool was completed by the registered manager and validated by the district manager on a quarterly basis. This audit was linked to the Care Quality Commission (CQC) key lines of enquiries which highlights good practice and evidence for when the service is inspected. The audits ensured care plans were completed fully and reviewed, looked at finance and budgets and if the service was operating within the CQC five key questions of safe, effective, caring, responsive and well-led.

Further audits of the home completed by the registered or deputy manager included the management of medicines, accidents and incidents and premises safety. The registered manager told us they felt well supported by the district manager.

This meant the provider and management of the home were consistently monitoring and reviewing the service provided for safety and to improve the care and support of people living at Wellington Lodge.

The registered manager had submitted notifications to CQC of events that had occurred at the service. This was a legal requirement as part of the registration. We found all notifications had been received. This meant the registered manager was aware of their responsibilities of their role.