Care Worldwide (Ashton) Limited

Moss Cottage Nursing Home

Inspection report

34 Manchester Road
Ashton Under Lyne
Lancashire
OL7 0BZ

Tel: 01613432557

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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 26 and 27 September 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Moss Cottage Nursing Home on 29 August 2013, at which time the service was compliant with all regulatory standards inspected.

Moss Cottage Nursing Home is a nursing home in Ashton Under Lyne, providing accommodation, personal care and nursing care for up to 34 older people with physical disabilities and dementia. There were 32 people using the service at the time of our inspection.

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

The service excelled in caring for people at the end of their lives in a sensitive, dignified and inclusive fashion. Staff valued the relationships they made with people who used the service, demonstrating this through their dedication to meeting people's needs and respecting people's preferences up to, including and after death.

Person-centred care plans were in place and staff had ensured information about each person was readily accessible. We saw regular reviews took place with the involvement of people and their family members and found the care delivered was done so in an inclusive way that focussed on each person's needs and preferences.

The atmosphere at the home was relaxed, welcoming, respectful and calm. People who used the service, relatives and external stakeholders were consistent in their praise of staff who behaved extremely patiently and in a dedicated manner. We observed staff interacting with people in this way and gathered a range of superlative feedback regarding the caring attitudes of all levels of staff. The notion of treating people who used the service as staff would their own relatives was well evidenced through our observations and conversations and was indicative of an extremely caring service.

There were sufficient numbers of staff on duty in order to safely meet the needs of people who used the service, with the registered manager regularly assessing people's dependency and ensuring their needs could be met.

All areas of the building were clean and well maintained, including external areas.

Staff were trained in safeguarding and demonstrated a good knowledge of safeguarding principles and what

they would do should they have any concerns, whilst people who used the service confirmed they felt safe.

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

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

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

People received the treatment they needed from onsite nursing staff or prompt and regular liaison with GPs, nurses and specialists.

Mandatory staff training was regularly updated to ensure staff had a good working knowledge of people's needs, whilst an effective training matrix ensured staff refreshed their knowledge regularly. Staff had received training in Fire training, Pressure Sores, Moving and Handling, Deprivation of Liberty Safeguards/Mental Capacity Act, Continence Care, Equality and Diversity, Infection Control, Control of Substances Hazardous to Health (COSHH), Health and Safety, Dementia Care, and Safeguarding.

Staff received regular supervision and appraisal processes as well as regular team meetings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Staff displayed a good understanding of capacity and consent and we found the provider had followed the requirements in the DoLS.

Group activities took place regularly, such as in-house entertainment. Likewise, one-to-one time was offered to people by the activities co-ordinator. There was an opportunity to improve the way activities were planned and documented, which the registered manager and clinical manager agreed to pursue. Relatives and people who were able to communicate their preferences confirmed they enjoyed the group activities.

People who used the service, relatives and external professionals we spoke with were complimentary about the registered manager and the team as a whole. We found morale to be high and a strong team ethic in place, with a culture consistently focussed on ensuring people received a high quality of dignified care in place they considered home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people were individually assessed and plans were in place to ensure staff were aware of and could reduce these risks.

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

The administration of medicine was safe and in line with issued by the National Institute for Health and Clinical Excellence (NICE), with clear auditing and oversight of systems in place.

Is the service effective?

Good

The service was effective.

Staff had received a range of training at induction as well as refresher training to keep their knowledge current and to meet the changing needs of people who used the service.

People's medical needs were met by on site nursing staff and through regular liaison with a range of health care services such as dentistry and chiropody.

People with a range of dietary needs received a choice of nutritious meals, which people consistently told us were enjoyable.

Is the service caring?

Outstanding

The service was extremely caring.

People who used the service, relatives and professionals were unanimous in their praise of the dedicated, affectionate and caring attitudes of all members of staff.

Staff had developed meaningful, trusting relationships with people who used the service over a number of years to provide high levels of continuity and contribute to good health outcomes for people.

End of life care planning and support was outstanding and

informed by nationally recognised best practice. People's relatives and professionals confirmed staff supported people at the end of their lives in an extremely compassionate manner.

Is the service responsive?

Good

The service was responsive.

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

There were a range of group activities in place, along with one to one time for people who preferred it.

People's transition to and from the service was well managed and recorded to ensure people's needs were shared at the point of moving from one service to another.

Is the service well-led?

Good

The service was well-led.

The registered manager and clinical manager had successfully developed and maintained a culture that focussed on delivering dignified and personalised care to people who felt at home.

Auditing systems were rigorous and ensured errors were identified and rectified.

The registered manager had achieved accreditation in local and national schemes to provide additional assurance that people's needs were being met by staff who were appropriately skilled and supported.

Moss Cottage Nursing Home

Detailed findings

Background to this inspection

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

We visited the service on 26 and 27 September 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Expert by Experience. An Expert by Experience is a person who has relevant experience of this type of care service. The expert in this case had experience in visiting services for older people and people living with dementia.

We spent time speaking with people and observing interactions between staff and people who used the service. We spoke with four people who used the service and five relatives. We spoke with ten members of staff: the registered manager, the clinical manager, a nurse, four care staff, the activities co-ordinator, the cook and the handyman. We spoke with a visiting Macmillan nurse. Following the inspection we spoke with an external training professional.

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

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

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

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

Good

Is the service safe?

Our findings

One person we spoke with told us, "I feel very safe here – there are never any problems," whilst a relative told us, "I visit regularly but I am confident [Person] is safe when I'm not here." External professionals we spoke with agreed that staff had ensured people who used the service were kept safe through appropriate training and involvement of external agencies where required, for example where there was a concern about someone's wellbeing.

We saw pre-admissions assessments were made to identify the main areas of risk to people. These assessments covered the environment, eating and drinking, breathing, communications and mobilisation and helped the registered manager and clinical manager establish if they were able to meet people's needs. More comprehensive risk assessments and plans were then put in place. We reviewed a range of risk assessments and found them to be up to date and specific to the individual hazards people faced, as well as having regard to people's preferences. For example, where one person was at heightened risk of falls. We saw the risk assessment identified controls in place to help keep the person safer, such as additional checks and equipment. The plan also made clear how to communicate with the person whilst supporting them, stating they, "Do not like a lot of noise." We observed staff supporting this person gently and in a hushed tone, which demonstrated they had regard to the risk assessments in place. Staff we spoke with were aware of the risks faced by people and how they should reduce these risks by following the actions set out in the risk assessments.

During our inspection we observed people to be at ease with care staff and displaying no signs of anxiety. Where one person was anxious we saw staff supported them in line with their assessed needs and ensured these behaviours were de-escalated through gentle distraction.

We saw the storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's medical records contained their photograph, any allergy information and emergency contact details. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. These records were checked by the nurses at the handover of each shift, minimising risks. Controlled drugs were securely stored. Controlled drugs are drugs that are liable to misuse. We reviewed a sample of people's administration records of controlled drugs and found it was accurate and corresponded to the controlled drugs remaining.

With regard to 'when required' medicines such as paracetamol, we found the service had recently introduced specific instructions for each of these medicines to ensure staff administering medicine knew when a person may require these medicines. We found one person's medical records had yet to be updated with this information. This was rectified during our inspection. Staff displayed a good understanding of people's 'when required' medicines and how they would communicate the need for such medicines to staff. Staff received appropriate training to ensure they had the skills required to administer medicines, whilst their competence was regularly assessed.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a

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

Safeguarding training formed part of the induction of new staff and we saw it was discussed at staff supervisions on an ongoing basis. Staff we spoke with displayed a clear understanding of safeguarding and were able to describe the risks of abuse people might face and how they would respond if they felt this was the case.

With regard to bed rails we saw each member of staff was required to sign that they had read the service's policy and we saw anyone using bed rails had been assessed. We saw these assessments were reviewed monthly or more regularly and, where no longer appropriate, the use of bed rails was discontinued.

We found there were sufficient staff on duty to meet the needs of people who used the service, with the registered manager, two nurses, 6 care staff, one receptionist, four domestic staff, the handyman and the cook on duty at the time of our inspection. People who used the service, relatives and staff all told us they felt there were sufficient staff to meet people's needs. One member of staff said, "It can get busy but most of the time we are okay for cover." The consensus of opinion was that there were sufficient staff to meet people's complex needs. Another staff members told us, "Without having two nurses we couldn't provide the levels of care we do – there are a lot of people with very complex needs." External professionals we spoke with confirmed they felt the service had sufficient staff on duty to deliver care safely. The registered manager told us, "We will not compromise on safety and I make sure we have enough staff." We saw they had assessed each person's levels of dependence and staffed the service accordingly; we found staffing levels to meet people's needs and ensure they were safe. This meant people using the service were not put at risk due to understaffing.

We saw appropriate pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw the registered manager had asked for at least two references, proof of ID and had completed interviews with candidates. This meant the service had a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found all areas of the building, including people's bedrooms, bathrooms, kitchens and communal areas to be clean and free from odours. Whilst the last local infection control team audit was in 2013, it had found the service to be, "100% compliant." The registered manager and handyman undertook regular walk-around checks of the service and we saw a maintenance book was used to document any required repairs. One relative commended the attention to cleanliness by staff, stating, "Everything is always clean, for instance I spilled some coffee on the sheets and the staff changed them immediately." Another relative told us, "It's always spotless and I come in at all times."

With regard to the premises we saw Portable Appliance Testing (PAT) and periodic electrical testing had been undertaken, whilst the gas boiler had been serviced. The fire alarm and emergency lighting were tested regularly, with regular fire drills, whilst fire extinguishers had been serviced. One recent member of staff was yet to have fire safety training – this was rectified during our inspection. We saw lifting and hoisting equipment had been regularly tested and service in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Water temperatures were regularly checked to ensure people were not at risk of scalding, whilst a periodic legionella inspection had been undertaken. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

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

We saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. These were easily accessible in a communal area and easy to follow. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

We found people who used the service were supported by staff who had a good awareness of their needs and the training and support required to ensure people experienced healthy outcomes.

One visiting professional said, "They always know the resident really well. They can always give me a proper history." Other external professionals we spoke with confirmed they had confidence in the knowledge and ability of staff at the service. One told us, "The home accepts residents with complex needs and we receive positive feedback about how the home meets these needs."

There was a consensus of positive feedback regarding the ability of staff to communicate with a range of people who were unable to verbally communicate. One person who used the service told us, "The staff are very good and people depend on them. Staff know what people want. The nurses understand each patient even though they can't speak." Another person who used the service said, "Staff know with a nod or a wink – they don't have to shout across the room." One relative told us, "All [Person's] needs have to be interpreted by the staff picking up signals and they are totally dependent on staff. There have been little or no issues with the levels of care – quite the opposite." Another said, "[Person] doesn't speak so staff have to understand their demeanour and facial expressions. Now they know their little ways." Relatives consistently told us they felt staff were equipped to care for people who used the service. This demonstrated people's relatives and professionals alike had a high degree of confidence in the skills and knowledge of staff.

Staff training was well managed and we saw the administrator used a training matrix to track who was due to refresh certain training courses. We saw staff had received a range of training that equipped them to help meet people's needs, including Fire training, Pressure Sores, Moving and Handling, Deprivation of Liberty Safeguards/Mental Capacity Act, Continence Care, Equality and Diversity, Infection Control, Control of Substances Hazardous to Health (COSHH), Health and Safety, Dementia Care, and Safeguarding.

Where people's needs changed we saw staff had been trained so they could continue to provide good levels of care to people. For example, where one person's dietary needs changed we saw staff had been appropriately trained to support percutaneous endoscopic gastrostomy (PEG) feeding. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate.

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

We saw staff sought and adhered to advice from external professionals. For instance, we saw advice from the Speech and Language Therapy team (SALT) had been added into people's dietary care plans and risk assessments.

All people who used the service and relatives we spoke with were complimentary about the food provided by the service. One person said, "It's fresh here – I can tell when it's not. I used to be a cook and I know what I like – I have never had to send anything back but I wouldn't be afraid to." Another person said, "The food is excellent no matter which of the two chefs cooks it. There is always a choice." One relative told us, "The food is fabulous. I had a portion of the home made beef stew a few days ago and it was lovely - just like my mother made." They and others confirmed people could choose something not on the menu if they preferred.

We saw the menu was a four-week rolling format, with choices at each meal. We also saw refreshments and snacks were regularly offered to people who used the service throughout the days of our inspection. Kitchen staff were aware of people who required specialised diets, for example a soft diet or a low sugar diet, and liaised well with nursing staff to ensure they aware of any changes in people's needs. The cooks sought people's menu preferences each day.

People's weights were regularly monitored using the Malnutrition Universal Screening Tool (MUST). This is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw evidence that people who had previously been at risk of malnutrition had successfully put on weight and maintained this.

We found the dining experience to be pleasant, with tables spaciously set out and staff interacting with people in a patient and attentive manner, supporting people who required help.

Through reviewing a range of care files we saw people were supported to access health care services such as GP visits, Speech and Language Therapy (SALT) appointments, dental appointments, hospital reviews and chiropody services. Relatives confirmed people had their health care needs met through prompt liaison with external services. One relative told us, "They needed a dentist despite it being 9pm at night. Staff didn't hesitate and made sure something was done quickly."

We saw evidence of good health outcomes for people. For instance, one person moved to the service with a poor prognosis from the hospital and was unable to mobilise independently. During the inspection we saw them moving with the aid of a walking frame and care records confirmed they had seen significant improvements in their mobility since moving to Moss Cottage. We spoke with this person's relative who told us, "[Person] has come on leaps and bounds. They couldn't lift a cup before and can do a lot more now – they're a different person."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of the principles of the MCA and the importance of DoLS. We saw one instance of a person's capacity assessment

not being documented clearly – the clinical manager rectified this during the inspection. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises we saw it was in a good state of repair, with wide, bright corridors and communal spaces. We saw some bedrooms were en suite and there were ample bathing facilities throughout, with ceiling tracking hoists in place to ensure people could be supported adequately. The building had a spacious lounge/dining room area as well as a separate quiet lounge.

Outstanding ☆

Is the service caring?

Our findings

We received unanimously exceptional feedback from people who used the service, relatives and external health and social care professionals regarding the caring attitudes of staff. One person who used the service said, "I want you to put it down on paper how good they are. I think people should know. They have wonderful relationships with us. I've gotten to know them over a long time and we're close now. They are courteous and treat me with dignity. They are patient. Well, patient isn't the word. They have the patience of a saint in a church." Another person who used the service said, "The staff and management are absolutely superb, so respectful. They are like an extended family and I'm proud to be part of that family."

Whilst we could not speak at length with the majority of people who used the service because of their communicative difficulties, we observed staff interacting with people who used the service, showing affection, sharing jokes where appropriate and exchanging positive gestures and smiles with people who were unable to verbally communicate. Throughout the inspection staff behaved in a caring and patient manner with all people who used the service.

Relatives we spoke with similarly praised staff in superlative terms. One relative told us how they attributed the improvements in their relative's wellbeing to the care given by staff. They said, "They were amazing. They didn't give up on [Person]. They never give up on a person. The hospital thought they would not live long but they have thrived thanks to staff taking care and time and love over them. They take the time needed to make sure people are cared for and the difference is remarkable. [Person] is so happy and content now." Another relative said, "They are absolutely fantastic at supporting people, from the top all the way through the staff. [Person] went into the service with three weeks to live and lived for four years – I put this down to the dedication and compassion of the staff."

Complimentary letters and thank-you cards provided additional feedback consistent in their exceptionally high praise. One letter for example read, "I must commend your staff, at every level, for their friendly attitude and sense of humour, while at all times maintaining the all-important professionalism. The patience shown by [Person's] carers was remarkable." Another stated, "You treated [Person] as if they were a member of your own family, which is all we could ever hope for." This sentiment was corroborated by a range of relatives and people who used the service and was in line with the service's statement of purpose, which stated, "Each service user is treated with respect and that their dignity is preserved at all times, and their right to privacy is observed and that care is planned on an inclusive basis." We found this to be the case and that staff successfully met the Mum's Test by treating people who used the service as they would expect a loved one to be treated. The Mum Test is something CQC inspectors consider and means considering whether they would be happy for someone they love and care for to use a service.

The thank-you card went on, "[Person] was very happy here and died with the same dignity they had all their life. Dignity was shown to [Person] in the last few years here by everyone." We found the service excelled in caring for people at the end of their lives in a sensitive, dignified and inclusive fashion. One visiting healthcare professional stated, "They are so good at end of life care." A number of staff had successfully achieved and maintained Gold Standards Framework (GSF) accreditation. GSF is a nationally recognised

programme providing a framework for improving end of life care. The registered manager had used this resource and knowledge to ensure people could have a dignified end to their life. For example, each person had an end of life care plan and people were supported to discuss their end of life preferences alongside relatives, such as the type of service they would like, any music and what was important to them. One relative told us, "They listened to what was important to [Person] and put it in place. It meant a lot to us to know they respected [Person's] wishes as much as they could. [Person] wanted to be there when they died – they felt safe and they knew the levels of care they were getting."

This relative went on to describe how at Christmas time the registered manager invited back relatives of people who had died to hold a remembrance service. They told us relatives could reminisce about their loved one with the people who knew them well. They stated, "It's an opportunity to celebrate and talk about people we've lost. It's the one place you can go and grieve safely and recollect. They are comfortable about talking about death and dying but always find something, some memory, to lift you. They are fantastic and so supportive." This demonstrated staff successfully and sensitively supported people at the end of their lives, respecting their wishes and the wishes of their families. Staff valued the relationships they made with people who used the service, demonstrating this through their dedication to meeting people's needs and respecting people's preferences up to, including and after death.

One relative told us about how staff had regard to their wellbeing when they visited. They stated, "I walk in Moss Cottage in the morning and it feels like a home. All the staff are supportive of me and the family." They stated how they had felt supported and informed by staff despite their initial anxiety and distress about their relative being in a care home. They stated the reassurances they received from staff contributed to their confidence in leaving their relative at the home and how they were then more able to support their relative when visiting. They stated, "They put me at ease as well as looking after [Person]. I feel as if I am leaving them with lots of friends." This demonstrated that staff recognised the importance of relatives and fully involved them in the planning and delivery of care, taking the time to know and support relatives.

We observed staff knocking on people's doors and waiting for an answer before entering. We asked how the service ensured people's dignity was respected in other ways. The registered manager described regular informal and formal conversations with staff and we saw the topics of dignity and respect being championed in staff supervisions. On the wall in a communal area we saw the registered manager had put up posters regarding what they understood dignity to constitute in a series of statements. The service had also successfully attained accreditation through Tameside and Glossop NHS 'Daisy' accreditation scheme. This meant the service had provided a range of documentary evidence and also been inspected over an afternoon to observe staff interactions with people. The accreditation demonstrated visiting professionals were satisfied that staff at Moss Cottage had embedded dignity and respect into their day to day work. This demonstrated the registered manager had used a range of internal and external tools to ensure a respect for people's dignity was at the forefront of interactions with people who used the service.

Consent was integral to care, with staff asking people who used the service if they would like to move before helping them to mobilise, and explaining all aspects of care to them. Care files contained consent, for example to share personal medical information with healthcare professionals, as well as to open people's mail. This demonstrated the service had regard to the specific decisions people needed to consent to and we saw they sought consent from people or through discussion with people's relatives or other advocates.

All relatives we spoke with confirmed they were made to feel welcome when they visited. One told us, "Staff are always welcoming and I work shifts, so I come at all times. The atmosphere is always the same, always homely." This helped to ensure that people who used the service felt more at home.

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

Relatives and healthcare professionals pointed out the reassuring nature and positive impact of the continuity of care. We saw staff turnover was low and that the service had used agency workers only extremely rarely. One healthcare professional told us, "They value getting to know people and I see the knock-on effect of that. I support one person who has serious memory issues but they have built up a rapport through having the same people care for them. Staff know [Person] and they have trust in staff." This demonstrated the registered manager had successfully achieved and maintained a culture that valued the importance and impact on people of maintaining a continuity of care.

We saw rooms were pleasantly decorated and personalised to people's tastes, for example with their own furniture and photographs. We saw care plans had regard to people's individual needs and preferences, for example one person liked to have their hair done once a week. People with religious beliefs had access to a local priest and nun, whilst the service had regular 'Free Church' services. This meant people from all denominations could enjoy the communal and hymnal aspects if they chose, but also had access to ministers from their own denomination.

We found care plans to contain comprehensive levels of information regarding people's likes, dislikes and personal histories. When we spoke with staff they were able to tell us about people's needs and preferences in detail.

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

We found the registered manager, clinical manager and all members of staff had contributed to establishing an extremely caring culture that had regard to each person's needs and ensured people were included in decisions regarding their care. The compassion and sensitivity displayed by staff members was outstanding.

Good

Is the service responsive?

Our findings

We gathered a range of positive feedback from people who used the service, relatives and external professionals regarding how people's changing healthcare needs were met. This was supported by discussions we had with staff and the documentary evidence we viewed in people's care files. One healthcare professional told us, "They don't ring out of habit or use us as a crutch – they get in touch if they need to." Another external professional told us, "They engage well with stakeholders, communicate well and are stable."

When we reviewed people's care files we saw a range of evidence indicating they had received prompt and responsive care to meet their changing needs, for example through liaison with physiotherapy and the Speech and Language Therapy (SALT) Team. We saw people's care files and the health information therein were regularly reviewed by the nurses to establish whether the current care plans and support in place were sufficient. This ensured care and nursing staff and visiting professionals had the right information about people's needs.

We saw care plans were detailed and written in a person-centred way, focussing on the needs of each individual through a range of assessments and care plans. For instance, where a care plan explained to staff the assistance someone required when mobilising, it went into a good level of detail not only about what physical help they required but how they liked to be spoken to and how staff could provide reassurance. Each contained the person's photograph, keyworker information and a 'This is My Life' document, which contained background information about the person's life. We saw each person's care planning was made with the benefit of access to information from external health and social care professionals, and people's family or advocate. Where staff became aware of visiting relatives who had not seen the person who used the service for fifteen years, they asked them to take away and fill in a 'This is My Life' document to ensure they had the most complete picture of the person's background. This meant staff pro-actively continued to gather information about people's personal histories after they moved into the service.

People were protected against the risk of social isolation by being supported to take part in group activities, through regular contact with family members and advocates and through the visits of external visitors, such as an entertainer, a twice yearly theatre group, Christmas and summer fayres and coffee mornings, as well as a visit from a donkey. This visit, facilitated by a local charity, was celebrated through the display of photographs in communal areas.

We saw the provision of activities for people who used the service was positively received. Feedback from recent service user questionnaires showed that people who used the service were happy with the group activities available. One person who used the service told us, "I enjoy the activities – drawing, making things, watching television, whatever I like. It's our home."

A newsletter was produced by the service to highlight what activities were anticipated over the next few weeks. On relative we spoke with confirmed this was readily available and that they valued this information.

The service employed an activities co-ordinator and we saw them interacting with people who used the service on a one-to-one basis. We reviewed people's care files and saw the 'Activities' record, a daily record of activities undertaken by people, was not always filled in accurately, nor would it provide a meaningful overview of whether the person had enjoyed those particular activities. The clinical manager and registered manager agreed to review this aspect of documentation to make it more effective in terms of helping to identify people's preferred activities.

We saw resident and relative meetings were held intermittently. The registered manager acknowledged they had not been as well attended as they had hoped but would continue arranging them. We were also able to establish that resident and relative feedback was sought outside of this meeting context on a formal and informal basis, through surveys and through one-to-one time with people who used the service. This demonstrated the registered manager found ways to seek feedback from people who used the service and their relatives.

We saw information regarding how to make a complaint was clearly displayed in communal areas. Relatives we spoke with knew how to make a complaint and who to approach, as per the registered provider's policy, although they told us they had no reason to complain. One person who used the service told us, "I have no complaints, none at all, but I would be happy raising things if I needed to."

Relatives confirmed they were regularly involved in people's care reviews and consulted regarding changes to people's needs. One relative said, "Every request was met with good will and no suggestion was ever resented or ignored." Another relative told us, "[Person's] care was always discussed and agreed with myself." Another said, "I get regular updates either on the phone or when I come in." We saw relatives had been involved in updating and reviewing people's care plans.

With regard to the transition between services we received positive feedback. One relative told us, "The transition was a smooth as it could be. Staff took into account [Person] being very withdrawn and were very supportive." We saw there was a 'Return from Hospital' document in place whereby nursing staff would undertake another review of the person's needs at the point they returned from a hospital. The clinical nurse explained that this was to avoid the risks of any changes not being detected or passed on at the point of re-admission and to ensure the persons' changing needs could be met.

Good

Is the service well-led?

Our findings

The registered manager had extensive nursing and social care experience. They demonstrated a comprehensive knowledge of the needs of people who used the service and we observed numerous supportive and affectionate interactions between the registered manager and people who used the service. People who used the service reciprocated this warmth, sharing jokes with the registered manager. One person told us, "[Registered manager] is not just locked up in the office – they are great with me and make sure the others are okay." Another person said, "There is no one like them – can't speak highly enough of them."

Relatives were equally positive about the way the service was lead and managed. One told us. "The manager is approachable. You can go away feeling confident." Another said, "It comes from the top – [registered manager] visited them every day." This demonstrated the registered manager took an interest in the wellbeing of people who used the service on a personal level.

When we spoke with staff they confirmed they received good support from the registered manager and the clinical manager. One member of staff told us, "I love working here and the manager is very supportive." Another said, "The manager is always keeping an eye on things, in a good way." Another member of staff told us about a time they had suffered personal problems and stated they were supported flexibly and with discretion by the registered manager. They said, "They were extremely understanding, both the manager and the area manager."

External professionals we spoke with were complimentary about the registered manager's running of the service. One said, "The management is pro-active and engages well," whilst another said, "It's one of the good ones. It has always been well led in my experience and nothing tends to get missed."

In addition to the Gold Standards Framework (GSF) the registered manager had ensured the service received the Investors in People (IIP) gold standard in 2015. IIP is an internationally recognised framework providing accreditation for a service provider's people management processes. The gold standard achievement demonstrated Moss Cottage had more systems and process in place than required for the standard accreditation and at a recent review visit the service was found to be on course to maintain the gold standard. We spoke with the external assessor who told us, "[Registered manager] is committed to ensure staff have the competence to help people. The manager has a range of business skills but they're focussed into people's care." This demonstrated the service used external accreditation schemes to ensure it equipped staff to have the skills to meet people's needs.

One of the areas of strength identified in the IIP review visit was the stable workforce and low turnover of staff. We found this to be the case, with a number of staff having worked at the service for a number of years. The registered manager acknowledged they had had to use agency staff on occasion recently, but that this was a rare occurrence. We found staff morale to be high. One established member of staff told us, "It's a great team," whilst a newer member of staff said, "I was made to feel welcome," and we found staff we observed to work and communicate well together to meet the needs of people who used the service. Non-

care staff demonstrated a good understanding of people's care needs when interacting with other staff and relatives. This demonstrated there was a strong team ethic, good teamwork and a consistent focus on people using the service.

Staff confirmed they received a good level of vocational support from the registered manager, with one person telling us how the registered manager supported them to achieve an external qualification. Staff also confirmed they received good personal and emotional support, for instance if on returning to work having been off sick.

Quality assurance processes were appropriately planned with adequate resources in place. The clinical manager was allotted supernumerary time to undertake a range of audits on a monthly basis, including medicines audits, care plans, infection control and kitchen audits. We saw these checks were used to ensure all aspects of the service underwent a good degree of scrutiny. We saw any errors or inconsistencies were addressed, for example an incorrect recording of paracetamol on one medicines audit was rectified and staff underwent supervisions to ensure the error was not repeated.

We saw the registered manager undertook regular 'walkarounds' of the service to ensure the environment was clean and free from hazards. Whilst this specific 'walkaround' was not recorded we saw the handyman also conducted such checks and the maintenance book evidenced regular improvements being made.

The registered manager built and maintained strong working relationships with commissioning and other sector professionals by attending the provider forum and Clinical Commissioning Group meetings to discuss any concerns and share best practice. We saw the registered manager had also volunteered to represent nursing homes in the Tameside area at a meeting to discuss the impact of digital technology on the future provision of health and social care. Whilst this meeting had not yet taken place this demonstrated the registered manager was responsive to the possibilities new technologies and new models of care could bring to adult social care and was keen to actively contribute to these developments.

We found the registered manager had ensured the service remained part of the wider community, for example through inviting entertainers and other visitors to the service, arranging coffee mornings, Halloween events and visitors from a range of Christian denominations.

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

The registered manager and staff had a clear shared vision of the dignified and personalised care they wanted to continue delivering to people who used the service, in line with the statement of purpose. We found the registered manager and clinical manager had successfully established and maintained a culture that was focussed on providing compassionate and dignified care to people who felt at home.