Mariposa Care Limited

Roseway House

Inspection report

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06 August 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

We carried out an unannounced inspection of Roseway House on 31 July 2018 and 06 August 2018. This was the first rating inspection of the home since it was registered with the Care Quality Commission (CQC) in August 2017.

Roseway House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates people in one adapted building over two floors and on the date of this inspection there were 42 people living at the home, some who of whom were living with dementia.

The service had a manager who had been in post since April 2018. They were currently in the process of becoming registered with the Commission as a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had comprehensive safeguarding policies and procedures to help keep people safe. People at the home told us they felt safe living there and relatives agreed with these comments. The manager escalated all safeguarding concerns to the local authority and staff received training about safeguarding vulnerable adults. Accidents and incidents were recorded correctly, and investigated. If any further actions were required, they were acted upon and documented. Lessons learned from investigations were recorded and shared with staff, relatives and people.

Staff at the home were safely recruited and received induction training as part of their role. The manager ensured staff had access to on-going training to further develop their skills and knowledge. Staff received supervisions and appraisals from the manager and the frequency of these were in line with the provider's staff supervision policy. There were enough staff to support people safely. Staff attended regular staff meetings with the manager.

The premises were safe for people living at the home. There were regular checks of the premises, equipment and utilities. These were all documented and regularly audited by the manager. Infection control policies were followed by staff. We saw regular cleaning of the home during our inspection.

Medicines were managed safely. Protocols and procedures were in place to ensure the safe receipt, storage, administration and disposal of medicines. There was documented involvement from other health care professionals, for example GPs and dieticians, in people's care records.

People had access to a variety of food and drink. People were supported to maintain a balanced diet and they told us they were offered refreshments throughout the day. On the first day of inspection we observed

that staff were not suitably deployed at lunch time to support people. The manager acted upon this and on the second day of inspection there were enough staff present to fully support people with their meals. There were pictorial menus available for people to help them choose what they would like to eat.

The premises were suitable for the needs of people living with dementia. People were encouraged to have personalised bedroom. There was pictorial signage throughout the home to help people orientate themselves. The manager told us they were focusing on developing the use of pictorial signage for menus and information boards.

People told us they had access to wide range of activities and we saw records detailing activities people had attended. These activities were developed with people to make sure they could be fully engaged and they were meaningful to them.

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

People had personalised care plans and risk assessments. These were created in partnership with people, their relatives and professionals. These plans were developed from detailed initial assessments of people's needs and were regularly reviewed. Care records were accurate and up-to-date.

People had access to Independent Mental Capacity Advocates (IMCAs) and independent advocacy services if they wished to receive support. Information related to such services was on display in the home along with easy read safeguarding and complaints information.

We observed kind and caring interactions between people, staff and visitors. Staff were aware of what people liked and disliked and knew people well. People were treated with dignity and respect by staff.

The manager had a comprehensive governance framework in place which was in partnership with the provider. This framework ensured the quality and safety of the service provided to people. The manager and provider had a clear vision to improve the quality of people's lives and the care they received.

There were regular meetings with people and relatives to discuss any issues and receive feedback about the home. The provider carried out feedback questionnaires with people, relatives, staff and visitors to help continually improve the service. There was a complaints procedure in place which was used by the service to learn and improve the quality of care provided to people.

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 managed safely.

The premises were safe. Risks identified were assessed, mitigated and reviewed regularly.

People received care from staff who were aware of safeguarding procedures.

There were suitable staffing levels to meet people's needs.

Is the service effective?

Good

The service was effective.

People received care from staff trained to an appropriate level to support their individual needs in line with best practice, national guidelines and the Mental Capacity Act (2005).

People were supported to eat and drink to maintain a balanced diet.

Consent was sought before staff provided care or support to people.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

Staff promoted dignity and respected people's privacy.

People and their relatives were involved with planning their care.

Is the service responsive?

Good

The service was responsive.

People had access to and enjoyed a wide range of meaningful

social activities.

People received personalised care which met their individual needs and was regularly reviewed. People were supported with end of life care.

There was a robust complaints procedure in place which was used by the service to learn and continuously improve.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was in the process of becoming the registered manager. The manager was aware of their role and responsibilities.

There was a robust governance framework in place to monitor the quality of the service and rectify any issues identified.

The manager and provider had a clear vision, strategy and plan to deliver personalised care.

Roseway House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory 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 31 July 2018 and 06 August 2018 and was unannounced on the first day of inspection. The second day was announced. The inspection was carried out by two adult social care inspectors, one adult social care assistant inspector and a specialist advisor. The specialist advisor was a registered nurse.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events, which the provider is required to send to us by law.

During the inspection, we spoke with seven people who lived at the home, one visiting nurse practitioner, nine relatives and ten members of staff including the manager, administrator, one regional activities co-ordinator, the deputy manager, one nurse, one senior care assistant, a laundry assistant, a domestic assistant, and three care assistants. We reviewed the care records for five people living at the home and the recruitment records for four members of staff.

We looked at quality assurance audits, as well as a range of records relating to the management and safety of the home. We spent time with some people who lived in the home and observed how staff supported them. 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.

Good

Is the service safe?

Our findings

People, their relatives and staff told us Roseway House was a safe place to live. A relative told us, "[Relative] is safe here." One person's relative said, "It's (the home) clean and secure." Another relative commented, "I can leave here and be confident that dad is safe and happy." A member of staff said, "I feel people are safe living here."

The premises were safe, clear from clutter and we observed regular cleaning throughout both days of inspection. There were regular health and safety checks of the premises and equipment including firefighting equipment, portable appliance testing (PAT), bed rails and call bells. These were all audited monthly by the manager and recorded. Any issues identified were added to the home's overarching action plan, which was created in partnership with the provider, and actioned. All risks were fully identified, assessed and mitigated. People's personalised risk assessments were completed in partnership with people, relatives and health professionals. The home had a valid electrical installation safety inspection certificate.

There were risk assessments for the control of substances hazardous to health (COSHH). These included protocols and data information sheets for every product used at the home. There was a newly reviewed infection control policy in place and cleaning audits. Staff followed infection control procedures and used personal protective equipment (PPE) whilst supporting people.

The home was currently looking to recruit a chef however a member of the kitchen staff was seconded to this role. The kitchen was clean and tidy. Cleaning schedules were in place and staff observed relevant hygiene practices when preparing food. The home had recently received a food standards inspection by the local authority. The home achieved a rating of 5 which was rated as 'Very Good' in respect of food storage, preparation and hygiene.

The home had a business continuity plan in place which detailed what action should be taken in case of emergency or if something unexpected happened. There was a fire risk assessment in place at the home and this was used to develop people's personal emergency evacuation plans (PEEPs). A PEEP is an individual evacuation plan for a person who may not be able to reach an area of safety unaided or in a safe amount of time in an emergency situation. We reviewed the PEEPs for the service and these did not clearly specify the number of staff required to support people in an emergency and were very generic. The plans did not clearly detail how and what kind of support people needed to be safely moved. We discussed this with the administrator at the home who began to review and amend these immediately.

There were safeguarding policies and procedures in place to protect vulnerable adults. These were available for people, staff and visitors and in an easy read format if required. There was also information about the local authority safeguarding team and the Care Quality Commission (CQC) available to people should they wish to consult with either of these organisations. Staff had received training in safeguarding and whistleblowing. Staff were knowledgeable about what to do if they needed to raise a concern. One member of staff told us, "I have had safeguarding training and I am aware of the procedure for reporting concerns." Another staff member said, "I can recognise the signs of abuse and have reported it in other places I have

worked."

Accidents and incidents were recorded accurately. These were all investigated fully, any actions required were documented and lessons learned shared with people and staff.

Staff recruitment procedures were robust. Staff personnel files contained relevant information including personal details, references, proof of ID as well as Disclosure and Barring (DBS) checks. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. Nurses were employed at the home and their registration details with the Nursing and Midwifery Council (NMC) had been checked to ensure they remained validated and registered to work as a nurse in the UK. We noted on the first day of inspection that one nurse's NMC registration expired on that day, however we were assured that the renewal was in progress.

Roseway House had sufficient numbers of staff to support people. We were made aware there had been a high turnover of staff in recent months. The provider ensured us that agency staff were sought to cover where required. The manager completed a monthly dependency audit to ensure the staffing levels were consistent with the needs of people using the service. When speaking with staff and visitors we were told that more staff would be appreciated. One staff member said, "The extra pair of hands would help us ensure our care is more person centred."

We identified on the first day of inspection, during lunch time observations, that some extra staff would be beneficial. There were occasions where staff were not present for some time in the dining room while assisting people eating in their rooms or, where people required assistance with personal care. The lack of staff presence in the dining area posed a potential risk should a resident have an accident or choke on food. We discussed this with the manager during the inspection. The manager arranged for additional staff to support in the dining room to make sure people were safely supported with their meals.

Medicines were managed safely. Medicines were securely stored in two locked treatment rooms and were transported to people in locked trolleys when they were needed. Medicine stocks were recorded when medicines were received into the home. This meant accurate records of stocks of medicines were available and nursing staff could monitor when further medication was required.

Medicines were given from the container they were supplied in and we observed staff explained to people what medicine they were taking and why. People's medicine support needs were accurately recorded in their care records and the medicine administration records (MARs) showed staff recorded when people received their medicines. Entries had been initialled by staff to show they had been administered. Protocols were in place to administer 'as required' medicines. 'As required' medicines are only needed for a specific situation, for example allergies, and are not prescribed as daily medication. The protocols assisted staff by providing clear guidance on when 'as required' medicines should be administered.

Good

Is the service effective?

Our findings

People living at Roseway House received treatment and support which was delivered in line with current national best practice standards and guidance, such as National Institute for Health and care Excellence (NICE) and the Mental Capacity Act 2005 (MCA).

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, for example, because of permanent or temporary problems such as mental illness, brain impairment or a learning disability. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). For the five people whose records we reviewed applications had been submitted to the 'supervisory body' within the local authority for authorisation to restrict their liberty, as it had been assessed that this was in their best interests to do so.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment. For example, for bed rails and life changing choices about serious medical treatment or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. Staff confirmed they had received training about working within the principles of MCA and could explain how the home supported people to make decisions One staff member told us about decisions for people's own wishes for end of life care. People, relatives, staff and other professionals were involved in the planning for this and people were able to make their wishes known and these were recorded.

Staff asked for consent before entering bedrooms or supporting people. One member of staff said, "[Person] can I help you with that?" Another staff member said whilst knocking on a bedroom door, "Is it okay to come in and help you?"

We reviewed the training matrix for the home. This detailed what courses staff had attended, identified knowledge gaps and due dates for refresher training. Staff we spoke with confirmed they received regular training to maintain their knowledge and skills in order to deliver care appropriately and safely. New staff we spoke with confirmed they completed mandatory training as part of their induction which reflected the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective and compassionate care.

The manager reviewed the training requirements of staff and identified any knowledge gaps or refresher

training needs. A member of staff told us, "I have done lots of training and have NVQ's." Staff received regular supervisions and appraisals in line with the provider's supervision policy. Supervisions covered duty of candour, safeguarding, wellbeing, training needs and policies.

People's care records showed details of reviews, referrals and appointments with other professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GPs, psychiatrists, specialist nurses, best interest assessors, dietitians and opticians. During the second day of inspection we spoke to a visiting nurse practitioner who regularly attended the home. They were working with staff to review emergency health care plans (EHCPs) for people. They told us that they worked in partnership with staff and people to develop the plans and regularly reviewed these. Care plans reflected the advice and guidance provided by other agencies.

Recognised assessment tools were used to help staff identify potential risks to people's safety. For example, the risk of developing pressure sores. Assessments were regularly reviewed and updated to ensure they reflected people's current level of risk. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin.

Some people received support with nutrition and hydration. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. Staff monitored some people's food and fluid intake to minimise their risk and recorded this on a chart which the nursing staff checked and evaluated in order to decide if further action should be taken. For example, referral to a GP, dietitian or speech and language therapist. One relative told us, "Staff were responsive when dad lost some weight, staff referred him to a dietician and now he is on track."

Kitchen staff had a good understanding of people's dietary requirements. People who had been identified as having difficulties with swallowing or at risk of poor nutrition were given soft foods and, where required, fortified foods. Staff had recently attended food texture training to help create meals which were suitable for people on soft diets. One person using the service had a gluten intolerance and the home ensured gluten free products were sourced to meet the person's needs.

People were provided with a choice of meals. We observed people asking for other meals that were not on the menu. Staff respected people's choices and arranged for these meals to be prepared for them. Staff knew what people liked and disliked. One member of staff asked a person, "Do you want me to get you a cheese sandwich instead? I know you love a ham sandwich but there's none at the moment but you like cheese too." One person told us, "I like the food sometimes and get to choose food." Another person said, "I am able to get food and a drink when I want", and "The food is beautiful."

The home had a 'dementia friendly' environment, particularly on the first floor. There were contrasting coloured doors and handrails as well as walls being decorated. The home had created its own bar called the 'Hudson's Bar'. Staff said the room was used regularly for special occasions and parties where residents could celebrate with their families. People's bedrooms were personalised with memorabilia items to help stimulate conversations. There was pictorial signage on bathrooms and toilets. Pictorial signage and menus help people visualise the planned meals, if they are no longer able to understand the written word. The manager told us that they were working on developing their pictorial usage throughout the home. The corridors and doorways were wide enough to allow for wheelchair access.

Good

Is the service caring?

Our findings

During both days of inspection at Roseway House, we observed staff continually demonstrating kindness, respect and compassion towards people using the service. Staff were always caring in their approach and took time to obtain consent before providing assistance. Care plans documented people's and their relative's involvement in their care planning. Consent was sought and there were signatures to record all parties involved in people's care. One relative said, "I am involved in meetings about Mum's care." Initial assessments were carried out with people where they were able to contribute to this process, so that the service could fulfil their own personal needs. These were all documented and included health, sleep, social and spiritual needs.

Equality and diversity policies were in place to ensure that people were treated with dignity and respect regardless of the sex, race, age, disability or religious belief. The staff made sure that people's dignity was integral to everything they did to support people. The manager and staff worked with people and their relatives to help increase people's confidence, maximise independence, choice and control where possible.

Some people had an interest in and continued to follow their chosen faith. The manager told us, "The ladies come from St Bede's (Catholic Church). They come in to visit and chat with people. It's like a befriending service. They also told us about likes they had with a pastor from the local Baptist Church and a priest from the local Church of England would visit people as and when requested. The regional lifestyle coordinator told us a person who used to live in the home, "was a Mormon and it was important to them for me to read a passage out of the bible to them every morning." The manager assured us they would support people to continue to follow their chosen religion or faith and would seek support from other religious bodies as and when required.

One person we spoke with said "I love the staff, everyone is nice". Another person said, "I am well looked after and the lasses are great." One relative we spoke with was recommended Roseway House by a friend and said, "Mum is safe here, there is a good atmosphere and lots of activities." All of the carers are very good and mum gets what she needs, they do a great job". Another relative told us, "The carers are very good and look after mum."

Staff had a good understanding of people and their needs. Staff were very busy supporting three to four people at times, however they were always calm and took time to speak with people as much as possible. We spoke with a number of people living at Roseway House as well as their family members and all were highly complementary about the care. Staff encouraged people to be independent and positively supported people with dignity and in the least restrictive way possible. We observed one member of staff encouraging one person to make their own drink. A relative told us, "They really do their best to tailor care to the needs of people."

People communicated their wishes to staff in different ways, for example, via pictures, phrases and gestures. People with communication needs had care plans to guide staff about how best to communicate with them and what different gestures they made may mean. The regional lifestyle co-ordinator said, "[Person] has a

communication book, pictures and phrases. We also have a board that he can write on or staff can use if there isn't a suitable picture or phrase already available to use."

During lunch observations staff were professional and approachable. Deployment of staff at lunch time was an issue initially and the manager asked additional staff to support people. It was noted that nothing was an issue for staff. They took their time to support people to eat at their own pace and engaged with people. There was a positive and friendly atmosphere for people and it was evident that staff were passionate about their role and impact they had on people. A member of staff told us, "We all really care and are passionate about what we do." Another staff member commented, "The people here are always my priority and I do all I can to give them the best I can."

During the inspection many visitors commented on how good staff were. Staff were responsive and felt reassured they were doing a good job. Many relatives commented on specific staff and how satisfied they were. One relative told us, "The team can't do enough. Nothing is a bother for them."

The manager was working with the provider to make sure that everyone living at Roseway House had a good and enjoyable quality of life. This included working closely with the regional activities co-ordinator to allow people to access meaningful activities and opportunities that were beneficial to them.

There was information, advice and guidance displayed around the home which was of benefit to people and their families such as local safeguarding contact information and leaflets on dementia care, advocacy services and advice on relevant topics of interest. At the time of inspection people were actively receiving support from advocacy services. Advocates help to ensure that people's views and preferences are heard.

Good

Is the service responsive?

Our findings

Roseway House provided personalised care for people. Care plans were developed from initial assessments of people's needs, including personal hygiene, diet, sleep and social interests. The care plans contained specific detail to instruct staff about how to support people. Care plans were reviewed monthly or more frequently if people's needs changed. Care plans included sections on people's social, sexual, cultural/religious and emotional needs, as well as their physical needs.

People's care plans had been written in a person-centred way. Person-centred care planning is a way of helping someone to plan their care and support, focusing on what is important to the person. Records showed that people and their relatives had been involved in their care planning and reviews. There was also recorded involvement from other professionals, for example GPs.

People's care records contained information about relationships that were important to them. Staff supported people to maintain these relationships. During the inspection we observed people receiving visits from relatives who were greeted by staff upon arrival. The manager told us about one person and said, "Her son lives in America so [regional lifestyle co-ordinator] set up for him to send over letters and emails. When [person] feels a little anxious we'll get her letters out and sit and read them to her." They went on to tell us this had a positive impact on the person and helped to calm them. The regional lifestyle co-ordinator told us about another person who was unable to attend their grandchild's wedding as it was too far for them to travel. They said, "We set up a facetime so she was able to be part of the day. She was so happy."

The service also organised a weekly playgroup in the home which took place every Thursday in the ground floor lounge. Children visited from a local playgroup named Rosebuds as well as young relatives and spent time with people. The regional lifestyle co-ordinator said, "They'll sit and play with play dough and things with the residents. The residents really enjoy it." They went on to tell us about one person who had benefitted from attending the playgroup with their grandchild and they had seen a positive impact. They said, "[Person] was one of the first to start attending. We pin pointed [person] as his granddaughter only saw him upstairs in the lounge. There was a big reaction with [person]. He would get stimulated over the hour and a half to the point you could hold a conversation with him."

The provider had a regional lifestyle co-ordinator who was predominantly based in the home and worked part time as the life style co-ordinator at the service. The home also employed an additional lifestyle co-ordinator who also worked part time in the service. They organised a programme of activities for people to enjoy in the home both on a one to one basis and in groups. The regional lifestyle co-ordinator said, "It's about knowing them (people), who they are and what they are interested in. Also, we try to pinpoint the ones who are at risk of social isolation. We tailor activities to people's needs and wants."

The regional lifestyle co-ordinator said, "We have a traditional market stall where we sell sweets, toiletries etc. We do it at least once a week." They went on to tell us they do this to promote people's independence in the home. During the inspection we observed people visiting the market stall, which was set up in the reception area, with and without staff support, to purchase toiletries, sweets and snacks. People also

enjoyed activities such as singing and a visit from the hairdresser. Activity planners showed the service had external visitors to entertain people such as magicians, singers and an organisation with different insects. They also arranged reminiscence activities for people. For example, an ice cream van visits the home every week as people really liked ice cream.

The provider had redecorated and redesigned specific rooms in the service to try and benefit people living in the home. One room had been converted into a pub style room named 'Hudson's bar'. The regional lifestyle co-ordinator said, "There are bar games at the moment as we are building it up. We're going to hire bar maids for the pub every Friday afternoon so they (people) can go to the pub and have a pint and a pub lunch."

People were also supported to access the local community and take part in community based activities. The regional lifestyle co-ordinator told us, "We're the first care home to do the South Tyneside parade. All of the craft based activities we were doing were geared towards making things for the parade such as costumes." They went on to tell us six people took part along with 10 children from Rosebuds, staff, friends and family. They said, "It was a lovely day and everyone enjoyed it. After the walk we had a picnic in the park."

The regional lifestyle co-ordinator also told us about links and activities individual people enjoyed in the local community and how these had been organised to meet their individual interests and needs. They said, "I base things around lifestyle and try to recreate things from people's lives." One person attended a rugby club, another person had strong links with a local military group who were arranging an event in honour of the person for the 100-year anniversary of the Royal Air Force. The regional lifestyle co-ordinator was in the process of organising for a person to attend rehearsals with a local theatre group as they used to perform and had expressed a desire to do this again. Other community activities included shopping trips, walks in the park, outings to the beach and visits to local museums.

People had activity plans in place that were revised when required. The regional lifestyle co-ordinator said, "There's a lot of people who'll tell you what they want to be doing on a daily basis." These were evaluated with people where possible. The regional lifestyle co-ordinator completed diary sheets for people following an activity as well as quarterly evaluations to "pinpoint a decline in engagement, cognition or ability" of people. They said, "If there's a particular drop off in engagement and we don't know why, I'll investigate and implement an action plan."

The provider had a complaints procedure in place which detailed different stages of complaints and how different complaints would be dealt with and escalated if not resolved. People were provided with a copy of this when they first moved into the service and a copy of the procedure was on display in the home, this also included an easy read format. There was also a copy of the complaints procedure in 'easy read' format on display in the home. A relative told us, "The manager deals with any concerns straight away." The manager maintained a log of all complaints received about the service. Records showed the home had received seven complaints so far in 2018. All complaints were investigated and actioned in accordance with the provider's complaints procedure. Any actions identified were completed. The manager told us, "I also monitor complaints monthly and assess them for any trends." At the time of the inspection there were no trends identified. The manager sought feedback from people about the quality of care received. This included annual surveys to relatives.

At the time of our inspection staff were delivering end of life care to some people. We saw in care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. The care plan detailed where the person would like to stay and there were records of relative involvement. Staff told us

they had received training in end of life care and records confirmed this.

Good

Is the service well-led?

Our findings

At the time of the inspection the service did not have a registered manager. The previous manager had de-registered with the Care Quality Commission (CQC) on 10 July 2018. The new manager had been in post since April 2018 and was currently going through the registration process. A registered manager is a person who has registered with the CQC to manage the service. The manager clearly understood their responsibilities in line with the registration requirements of the service, and they had submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The atmosphere in the home was relaxed, friendly and welcoming. We observed staff interacting with visitors to the home. A relative told us, "Staff care and are so friendly. Everyone speaks and everyone is approachable." Another relative commented, "Great first impressions, everyone is just lovely and you are made to feel welcome." A compliment the service received from relatives of a person who used to use the service stated, "Us, as a family have been made very welcome."

The manager operated an 'open door' policy. They told us they spent time on the floor around the home to make sure there was a management presence and people could approach them if they wanted to. They said, "It's very open door. I like to keep my door open. I also like to be known and think it's very important to be out on the floor." They went on to tell us, "I'll sit and talk to people and make sure they're okay and that their nails have been cut and cleaned. I'm hands on." During the inspection we observed staff, people and relatives approaching the manager in different areas around the home. A member of staff told us, "Support from everyone is really good and the new manager is fantastic. I am supported by the manager." A relative told us, "The manager and administrator are really approachable."

The manager assisted us with the inspection. Records and documents we requested were produced promptly and we were able to access care and staff records as required. Throughout our inspection we found the manager, administrator and care staff to be open, approachable and forthcoming when we spoke with them.

A range of staff and management meetings regularly took place in the home to discuss the quality and safety of service provision. We reviewed minutes of meetings which showed discussions included changes in the home and management, records regarding people, lifestyle support, equipment in the home, menus, support available to staff, training, incidents, lessons learned and best practice. Any required actions were included within the minutes and revisited during the meeting that followed.

The manager and senior staff completed regular audits around the quality and safety of the service. These included medicines management, catering, care plans, falls, safeguarding concerns, complaints, premises and fire safety. All findings were recorded as well as any identified actions and trends. For example, a trend was identified regarding a specific time of day and night when the majority of falls had occurred. Action taken included implementing an additional nightshift worker and securing one to one support for two people who were assessed as being at high risk of falls.

The findings from the manager's audits fed into regional audits. An improvement action plan was produced by the regional manager based on their findings from the audits. The manager worked through the improvement action plan and it was reviewed during the next monthly audit.

The service worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. The manager kept up-to-date with relevant changes, and had effective systems in place to cascade the information to all staff.

People and their relatives were involved in planning and developing the service through regular resident's and relative meetings. Minutes of meetings included discussions around changes within the home, the new manager, the atmosphere in the home, activities and developments in and outside of the home including the Hudson's bar, creating a new barber's, and developing the garden area.

The manager informed us they would be sending questionnaires out to people and relatives six months after their start date with the service. This was to enable them to gather people's views on the changes and developments they had put in place since being in post. In the meantime, they informed us that they gathered the views of people and relatives through the resident's and relative's meetings as well as reviews they received about the service.

The regional lifestyle co-ordinator created a monthly newsletter about the service which included information about activities and improvements to the home. This was displayed around the home and a copy was sent to every person's relative, to keep them updated.

The service had received a number of 'thank you' cards and letters from relatives of people who used the service. Comments included, "Thank you so much for the care you have provided to [family member]. God bless you all", "Staff have always shown care and kindness, even some love", "Thank you for all the kindness, support and care you have given to [family member]", "They (staff) were all professional and conscientious but they really cared", Staff "were all remarkable", "They treated the residents like members of their own family," and "Absolutely amazing home, my [family member] has gone from strength to strength."

Providers are by law required to display their most recent quality rating in the home and on any website associated with the home. We saw the most recent rating was available on the home's notice boards and highlighted on the provider's website page related to the home. This meant people and relatives had information on the quality of the home and the care being provided.