T.L. Care Limited

Gables Care Home

Inspection report

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Date of inspection visit:
25 January 2016
26 January 2016

Date of publication:
30 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 January 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected in 2013, and at that time was meeting the regulations we inspected.

Gables Care Home is a purpose built 64 bedded service. It provides nursing and personal care for older people, including people living with dementia. There are four units within the service, set out over both floors. At the time of the inspection 56 people were using the service.

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

Medicines were not always managed in a safe way. Medicine records were not always completed fully, and care plans for people using 'when required' medicines contained limited detail. We made a recommendation about medicines management

Risks to people arising from their health and support needs or the premises were assessed, and plans were in place to minimise them. A number of checks were carried out to monitor the safety of the premises.

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

Robust recruitment procedures were in place to ensure that only suitable staff were employed.

Needs of people were assessed on a regular basis to ensure that staffing levels were sufficient to support people safely.

Staff received training to ensure that they could appropriately support people, and the service was starting to use the Care Certificate as the framework for its training.

Staff received support through supervisions and appraisals, though we did not see any records of these.

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

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for.

The service worked with external professionals to support and maintain people's health. Care plans contained evidence of regular involvement in delivering people's care by external professionals.

Staff treated people with dignity, respect and kindness. People and their relatives spoke highly of the care they received. Staff knew how to adapt their communication to have meaningful engagements with people.

The service provided people with information on advocacy services

Care was planned and delivered in way that responded to people's assessed needs, including any specialist needs they had. Care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to care plans where needed.

People had access to a wide range of activities, internally and in the wider community.

The service had a clear complaints policy that was applied when issues arose. There was evidence of investigation of complaints and outcomes were documented.

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

The manager and provider carried out regular checks to monitor and improve the quality of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicine records were not always completed fully and with enough information to support people with their medicines. We made a recommendation about medicines management.

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

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

People were supported by staff who had been appropriately recruited and inducted.

Is the service effective?

Good

The service was effective.

Staff received training to ensure that they could appropriately support people. We were told staff received support through supervisions and appraisals, however we did not see recent records of what took place at these.

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

People were supported to maintain a healthy diet.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

People and their relatives spoke highly of the care they received. Staff knew how to adapt their communication to have meaningful engagements with people.

The service provided people with information on advocacy services.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered in way that responded to people's assessed needs, including any specialist needs people had.

People had access to a wide range of activities.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Good

The service was well-led.

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

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

The manager and provider carried out regular checks to monitor and improve the quality of the service.

Gables Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 January 2016 and was unannounced. This meant that the registered provider did not know we would be visiting. The service was last inspected in 2013, and at that time was meeting the regulations we inspected. At the time of the inspection 56 people were using the service, some of whom were living with dementia.

The inspection team consisted of one adult social care inspector, a specialist professional advisor (SPA) in this case a nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The registered provider completed a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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

During the inspection we spoke with seven people who lived at the service and six relatives. We looked at four care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with 10 members of staff, including the manager, the deputy manager, nurses, senior carers and care and ancillary staff. We looked at five staff files, including recruitment records.

We also completed observations around the service, in communal areas and in people's rooms with their permission. We also undertook observations using the Short Observational Framework for Inspection (SOFI). SOFI is tool that is used to measure people's experiences of care when they have difficulties in communicating.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I feel safe here." Another said, "I feel safe. I have been here a long time." Relatives said that people were safe at the service. One said, "If I don't come for a few days I don't worry, I know [the person] is safe." Another relative said, "Oh it's nice to know [the person] is safe." A third said, "I have never seen anything to bother me and I have been coming a long time."

We looked at the way medicines were managed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. Controlled drugs are medicines that are liable to misuse. Systems were in place to ensure that the medicines had been ordered, stored and administered appropriately. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys for the treatment room. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We saw staff explain to people what medicine they were taking and why. People were offered a drink of water and the nurse checked that all medicines were taken. The MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. Fridge temperatures were monitored and recorded together with room temperature. We saw a twice daily count of controlled drugs signed for by nursing staff. Medicines were stored safely and securely.

One person received their medicines covertly. The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example mixed with food or drink. There was a letter in place from the GP authorising covert medicines for the person, but there was no evidence that a best interest meeting had taken place involving the GP, the pharmacist, staff from the service and the person's family to consider whether covert administration was in the best interests of the person. We recommend that the service reviews and adopts the National Institute for Health and Care Excellence (NICE) guidelines on covert medicines.

We saw written guidance kept with the MAR charts, for the use of "when required" (PRN) medicines. However, we saw limited detail on the PRN care plans related to when medicines should be given and one person who should have had a PRN care plan for two of their medicines did not have one. The manager told us that all PRN care plans would be reviewed. We also saw inconsistent transcription and completion of topical medicines application records to show the topical preparations people were prescribed, including the instructions for use and the associated body maps. In addition, the associated MAR chart for one person was not signed. The manager said this would be remedied immediately.

Risks to people were assessed and steps were taken to minimise them. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and

action taken to reduce the risks and keep people safe. Standard supporting tools such as the Braden Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments. Risk assessments were reviewed on a monthly basis to ensure that they reflected people's latest support needs. These meant that procedures were in place to monitor and address risks to people.

Risks to people arising from the premises and environment were also monitored. Environmental and fire risk assessments had been undertaken, and where remedial action had been identified as required the manager told us it had been taken. Maintenance staff carried out monthly checks of the premises and equipment, including water temperatures, emergency lighting, window restraints, wheelchairs and profiling beds. Required certificates in areas such as electrical testing, fire alarms gas safety and legionella were up to date. Throughout the inspection we saw ancillary staff cleaning communal and bathroom areas, and observed all staff ensuring that such areas were free of clutter and other trip hazards. Where staff supported people who used mobility aids, this was done at an appropriate and safe pace. We saw that staff used personal protective equipment such as gloves and aprons where appropriate to assist with infection control, and there were stocks of these readily available.

Accidents and incidents were recorded, and these included details of where and when they occurred so that any patterns could be spotted and remedial action taken. The manager said, "Every month I carry out an accident review, including lessons learned." They told us the aim of this was to minimise the chances of accidents occurring. This meant that potential risks to people's safety in the premises were assessed, managed and reviewed.

There were plans in place to provide a continuity of care in emergency situations. Each person had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. Each person's PEEP contained an overview of their support and mobility needs, and then details of how they needed to be supported in emergency situations. However, we saw that some people's PEEPs were not stored in the folder for unit they lived on which meant it was not always easy to locate the necessary information. When we asked the manager and area manager about this they said the administrator would organise the PEEPs correctly. We also asked about how the service planned to provide care in the event of an emergency requiring the building to close for a period of time. We were told that arrangements were in place with other services to provide a continuity of care.

Staff understood safeguarding issues and the types of abuse that might occur in care settings, and procedures were in place to deal with them effectively. The manager said, "I always phone up [the local authority safeguarding team] for advice." There was a safeguarding policy in place, though we noted that it was a generic policy and there were several sections that had not been completed to make it directly relevant to the service. Staff were able to describe the types of abuse they looked out for and what they would do if they had any concerns. One said, "I am very familiar with safeguarding issues. We look out for any forms of abuse, such as physical or verbal. If I saw something I wasn't happy with I would report it to my line manager, and I am confident they would take it further." Another member of staff said, "I look out for physical and emotional abuse. I would definitely whistle blow, without a doubt." Where incidents had occurred, there was evidence that they had been investigated and remedial action taken. This meant procedures were in place to address safeguarding issues if they arose.

Staffing levels were based upon people's assessed levels of need. These were reviewed on a monthly basis, or if there was a significant change in the numbers of people living at the service or their support needs. At the time of the inspection, staffing levels between 8am and 8pm were two nurses, two senior carers and

eight care assistants. Staffing levels between 8pm and 8am were one nurse, one senior carer and six care assistants. We visited early in the morning to check night and day staffing levels, and observations confirmed that they matched the levels set out on the dependency assessment. During the inspection we observed that staff responded to people who needed support quickly, and that call bells were answered promptly. We spoke with day and night staff, who said there were enough staff to support people safely. One member of staff said, "It's okay [on my unit], there are enough [staff] here." Another said, "I think we have enough [staff] definitely…We get [help] if we need it." A third member of staff said, "I think there are enough staff. You never feel rushed. Sometimes it's busy but it's fine." Another said, "I think there are enough staff." Relatives told us there were enough staff to support people. One said, "seems enough staff here, I've never seen anything amiss". Another said, "there always seems plenty of staff, never seen anything to worry us."

Recruitment procedures were in place to ensure that only suitable people were employed. Staff files contained applications forms detailing their employment history, and interview checklists showed applicants were asked questions about their care skills and knowledge. Two references were sought before staff were employed, as well as a disclosure and barring service check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. Staff were also required to provide proof of identify and address and, where necessary, proof of professional qualification.

Good

Is the service effective?

Our findings

Staff told us they received the training they needed to support people effectively. Mandatory training was given in areas including moving and handling, safeguarding, dementia awareness, the Mental Capacity Act 2005, medicines and fire safety. Mandatory training is training that the provider thinks is necessary to support people safely. Staff also received refresher training in those areas. Records showed that between 90% and 100% of staff completed mandatory training in 2015. We asked why not all staff had, and the manager told us that the service had decided enrol staff on Care Certificate training from November 2015, and that staff who had outstanding training at that time would receive it in their Care Certificate training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. Staff files contained certificates to evidence staff completion of training. The area manager told us, "We have a training manager within the company who does the training… [and] a designated training day every month." Staff said they felt they received the training they needed to carry out their roles. One said, "The training is quite good. We get a lot of it. You get time off for mandatory training and we get enough time and support for it."

Staff received regular supervisions and appraisals, though we did not see recent records of what took place at them. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. A log of supervisions and appraisals appeared to show that some staff had not received them in the 6 months leading up to the inspection, and the only supervision and appraisal records on staff files were dated November 2014. The manager said, "supervisions are every two months and appraisals are annual…we have done supervisions and appraisals but just haven't caught up with the filing yet." Staff told us that they had received supervisions and appraisals, and felt they could raise issues with management if they needed additional support or training.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that assessments had been undertaken to check whether people's care plan would amount to a deprivation of the person's liberty and it was deemed necessary for a written application to be submitted to the local authority for a DoLS authorisation. The manager kept a central record of people who were subject to DoLS authorisations, any conditions attached to them and the expiry date. This meant a clear record was in place where people had been deprived of their liberty to receive care and treatment.

Where necessary, assessments had been undertaken of people's capacity to make particular decisions and if it had been deemed that people did not have capacity. We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

Staff had a working knowledge of the MCA and were able to describe how they applied its principles when supporting people. One member of staff said, "[The MCA] is there to protect people if you [are considering] whether they can make a decision for themselves." Another said, "[The MCA] is there to see if people are capable of making decisions or whether they need help in making decisions. You never make assumptions about people's capacity."

People were supported to maintain a healthy diet. There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. We saw that people's MUST scores recommended that their weight be monitored on a weekly basis but that this had not been done. The manager said it would be arranged immediately. Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day, did not accurately document the amount of food a person consumed, for example portion sizes. Care records we looked at included notifications to the kitchen regarding food likes, dislikes and dietary needs. This meant there was good communication between care and catering staff to support people's nutritional well-being and access to specialised diets.

Most people choose to eat in the dining rooms at mealtime, though some were supported to eat in their rooms. The dining rooms were set with cutlery and condiments, and people enjoyed their meals in a relaxed and unhurried environment. People appeared to enjoy the food. Where people needed assistance with their meals, this was done discreetly and with respect and staff encouraged people to do as much as they could before asking if they needed help. Where people had chosen to eat in their rooms, there was no delay in them receiving it.

People spoke positively about the food at the service. One said, "the food is grand." Another person said, "the food is good." A third said, "nice food." A relative told us, "the food here is good, a lot of nice choices."

People were supported to access external services to maintain and promote their health and wellbeing. People's care records showed details of appointments with and visits by healthcare and social professionals and we saw evidence that 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 General Practitioners (GPs), district nurses, diabetes nurse specialists, nutrition nurse specialists, dietician, chiropodists and the speech and language team (SALT). Care plans reflected the advice and guidance provided by external health and social care professionals. A health professional who was visiting a person told us, "[The service is] doing everything they should, they do what we ask and we have never seen a problem here." This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice to ensure that the individual needs of the people were being effectively met.

Good

Is the service caring?

Our findings

People were treated with dignity and respect. Staff spoke with people in a familiar and relaxed but professional way. Staff knocked on people's doors before entering their rooms. When people indicated that they required support, staff approached them and asked how they could help in a discreet and private way that helped to maintain the person's confidentiality. Where staff were reviewing documentation about a person we saw that they moved to private areas of the building so that people's records would not be overseen. We asked staff how they treated people with dignity and respect. One said, "You have to remember it is their home. We are the visitors." Another said, "[We] always treat people with dignity and respect. I treat [people] like they are my own parents. [For example] you explain what you are doing, knock on doors and give [people] a choice."

People spoke highly of the care they received from staff. One person joked, "It's okay. Sometimes the staff give you cheek, usually they are okay, mind I give them cheek first so it's only fair." Another person said, "[It's] very good here, I like it." A third said, "It's grand. The [staff] are smashing, especially [a named carer]. We get good care." Another person said, "It's very good, they look after me well." Another said, "It's nice here. They look after me."

Relatives told us that the service was caring towards people, and that families were involved in people's care. One said, "Oh, it's grand. [My relative] has lived here for a while and is living with dementia. They look after him well." Another relative said, "We're very happy with it, it's champion. They ring us if there is anything wrong and…we just pop in when we want. [The staff] are lovely." Another said, "We are happy with it. It suits our needs…they look after [the person's] needs as we would like." A fourth relative said, "I can't praise it highly enough. It's really good, a high standard. They have been very good with [the person]…they got it right…they give me a call if there is anything wrong and they look after [the person] really well and [the staff] are nice. If you say anything they are straight onto it."

Relatives of people with behaviours that challenge or specialist support needs spoke highly of the way staff cared for people. One said, "[The person] moved here from another home, and what a difference. The other place refused to have [the person] back as they said [they] were too challenging. Well look at them now. [The person] has only been here [a short time] and can already walk without their frame. They look after [the person] so well... they had dozens of unseen falls before but never since moving here." The relative of another person said, "We couldn't manage at home but they have sorted things here."

Staff made an effort to speak with people as they were moving around the building, which people clearly enjoyed. In one case, we saw a person talking to another person about how they had a craving for some cockles, and a passing member of staff stopped and offered to walk to the local shop to buy some for them. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is tool that is used to measure people's experiences of care when they have difficulties in communicating. We saw staff adapting their communication methods to ensure that they could have meaningful engagements with people. One member of staff told us, "You look at how people can communicate and change to [suit] them. You get to know the person, and [people living with dementia] can…communicate." Another member of

staff said, "[Staff] get to know [people] well. Care plans have enough information on people's preferences but you can't take away communication."

Nobody was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard. The area manager said, "No-one uses an advocate. We usually have advocacy services advertised on the display board but that was taken down when we redecorated." We were shown leaflets advertising local advertising services that were available for people to access in the reception area.

Good

Is the service responsive?

Our findings

Care was planned and delivered in way that responded to people's assessed needs. Records confirmed that pre-admission assessments were carried out and people's needs were assessed before they moved into the service. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure their safety and comfort. Following an initial assessment, care plans were developed detailing people's care and support needs to ensure personalised care was provided to all people.

A personal care plan for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs was written using the results of the risk assessment. Staff knew the individual care and support needs of people as they provided day to day support, and this was reflected in people's care plans. Care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For example, one person's care plan identified the need for a specialised mattress and contained instructions on how staff should check to ensure it remained suitable for the person. Care plans also detailed what the person was able to do to take part in their care and to maintain some independence. Dependency assessments were carried also carried out, to ensure that staff had the capacity and skills to be able to provide appropriate care. The care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to care plans where needed.

People with specialist support needs had specific care plans in place to support them in those areas. This included epilepsy, diabetes and tracheostomy care. These contained detailed information that would allow staff to support people with those specialised needs. For example, one person's tracheostomy care plan contained guidance on how often – and how – staff change the person's dressing and clean their equipment. We noted that some of the specialist care plans had not been updated for some time, and the manager told us that they would be reviewed immediately.

Staff told us that people and relatives were involved in care planning. One member of staff said, "We have relatives involved in care planning, and we always tell people that they can read plans if they want to. They all know what is in the care plan." A relative said, "We did the care plan when [the person] came in."

People had access to a range of activities. A weekly activities list was displayed around the service, and this included physical exercise, games and one to one time. The service had links with a learning disabilities service, and people from that service were encouraged to visit and play games. During the inspection we saw a visitor from the learning disabilities service playing dominos with people. We also observed arrangements being made for a visit by pupils at a local primary school for a story telling and singing session. The activities co-ordinator told us that they received funding from the service to organise activities, both within and outside of the service. They said, "If I need something I just ask the administrator for it."

People we spoke with confirmed that they had access to activities. One person said, "there is stuff to do, singing and games if you want." Another said, "there is things to do but I like it here [own room] I sit and watch the telly…the garden's lovely but the weather has been bad." Another said, "the garden's nice but you

can't get out there just now with the rain." A fourth person said, "I do what I want, some stuff goes on as well." During the inspection we observed people congregating in communal lounges and enjoying chatting with one another. We also saw two people talking about visiting a local pub but worrying that they would have to take a bus, who were then reassured by another member of staff who said, "No you wouldn't it's only at the corner we can take you down".

There was a complaints policy in place, which was publically displayed in the reception area and accessible to people and their relatives. This contained details of how complaints would be investigated, time frames for dealing with them and contact details for external bodies (including the Commission) people could contact if they were not satisfied with the outcome. Five complaints were recorded in 2015, covering areas such as staffing levels and care delivery. There was evidence of investigation of the complaints, including witness statements, and outcomes were documented. The area manager said, "Normally if [the service] has a few complaints I tell them to review it. I know as they send me a weekly log. I get involved if a complaint is made anyway."

Good

Is the service well-led?

Our findings

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

We asked staff about the culture and values of the service. One said, "All the staff here are warm, friendly and caring. They have a joke with [people]. The staff care." Another said, "I love it here. The best part is the people and staff. Everyone is lovely." A third said, "Everyone is made very welcome. Everyone is treated the same. The only important thing is that [staff] do the job well." A fourth said, "This is a care [emphasising that word] home. People are well cared for."

Staff told us that they felt supported by the manager. One said, "I feel very supported by [the manager] and [the area manager]. It's very much an open door policy. [The manager] is very hands on and is always there to help. You can speak to [the manager] at any point…and they listen." Another said, "I feel supported. [The manager] always asks if there is anything I need to help me [do my job]. [The manager] is always there." Another said, "I have never had to go to management but [the manager] is always around and is absolutely lovely. You always see them around, always asking if we're okay. [The manager] is a nice boss. The deputy manager is nice as well. They always ask how we're doing." A fourth member of staff said, "I can go to the manager and say anything and it gets addressed. [The manager] never leaves things. We have lots of conversations and [the manager] comes up every morning during handover." Another said, "The manager is okay. Everything I need has been sorted."

The manager carried out a number of weekly and monthly quality assurance checks. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. These included checks of any accidents and safeguarding incidents, environmental checks, care observations and care plan audits. Records confirmed that between four and six care plans were audited on a monthly basis by the manager or the deputy manager. Where remedial action was needed an action plan was produced and issues were addressed. For example, we saw that an audit of one care plan identified that some information was missing. An action plan was in place and the highlighted issues had been remedied.

We asked the manager if any trends were identified in the audits. They said, "It's more niggles I find, things like care plans not pulling information through. So, for example, where a person has had a dietician referral it isn't always pulled through to the actual care plan." The manager said they checked to ensure any remedial action identified had been taken.

The area manager also carried out quality assurance checks on behalf of the registered provider. The area manager said, "Every week I get a home manager report, including any complaints, safeguarding referrals, any inspections and weekly weights." The area manager also carried out monthly inspection visits, with the most recent occurring in December 2015. These inspections covered areas including accidents, safeguarding referrals, care observations and seeking feedback from people using the service. Where issues had been identified, we saw that action plans were put in place to remedy them. For example, during one

visit the area manager identified that a person needed to have their care plan updated due to recent weight loss. A date for completion of this was set, and the plan was signed to confirm that the action had been completed.

Feedback was sought from people and their relatives through questionnaires, which the manager said were sent out roughly every six months. The latest survey had been completed in January 2016, but the results had not been processed at the time of the inspection. The most recent survey for which results were available was from July 2015. 13 people responded to the survey. The feedback we saw was positive, with people and their relatives praising staff. One person wrote, 'All staff on [a named unit] are good.' A relative wrote, 'It would be very unfair to nominate anyone [individual for praise] as all of the staff are exceptional.' Staff received a similar feedback questionnaire, on an annual basis. The most recent survey was in January 2016, but the results had not been processed at the time of the inspection.