Aegis Residential Care Homes Limited

The Clough Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 on 29 October 2014 as part of our regulatory functions. This inspection checked 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. At the last inspection in October 2013 the home was found to be meeting all the regulatory requirements.

The Clough Care Home is a residential home accommodating up to 30 people in single rooms. Five rooms have en-suite facilities and there are four further bath and shower rooms. There are two lounges, a dining room and a conservatory and a new updated lift facility has recently been installed within the home.

There was a registered manager at the home. 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.

There were some aspects of the meal time we observed that would benefit from some improvement. These included the seating arrangements, timings of the

Summary of findings

sittings, cleanliness of the tables for the second sitting and communication with people who used the service around menus and choices available. We spoke with the manager about these concerns and they agreed to review the mealtime experience and make some changes, some with immediate effect.

The home was clean and tidy and people who used the service were well presented on the day of the inspection. We observed staff interacting with people who used the service and visitors with respect and people we spoke with told us the staff and management were approachable and concerns were dealt with in a timely way.

Activities and entertainment were offered to people who used the service on a regular basis. Those who did not wish to join in were free to follow their own interests and were supported to do this.

Care records were complete and up to date and included health and personal information and appropriate risk assessments. Staffing levels were adequate to meet the needs of the people who used the service. Staff files evidenced robust recruitment, thorough induction processes and regular supervision and appraisals.

Staff at the home had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which help ensure people do not have their liberty unlawfully restricted. The manager was aware of how to apply for DoLS authorisation and was endeavouring to work within the local authority guidance with regard to making applications.

Summary of findings

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.

Staffing levels were adequate to meet the needs of the people who used the service. Health and safety and environmental checks, repairs and maintenance were carried out in a timely way.

Medication was administered by trained staff and there were robust systems in place to minimise the risk of errors.

Staff we spoke with demonstrated a good understanding of safeguarding issues and were confident they would recognise signs of abuse or poor practice and would report these appropriately. Staff were aware of how to access guidance and policies.

The care plans we looked at included up to date risk assessments, which were reviewed on a regular basis.

Is the service effective?

Requires Improvement

The service was not completely effective.

People had some choice around meals and where to eat. However, some people were unaware of the choices and the menu was not accessible to all. There were some difficulties with the dining experience, such as staff and people who used the service being unable to manoeuvre around the dining room easily.

Some people had to wait a considerable length of time for their meal and tables had not always been cleaned. The manager agreed to address these problems immediately via a full mealtime review.

Care plans were up to date and complete and included signed consent forms where people were able to give informed consent. There were monitoring charts included in some care plans, which allowed staff to monitor issues such as weight loss and make referrals to other agencies or professionals as appropriate.

Management and staff and demonstrated a good understanding of the Mental Capacity Act (2005) MCA and Deprivation of Liberty Safeguards (DoLS). They were hesitant to send in applications due to the local authority backlog, but agreed to complete some after discussion.

Is the service caring?

Good

The service was caring.

Summary of findings

We observed staff interacting well with visitors and people who used the service and most people we spoke with, including people who used the service, visitors and professionals, told us staff were caring and respectful. People who used the service were well presented and looked well cared for.

Care plans included a range of personal and health information that was complete and up to date. New documents were being completed by staff with people who used the service, in order to gain a fuller picture of each person.

We spoke with four care staff who were able to explain their roles and give examples of how they preserved dignity and privacy and maintained respect for people who used the service. They had completed training in a number of relevant areas and possessed appropriate skills and knowledge to undertake their roles effectively.

Is the service responsive?

Good

The service was responsive.

Care plans and risk assessments reflected individual needs, preferences and care delivery.

There were a number of activities on offer, including reminiscence, exercise and entertainment. People were supported to join in if they wished to. They were also encouraged to follow their own individual pastimes and interests.

The home sought feedback and suggestions from people who used the service in a number of ways. These included informal conversations, relatives' meetings, questionnaires and surveys. The home was about to trial a relatives' surgery for one evening per week to try to enable more people to offer feedback and discuss issues and concerns.

Complaints were dealt with appropriately, in line with the company's policy.

Is the service well-led?

Good

The service was well led.

The management were highly visible around the home and were said to be approachable, responsive and open to new ideas and suggestions, by staff, people who used the service and relatives.

Partnership working was good and communication between the home and other agencies and professionals excellent.

There were a number of audits and checks in place and these were up to date and complete on the day of the visit. Issues identified were noted and actions put in place in a timely way.

Feedback from people who used the service and relatives was sought in a number of ways, including informal conversations, questionnaires, relatives' meetings and surveys.

The Clough 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.

The inspection took place on 29 October 2014 and was unannounced. The inspection team consisted of a lead inspector from the Care Quality Commission 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.

Before the inspection the 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 also reviewed information we held about the home in the form of notifications received from the service.

Before our inspection we contacted Bolton Local Authority contracts team who commission services from the home. We also contacted health and social care professionals who provide care and support to people living in the home. These included the practice manager of the local GP surgery, a GP from another surgery who visits the home occasionally, the District Nurse Team Manager, whose team visit the home regularly, and two social care professionals who visit the home on a regular basis.

We contacted the local Healthwatch service for information. Healthwatch England is the national consumer champion in health and care.

We spoke with three people who used the service, five members of staff, including the manager, one member of auxiliary staff, three relatives and one professional visitor to the service. We also looked at records held by the service, including four care plans and two staff files. We observed care within the home throughout the day.

Good

Is the service safe?

Our findings

One person who used the service and one visitor felt there were enough staff. Another visitor said, "Some days they are more sparse than others". One person who used the service said "They sometimes fall short, possibly when some are on holiday or away sick". We asked if people felt the home was safe. Everyone spoken to said they felt they were safe, both from the outside world and from harm within.

We spoke with three care staff and they demonstrated a good knowledge of safeguarding issues, including how to recognise possible poor practice or abuse and how to record and report any concerns. They were aware of the company's policy and guidance and knew where to access this should the need arise. The home had always responded appropriately to any safeguarding issues identified.

We looked at four care plans, which set out each person's care needs and how the home would address these needs. Appropriate risk assessments for issues such as moving and handling, falls, nutrition and skin integrity were in place. These had been regularly reviewed and had been updated where needs had changed.

We looked at two staff files and saw evidence of a robust recruitment process. This included the obtaining of proof of identification, two references and a Disclosure and Barring Service (DBS) check. A DBS check helps a service to ensure people's suitability to work with vulnerable people.

We observed sufficient staff on duty to respond to the needs of the people who used the service on the day of the inspection and staff spoken with felt there were enough staff. Although some people we spoke with felt there were occasions when staffing was short, due to staff sickness or annual leave, we looked at staff rotas which indicated that staffing levels were adequate. The manager told us they usually managed to cover for sickness and leave from within their regular staff members. Either the manager or deputy were always on call and willing to come in to the home if there was a problem.

We observed staff struggling to transfer one person effectively from the dining table back to the lounge, ie this was taking more time and staff than was desirable. We spoke with staff about this and were told this person had been admitted in the last couple of days from hospital on the understanding a piece of equipment would be supplied on discharge. This had not happened and the person had arrived at the home unable to weight bear.

We discussed this at length with the manager, who told us the hospital had been contacted and had agreed to send the equipment. They did not want to upset the person and their relatives by returning them to hospital and felt able to manage in the short term whilst awaiting the equipment. In the meantime there was no moving and handling risk assessment in place for this person to be moved without the equipment. We asked the manager to complete a risk assessment around this issue and this was done immediately. This would help ensure that there were clear instructions about how many staff were required and how much time needed to move this person prior to the equipment being delivered.

We spoke with the senior member of care staff on duty, who was responsible for the administration of medication on that day. They told us there were only trained members of staff who administered medication and these were kept to a minimum to reduce the risk of medication errors.

All medication administration records (MAR) included a photograph of the person and the date of the photograph. These were updated regularly to ensure the information was current and the photograph recognisable. Samples of staff signatures were kept with the medication so that these were recognisable in case any transaction needed to be tracked.

We were shown the medication room, where all medication was stored securely. There was a controlled drugs cabinet, which was locked. Controlled drugs were signed for by two people as required in a controlled drugs register. Signs with references to the home's medication policy, flow charts and guidance were attached to the cabinets in the medication room for staff to refer to if required. Medications which needed to be kept refrigerated were stored appropriately and we saw temperature checks taken daily to ensure the correct temperature was maintained. Daily medication audits were carried out to provide another means of ensuring safety for people who used the service.

The staff member showed us their systems for ensuring the safe administration of medication. These included recording of refusals of medication, timing charts for medication that needs to be spaced out over periods of

Good

Is the service safe?

time, recording of medication used as and when required (PRN) to ensure this was given safely, the ordering and disposal systems, both of which incorporated cross referencing of documentation to minimise the occurrence of mistakes.

The staff member we spoke with demonstrated a good understanding of different medications, their uses and requirements. Certain medication, generally administered on a weekly basis needs to be given on an empty stomach and with the person sat upright. The staff member explained that, when a person required this, they requested it should be prescribed for the same day of the week as others taking the same medication. This meant all were given on the same day, reducing the risk of errors being made.

With certain drugs, such as anti-coagulant medication, there are a number of challenges. For example the person requires frequent blood testing, resulting in a variable dose. There is also the possibility of interaction with other medication and foods. The staff member was able to explain these difficulties and show us a three way check used in the case of this medication to help ensure safe administration.

No one at the home was currently self- administering medication. However, the staff member told us they would support anyone who was able and wished to do this. A lockable cabinet would be provided for the individual's room for safe storage of their medication. There was no one requiring covert medication at the time of the inspection. Covert medication is a way of giving medication in or on food or in a drink. The staff member we spoke with was able to explain the implications of the Mental Capacity Act (2005) in relation to people having capacity to take responsibility for administering their own medication and with regard to administering covert medication, when a multi-agency best interests decision would be required.

We saw that a new lift had been fitted at the home, with the minimum of disruption for people who used the service. The manager told us this lift was better for people who used the service for a number of reasons. The lift was easily accessible, but had safety precautions so that only staff could access potentially hazardous areas within the home. Another benefit was that, as laundry now did not need to be carried through communal areas, this minimised the risk of cross infection.

In the course of the visit one person who used the service told us their carpet was loose and in need of repair. We mentioned this to the manager as this should have been picked up by staff and reported. The handyman was on leave but the repair was carried out immediately by a staff member.

We saw a range of safety checks undertaken at the home, including environmental and health and safety checks. There were two hourly night time checks made on residents by care staff to ensure their well-being and safety. The staff followed a check list to ensure all expected areas had been inspected throughout the night.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they felt staff knew how to support them and had the skills and knowledge to use the equipment needed.

We observed a meal time at the home. We saw the dining room had recently been refurbished and looked very attractive, but the new chairs purchased by the home were rather big and heavy and staff struggled to move them around. Because of their size they left little room to manoeuvre which made it difficult for staff to assist people with mobility difficulties to and from the tables. On the day of the visit there was a Halloween theme in the dining room, which was decorated with skeletons, spiders and ghosts. One person stated they did not like the skeletons and ghosts, but most people who used the service said they enjoyed the themed decorations and celebrations.

Staff were seen to put on aprons at the mealtime observed, and said they cleansed their hands outside the kitchen, where they put on the aprons. There was music playing very quietly in the background.

We saw that two members of staff had attended safe swallowing training, as there were three people who used the service who had difficulties with swallowing. This helped ensure they were assisted correctly and staff were more confident in dealing with these issues. The manager told us there were plans to offer other staff this training in the future.

The meal was served in two sittings, those people who required a higher level of assistance being on the second sitting. We observed these people waiting for some time for their meal and when they sat down at the dining room tables these had been cleared of crockery and cutlery but had not been wiped of food debris. This was not only unpleasant, but could be a hazard to health due to the lack of appropriate hygiene.

We asked people who used the service if the food at the home was good at the home. One person who used the service said the meals were reasonable and went on to say, “One cook is better than the other”. Asked if they could have snacks and drinks at any time one person said, “Yes”. Another said, “Yes, they make you one if you ask. They forgot me the other day so I had to ask”. A third told us, “It is the best we’ve had today, we don’t get a choice”. This person said they had not seen the menu. We saw there was a menu board, but this was placed in an area of the dining room not visible to all.

Not everyone who used the service with whom we spoke was aware that they had the choice of where to eat their meals, though one person we spoke with took their meals in their room regularly. On the day of the visit there was only one main meal offered, which people who used the service told us was usual when they had their twice weekly roast dinner. We spoke with the cook, who said choice was always available stating, “They all know they can have an omelette or jacket potato, anything within reason”. We spoke with people who used the service, some of whom were unaware of this choice. We did not see second helpings being offered and no one requested more.

A hot or cold drink was given to each person with their meal. One visitor said they had observed staff assisting people with their meals and they seemed “considerate”. A person who used the service said “They (the staff) know what needs cutting up for me to be able to eat with a spoon or fork”.

Dessert was a Halloween themed bun. One person did not want dessert of a Halloween themed bun, as they did not like cream. They refused the alternative offered of yoghurt so chose to have the bun without the cream.

We went into the kitchen and observed it was clean and tidy, but the cooker was in need of a deep clean as it was quite soiled. There was a list of people’s dietary requirements for the cook to refer to. This would help ensure people were being served the correct food. We noticed that food in the fridge which had been opened did not display labels to say what date it had been opened on. This could mean people would potentially be served food which had passed its best and could be hazardous to their health.

We spoke with the manager and senior staff about the problems we observed with the meal time and in the kitchen. They discussed this and decided to review the whole dining experience, including the times of the sittings and the promotion of choice. The food in the fridge, which had been opened that day, was labelled immediately and

Requires Improvement

Is the service effective?

instructions given for this to be carried out each time food was opened. A member of staff was tasked with deep cleaning the cooker on the evening of the inspection visit to ensure its cleanliness for the next mealtime.

We looked at four care plans and saw that consent was recorded where appropriate, for example, for the administration of medication, and signed, where possible, by the person who used the service or their representative. Care staff had access to care files, which were reviewed regularly by senior staff, and they told us handovers from shift to shift were good.

We saw the home kept up to date records relating to weight in a weight loss file. The file contained the policy and guidelines relating to weight loss and a three monthly weight recording analysis. These records allowed staff to monitor people's weight loss and included actions taken, such as referrals to GPs and other appropriate professionals.

We had spoken to a number of health care professionals prior to the visit and were told that the home referred appropriately to other services, followed advice and guidance and worked well with each service to ensure people's health needs were supported. This was also evidenced within the care files via referrals, correspondence between services and detailed recording of instructions.

We saw there was a decision making record in each care file, detailing which decisions the person was likely to be able to make alone and which decisions they may require assistance with. We spoke with four staff members and they were clear about how they should assist people to make their own decisions where possible, in line with the Mental Capacity Act (2005) (MCA). Staff we spoke with had a good understanding of the principles of the MCA, though they had not received formal training. Senior staff had attended meetings on the subject and had passed on information to other staff members. The manager told us MCA training would be arranged for all staff in the near future.

We asked staff about Deprivation of Liberty Safeguards (DoLS), which are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Senior staff were aware of DoLS and knew how to refer for authorisation. However, they had been hesitant to make referrals due to advice from the local authority that there was a backlog of applications. After discussion they agreed to refer two people who used the service via the standard authorisation request form.

We saw the staff training matrix and saw the home's mandatory training was up to date and refresher dates were recorded. A number of staff had completed further specific training, such as end of life care, dysphasia awareness and safe swallowing, to enhance their skills and knowledge.

We also saw, within the staff files, evidence of comprehensive staff induction training and on-going training and development of staff. This was verified by the training matrix and the four members of staff we spoke with. Regular supervisions and appraisals were also evidenced within the staff files.

Good

Is the service caring?

Our findings

We spoke with three people who used the service and three visitors. When asked about whether people who used the service felt their privacy, dignity and independence were respected by staff. One said, "Yes, they are very respectful". A relative told us, "Yes, they are always polite and treat X as a person".

We asked if people received the care and support they needed in the way in which they wanted it. A person who used the service told us, "Yes, I do on the whole, but sometimes they are short staffed". A visitor, when asked about their loved one, told us, "She grumbles but the family is happy".

We asked people who used the service and their relatives if they had been involved in the preparation of care plans and knew what was in them. One person who used the service said, "Yes, but I don't think it has formally been reviewed, I think it is probably done as we go along". One visitor commented, "We haven't been asked about her likes and dislikes". Another said, "Yes, we have talked about it and I have seen it, I have also been in the office to chat about changes to it". A third visitor told us, "No, I have not been asked". We spoke with the deputy manager about people's involvement in care plans. They told us that they endeavoured to involve everyone to whatever extent they were able. However, those with dementia conditions may not always want to be involved or, if they had been involved, may be unable to recall this process.

People we asked said that visitors were always welcomed into the home. One visitor, when asked if they felt the staff knew and understood their relative's condition, said, "Yes, we have discussions on how to help her". Another visitor told us their relative, "Always looks cared for, the clothes are immaculate, she always has a necklace on". They went on to say the staff always appear "very calm, even if the service user is shouting".

Prior to the inspection we spoke with a number of agencies and professionals who regularly visit or have dealings with the home. None had any issues or concerns to raise. One professional told us they had, "No concerns whatsoever, communication is fantastic, referrals are made appropriately and advice is followed. We spoke with an auxiliary member of the staff team who was not involved with administering direct care. They told us "Staff are nice and very caring".

We spoke with four care staff who were clear about their roles and responsibilities within the home. They were able to demonstrate by giving examples that they had the skills and knowledge necessary to carry out their roles in a caring and effective manner. We observed staff throughout the day of the visit actively encouraging people to be involved in whatever activity or event was happening. We saw that choices were offered and people's decisions respected. Some people chose to spend most of the day in their own rooms, following their own pursuits. This choice was respected and people were supported to do this, but staff checked on them at regular intervals to ensure they continued to be content and happy with their occupations .

We looked around the home and saw it was clean and tidy and people who used the service were well presented, dressed smartly and many had visited the hairdresser that day. All the people who used the service and relatives we spoke with said the home was always clean and fresh.

This is me booklets were a work in progress at the home. Staff were completing these with people who used the service and they were to include subjects such as personal information, background, family, treasured possessions, interests, job history, places, routines, worries and things that would make them feel better, sensory information, communication, mobility, sleep, personal care, medication, food and anything else important to the person involved. A few of these had already been completed. These would be used as an addition to the care plans to help staff have a good understanding of each person who used the service.

Good

Is the service responsive?

Our findings

We asked people who used the service if staff responded quickly and efficiently if they required assistance. When asked if they were ever kept waiting one person said, "Yes, on the odd occasion, but they always explain why". Another told us, "Yes, when we are going to bed it can take them a while with some of the residents, so I have to wait a while". Having looked at staff rotas and spoken with staff, the staffing levels were adequate to meet the needs of the people who used the service. Staff told us people would be kept waiting occasionally if someone required extra help on a particular instance.

We asked if people who used the service and their relatives felt staff would respond properly if they were unwell. All said yes. One visitor said that staff accompanied people who used the service and their relatives to hospital appointments. This relative gave an example of when their loved one was taken to hospital by staff and relatives were immediately informed. Staff stayed with the person whilst an assessment was carried out and then brought them back to the home.

We asked about choice and all the people we spoke with who used the service said they were able to make decisions about their care, for example, what they wanted to wear each day and where to sit. Asked if their preference of a male or female carer was respected one person who used the service said, "Yes, I prefer a female but X is a male carer and I will allow him (to administer personal care)". Asked about preferences for showers or baths and times of these, we were told these choices were respected.

A visiting district nurse with whom we spoke said they felt the home was of a good standard and that it continued to improve. They told us in their experience people who used the service were not kept waiting when they had pressed their buzzers.

We looked at four care plans and saw that personal preferences were recorded within them. These included preferred times for rising and retiring, preference for a bath or shower and whether the person wished to have a male or female carer. People's particular support needs and requirements were reflected in the care plans and risk assessments we looked at.

There was a sign in the lounge saying "The Season is Autumn, The Weather is Cloudy". This helped people who used the service with orientation to time. The signage around the home was not very prominent or accessible to people who had dementia. We discussed this with the manager and deputy who agreed to look at improving the signage around the home.

We saw posters in the entrance hallway advertising the hairdressing service and pampering. There were no posters in prominent places for people who used the service to see about any other activities. However, we observed staff talking to people who used the service about upcoming entertainment and activities, for example, the imminent visit of the mayor to the home. We spoke with the manager about the possibility of advertising upcoming entertainment and activities via posters so that people who used the service could have visual reminders of what was coming up.

Staff showed us a Titanic themed wall, which had been suggested by some people who used the service. We were told the local Mayor was to visit the home the following week, which people who used the service were looking forward to. Regular events included entertainment by Havana Nights Latin American dancers and exercise sessions. A Christmas party and pantomime were planned as part of the Christmas festivities.

We asked people about activities and one visitor said, "Someone comes in singing, another doing seated exercise, they do reminiscence – there is an old (fashioned) radio in one of the lounges, and if there's a special occasion they decorate the place, like today for Halloween". One person who used the service said they were aware of singing and musical movement but preferred to stay in their room reading, doing crosswords and watching TV. They told us, "If I run out of things to read they have a library here with lots of books". Another person commented, "There's only singing, no dominoes or bingo or things like that".

The home had recently instigated a "Magic Moments" book where staff recorded information about one to one chats, sing songs, post received or any other interactions that they felt were meaningful or significant to people who used the service.

We saw a recent newsletter produced by the home, which included a welcome to new residents, information about forthcoming activities and entertainment, updates on the refurbishment programme, residents' birthdays and staff news.

Good

Is the service responsive?

An activities questionnaire had been completed recently to ascertain which activities people enjoyed most and gather suggestions for further activities. Trips out and baking sessions had been suggested and one person who used the service had offered to give a talk on the history of the area. This was to be arranged in the near future.

A questionnaire had also been distributed on the subject of food. Responses to this had been very positive. For example, the results of a residents' survey had shown a high level of positive feedback, comments included “The staff are very caring and friendly”, “Communication between staff and relatives is excellent”.

We looked at the suggestion/comments book and saw comments such as, “Can’t think of a better place I would rather have my X”, “Thank you for all the help you have given my X. She is taking a lot more interest in things now”.

We saw a number of recently received thank you letters and cards, which included messages such as, “Just to say a very big thank you to you all for the love and care you gave to our X”.

On the day of the inspection a singer came into the home for the afternoon as part of the Halloween party event. The majority of the people who used the service sat in a circle in the lounge to watch this. The lounge and dining room were decorated with webs, ghosts and party tableware. We observed the staff making people comfortable and drawing the curtains where the sunshine was shining into their faces.

The manager told us they do not employ an activities coordinator but some of the carers took the lead in activities. For example, two carers have recently undertaken training in how to facilitate “Our Organisation Makes People Happy” (OOMH) which consists of exercise classes designed to enhance the physical and mental well-being of older people. The staff told us this had so far been very popular and successful.

We saw minutes of a recent relatives and residents’ meeting where activities and entertainment had been among the discussions. The manager told us these meetings were not well attended due to people’s other commitments. The home had decided to trial a late evening surgery for relatives to see if this would encourage people to discuss any issues or concerns and to put forward any suggestions for improvements to the home. This demonstrated a commitment by the management to encouraging feedback and communication from relatives.

No one we spoke with had made a formal complaint. One person who used the service said they had made a verbal complaint and they were very happy with the way it was handled by the deputy manager.

We looked at the complaints log and saw that complaints were followed up appropriately and in line with the home’s policy. This policy was displayed prominently within the home.

Good

Is the service well-led?

Our findings

There was a registered manager in place at the home. 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.

We spoke with the manager, who demonstrated a clear understanding of their role and responsibilities.

We spoke with a number of other professionals prior to the inspection, including two GP practices, Bolton Local Authority social care staff and the local district nursing manager. All felt the home offered a good standard of care and had no concerns about care delivery at the home. We were told that appropriate referrals were made, advice followed and communication between themselves and the home was good.

All the people who used the service and the visitors we spoke with knew who the manager and deputy were and felt able to approach them with any concerns or issues. They told us they felt they would be listened to and the management would act on their comments.

We spoke with the deputy manager who described a good partnership and understanding with the regular GPs that visited the home. They demonstrated, via examples about medication prescribed, that they had the confidence to challenge professionals if they felt it was in the best interests of the people who used the service.

The manager showed us evidence of walk rounds which they undertook approximately three times per week. Areas looked at included handovers, atmosphere, dignity, respect, cleanliness, activities, medication, management of the shift, staff communication, improvements needed, other observations. Issues identified were recorded and actions initiated, although occasionally things could be missed, such as the loose carpet in one of the bedrooms.

We saw minutes of general staff meetings, domestic staff meetings and senior staff meetings. All were well attended, and included discussions around care plans, standards of care, vacancies, night staff issues, staffing levels, training, policies and procedures, housekeeping, budgets and refurbishment, audits, events, thanks, infection control, complaints and any other business.

At one of the meetings it had been agreed to appoint a nominated person to be responsible for infection control at the home. A statement was to be displayed to ensure everyone would be able to quickly identify that person to communicate any issues or information around infection control to. Meetings provided an effective way of facilitating two way communication between staff and management. Senior staff also met separately and discussions included care plan reviews and complaints.

We saw that the area manager made weekly visits to the home and once a month a formal audit was undertaken by them. This resulted in any issues or concerns being identified and action plans being written. We saw examples of where training needs, refurbishment and maintenance had been highlighted and actioned.

We saw evidenced of a number of weekly and monthly audits carried out in the home, including equipment audits, area inspections, health and safety checks and, fire system checks. All were complete and up to date. The home had a contingency plan in place in case of emergencies such as fire, infection outbreak, loss of utilities or adverse weather.

Accident forms were appropriately completed and audit and analysis of these undertaken. We saw that patterns were identified and addressed, for example, peak times when falls occurred had been identified and staff had been given advice and guidance on how to be more vigilant at these times.

Staff, people who used the service and visitors we spoke with told us the manager was very approachable. They said that the manager was open to new ideas and any issues identified were dealt with immediately. We found this to be the case as the issues identified during feedback from the inspection, such as the new risk assessment needed, the repair to the carpet and the cleaning of the cooker, were dealt with immediately.

There was visible leadership as the manager was said by staff to be often on floor and the area manager made frequent visits to the home. We spoke with four care staff

Good

Is the service well-led?

who were well motivated and said there was a good atmosphere within the home. Staff we spoke with told us they were given encouragement around training and personal development.