J B Craven Limited

Castlethorpe Nursing Home

Inspection report

Castlethorpe
Brigg
South Humberside
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Tel: 01652657509

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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 undertook this comprehensive inspection on the 14 and 15 June 2018. This was the first inspection since the service was registered with the Care Quality Commission (CQC) on 14 June 2017.

Castlethorpe Nursing Home 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. Castlethorpe Nursing Home supports up to 59 people, some of whom may be living with dementia, have a physical disability or a sensory impairment. At the time of the inspection, there were 34 people who used the service and 18 people were funded to receive nursing care.

The service had a registered manager in post. 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.

People, their relatives and visiting professionals provided only positive feedback about the service.

We found aspects of the quality monitoring and management recording systems were limited and outdated. The registered manager acknowledged the need to improve and develop these systems and programmes. We have made a recommendation about obtaining a more up-to-date comprehensive recording system and audit programme to support continued service development.

The building was adapted to meet people's individual needs. The registered manager had ensured some redecoration and refurbishment had taken place and acknowledged further renewal was required, which was to be discussed with the provider. Equipment used in the service was maintained and any repairs were completed in a timely way. There were effective infection control training and procedures in place. People told us they were happy with the cleanliness of the service. Accidents and incidents were recorded and investigated.

Staff were recruited safely and checks were carried out before they started work in the service. There were sufficient care staff on duty to meet people's needs. There were ancillary staff, which enabled care staff to concentrate on caring for people.

People received their medicines safely from trained staff. The registered manager made sure that people at the end of their lives had the medicines they required to maintain their comfort and dignity. People who were being cared for in bed were regularly seen by staff to make sure they remained comfortable.

Staff had received training and had procedures to guide them in safeguarding people from the risk of harm and abuse. In discussions, staff were clear about how they would escalate concerns and which agencies

they would contact for advice. Staff had completed assessments with people to identify risk areas and the steps required to minimise risk.

People's health and nutritional needs were met. Records showed people had access to a range of community healthcare professionals for advice and treatment. These included dieticians when people lost weight and required additional support. The menus provided varied meals with choices and alternatives. People told us they liked the meals provided to them.

The staff supported people to make their own decisions and choices when they were able. When people were assessed as lacking capacity, staff consulted with relevant people when decisions were made on their behalf. We found some gaps in the records when restrictions were in place which the registered manager addressed following the inspection.

Staff received training, supervision and appraisal to ensure they were skilled and confident in meeting people's needs. There were staff meetings which enabled them to receive information and express their views. Staff told us they felt supported by management.

People were treated with respect, kindness and understanding. Staff demonstrated a good knowledge of the people they cared for, their preferences and abilities. People told us staff were friendly, caring and had time to sit and talk to them. We observed staff had developed good relationships with people who used the service and their relatives. People's privacy and dignity was respected by staff who encouraged people to be independent and make choices and decisions in their daily lives.

People's needs were assessed and planned. People and their relatives were involved in this process which helped staff to deliver support tailored to their needs and preferences, although we found some care plan records could be more person-centred. People were happy with the standards of care and support provided. The service had developed strong links with the community palliative care team and received a lot of referrals for end of life support.

People who used the service and relatives were positive about the activity programme, which included one-to-one sessions, group activities, entertainers and community trips. Relatives told us they could visit at any time and we saw staff supported people who used the service to maintain relationships with their friends and family.

The provider had a complaints procedure and people told us they felt able to raise concerns and these would be addressed by management. Staff described the culture of the organisation as open and management as supportive and approachable.

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.

Staff knew how to safeguard people from the risk of abuse and how to pass on concerns to relevant agencies. There were good standards of hygiene.

Risks to people had been identified and assessed and there was guidance for staff on how to keep people safe. The management of medicines was safe.

There was a good recruitment system and sufficient staff deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

People's consent was gained before care and support was provided. The provider adhered to the principles of the Mental Capacity Act 2005 when establishing capacity and decision-making.

Staff received appropriate induction, training, support and supervision to enable them to feel confident in meeting people's needs.

People were supported to eat a healthy diet of their choosing. People's health needs were met and relevant health care professionals were contacted in a timely way.

Is the service caring?

Good

The service was caring.

There were positive comments from people who used the service and relatives about the kind and caring approach of staff.

Staff treated people with respect and supported them to maintain their privacy, dignity and independence.

People's personal information was held securely and

confidentiality maintained.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans produced. People and their relatives were involved in this process which helped staff to deliver support tailored to their needs and preferences, although we found some care plan records could be more person-centred.

There was a range of activities within the service for people to participate in. Staff also supported people to access community facilities and to maintain contact with friends and relatives.

The provider had a complaints procedure on display and people felt able to raise concerns.

Is the service well-led?

Good

The service was not consistently well-led.

Systems for quality monitoring required strengthening in order to identify all shortfalls and support continued service improvements.

Feedback systems were in place to obtain people's views such as surveys and meetings.

There was a friendly, inclusive atmosphere and the registered manager was approachable and respected.

Castlethorpe Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 June 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an assistant inspector on the first day.

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 checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Before to the inspection, we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. 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. We spoke with six people who used the service, five people who were visiting their relatives and five health and social care professionals. We spoke with the registered manager, a deputy manager and three care workers, one of which also had the role of activity co-ordinator.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) and monitoring charts for food, fluid intake, weights and pressure relief.

We looked at a selection of documentation relating to the management and running of the service. This included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and

people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

People told us they felt safe in the service and most considered there were sufficient staff to look after them. Comments included, "The surroundings and empathy from the staff make me feel safe", "Staff are always available when I need them" and "Staff assist me when they can come, they could do with a few more. I haven't met one staff I don't like."

Relatives told us they felt safe leaving their family member in the care of the staff team. Comments included, "[Name of person] is absolutely safe, we have huge confidence in their care" and "Always plenty of staff on duty and everybody knows what the other person is doing. It is very safe here."

We found care was planned and delivered in a way that promoted people's safety and welfare. Potential risks to each individual person had been assessed and recorded in care files. These included risk of falls, choking, poor nutrition, risk of pressure damage, use of bed rails and moving and handling people safely.

Equipment such as specialist beds and pressure relieving equipment were used where assessments determined these were needed. The registered manager explained how they had purchased seven profile style beds in the last 12 months. They planned to provide more to meet the increasing dependency needs of the people admitted to the service and ensure that only the integral style bed rails would be used, which would better ensure people's safety needs were protected.

Clear and detailed behaviour support plans were in place which informed staff on the preferred strategies to use to reduce anxiety and keep people safe, if people displayed behaviours that challenged. We found one person's behaviour plan would benefit from more detailed directions for staff in relation to the action they would take if the person became violent and the registered manager updated the plan during the inspection.

The provider had policies and procedures to guide staff on how to safeguard people from the risk of abuse or harm. Staff had received training and in discussions were able to describe the different types of abuse and the procedure to follow if they had concerns. The registered manager had contacted the local safeguarding team for advice when required. We observed staff interactions with people and these were completed in a kind and patient way.

Equipment and utilities used in the service, such as the lift, hoists, fire alarm, call bells, hot water, gas and electrical items had been checked by competent people. Regular checks were carried out on bed rail safety; however, the records completed did not show the checks fully met current guidance in the safe management of bed rails. The registered manager confirmed the checks were thorough and they would amend the record format to demonstrate this. The lift had been out of service for two weeks due to delays with obtaining parts. Contingency arrangements were in place to ensure people residing on the first floor were safe and well-supported, to prevent any isolation. One person had been supported to choose another room on the ground floor to facilitate easier access and they told us how much they liked their new room.

The provider had a business continuity plan, which provided staff with guidance on what to do in case of flooding, outbreak of infections, fire or utility failure.

People's rooms and communal areas were clean and tidy. Good standards of hygiene had been maintained throughout the service and there were no unpleasant odours. Staff used personal protective equipment to help them prevent and control the spread of infection. The kitchen and laundry areas were clean and organised.

We saw accidents and incidents were investigated and appropriate action was taken to prevent their re-occurrence. For example, outcomes showed the involvement of healthcare professionals such as physiotherapists to assess people's needs for appropriate equipment. The recording of incidents was not as thorough and detailed as the accident recording systems and the registered manager confirmed they would be introducing a new recording format to ensure consistency.

People received their medicines as prescribed. We saw medicines were ordered, administered, recorded, stored and disposed of in line with national guidance. This included medicines which required special control measures for storage and recording. Stock control was well-managed and a recent stock audit by the local clinical commissioning group had found few shortfalls. Where people were prescribed medicines to be taken on an 'as required' basis, for example, pain relief and medication used for anxiety and low moods, protocols were in place for each person to guide staff as to how and when to administer these. All the medication administration records (MARs) were hand transcribed by the qualified staff, as the dispensing pharmacy did not provide printed MARs. The MARs were well completed, clearly written and signed by a second member of staff to ensure accuracy. We observed staff administer medicines safely, they were patient in their approach, they explained things to people and provided the appropriate support they needed to take their medicines.

At the time of our inspection 14 of the 34 people who used the service received funding for their nursing needs. Records showed the number of people who resided at the service on a permanent and short-term basis had fluctuated over the last 12 months and rotas showed the number of staff had increased where necessary. There were enough staff on duty to provide people with the care they wanted and needed. Levels of two qualified staff and five care workers were provided in the morning; in the afternoon this reduced to one qualified staff and five care workers and at night one qualified staff and three care workers were on duty. We observed a member of staff was not always present in the main lounge area to monitor people's safety. We mentioned this to the registered manager who took action to ensure there was a continued staff presence in this area.

We saw staff responded as soon as people requested assistance or were seen to need support. We saw they had time to sit and talk with people and engage with activities. Staff told us they thought there were sufficient staff to meet people's needs. Comments included, "It's quite good. Mostly we have enough time to spend with people, the shifts vary" and "Yes, the staffing is right and the nurses and manager help out a lot. We have an excellent team."

The provider had a safe staff recruitment system. Potential staff completed an application form so gaps in employment history could be identified, references were obtained and they attended for interview. A Disclosure and Barring Service (DBS) check was carried out to highlight any criminal convictions and barring from work in care settings. These measures assisted the provider in making safer recruitment decisions.

Good

Is the service effective?

Our findings

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.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who are not able to consent to care and support and ensures that they are not unlawfully restricted of their freedom or liberty. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities and had made 14 DoLS applications, two of which had been authorised by the placing authority and 12 were awaiting assessment. We found the registered manager had been late in making a reapplication for one person and gave assurance they were introducing a more robust monitoring system to prevent this in future. One person had lasting power of attorney (LPA) documentation in their care file. It was important staff had information about LPA and the extent of powers so they knew who to consult with regarding decisions made in their best interest.

Where people had been assessed as lacking capacity to consent to some aspects of care such as the use of bedrails, recording of decisions was inconsistent. Consultation with relevant others was sometimes verbal rather than recorded in best interest decision documentation. Following the inspection, we received confirmation that all outstanding records had been completed.

People who used the service told us staff gained their consent before carrying out any care tasks and they were able to make their own decisions. They said, "Staff always ask me about my care and give me choices, they [staff] are good like that." In discussions, staff were clear about the need to gain consent before care tasks were carried out; this was observed during the inspection. We observed staff delivering care and support to people in the communal areas of the service. They spoke with people, gave them choices and supported them to make their own decisions, for example what they would like to eat and where they wished to sit and spend their time.

People's nutritional needs were met. The menus provided people with choices and alternatives and special diets were catered for, which included textured meals and high calorie meals. We saw people had their nutritional needs assessed as part of their admission process; any risks such as swallowing difficulties or poor intake were highlighted and these were kept under review. Staff monitored people's weight and referrals were made to health professionals when required. Those people at nutritional risk had their food and fluid intake monitored, although individual daily fluid targets had not been identified, which we mentioned to the registered manager to consider.

New menus had recently been developed following consultation with people. Staff asked people what they

wanted to eat and pictorial menus were in place to help them to choose their meal. The meals looked nicely presented. Drinks and snacks were served in-between meals. We observed the snacks offered to people during the inspection were mainly limited to biscuits and we discussed developing the range of fortified snacks for people with weight loss, which the registered manager confirmed they would look into.

People's health care needs were met. Relatives confirmed they were kept informed of healthcare issues relating to their family member. We saw advice and guidance had been provided by a range of health and social care professionals such as GPs, community nurses, specialist nurses, dieticians, physiotherapists and speech and language therapists. This helped to ensure people continually received the most effective care to meet their needs. Healthcare professionals confirmed the service worked well with their team and kept them informed about any changes. They found the staff to be helpful and knowledgeable about the clients and their needs.

Staff had completed a range of training to ensure they had the skills and abilities to meet people's needs effectively. Essential training covered topics such as safeguarding, moving and handling, infection control, first aid, fire safety, health and safety, dementia awareness, communication, nutrition, confidentiality, mental capacity legislation and equality and diversity. The nursing staff had completed updates in clinical courses such as end of life care, venepuncture, verification of death, tracheostomy care, catheterisation and PEG [via a tube] feeding. There was some outstanding training for staff, but this had been identified and planned.

Staff told us training, supervision and support had improved since the registered manager had been in post. They felt well supported and confident in meeting people's needs. One member of staff said, "We have completed a lot of training and the work books are very comprehensive. Our work is marked and we get the results; if we haven't scored well, we have to do it again."

There were a good range of communal areas for people to watch television or join in activities, as well as quiet areas for them to sit and be alone. We found there had been some adaptations to support the needs of people who used the service. For example, there were grab rails in corridors, toilets and bathrooms and raised toilet seats. We found the décor in areas of the service looked tired and dated. The registered manager confirmed there had been more redecoration completed since he had been in post and explained the plans for refurbishment included redecoration of more bedrooms and communal areas, however, there was no formal renewal programme in place.

Good

Is the service caring?

Our findings

There were positive comments about the staff team approach and their caring attitude. People who used the service said, "Absolutely caring and kind, every day in every way" and "Very caring staff, always smiling and have a kind word for us."

The service had a friendly and homely atmosphere. We saw relatives could visit without restriction and we saw visitors freely coming and going as they wanted during our inspection. Relatives said, "We always get a good welcome. The staff are very kind and attentive to everyone" and "[Name of family member] doesn't talk much, but they smile and laugh when their favourite member of staff assists them. They absolutely adore [Name of member of staff] and we find that so reassuring."

Health and social care professionals told us the staff always upheld privacy and dignity during their visits. One health professional described how the registered manager had supported their client in a very caring and empathetic way which alleviated distress and anxiety. Another visiting professional had come to the registered manager's office to pass on their compliments about a member of staff's lovely welcome that day and how professional and supportive they had been during their visit. They considered the staff knew the person's needs very well and contributed very positively to the review. They said, "This is far beyond our experience of other care services."

There were lots of 'thank you' cards in the registered manager's office from people who had used the service temporarily and from relatives. These referred to the kindness of staff.

We observed staff had built up relationships with the people they supported. Staff spoke with people in a kind and patient way. They made sure they were on the right level to make eye contact them and had a friendly approach. We observed some people cuddling the staff and seeking comfort from them. The staff knew people's needs well and chatted easily with them and encouraged them to join in conversations. The staff provided explanations to people before carrying out care tasks such as support with transferring from wheelchairs to comfy chairs or walking with a frame. They were caring and patient in their approach.

People were treated with dignity and respect. We observed staff knocking on bedroom doors and asking if it was okay for them to come in, before entering the room. Staff described how they promoted core values of privacy, dignity, choice and independence. They said, "We always have the light on outside [the room] if dealing with personal care, so people know someone is in there" and "We make sure doors are shut and curtains are drawn. We let people do as much as they can. If people can wash their hands and face we let them do that. No taking over."

People were provided with information displayed on notice boards around the service. There were leaflets in reception about the service, safeguarding, how to complain and advocacy arrangements. The results of quality surveys, resident meeting minutes and the activity programme were displayed in the main corridor. There was some signage around the service but this could have been better and been in symbol/pictorial format; this would assist people living with dementia to find their way around their home. Most bedroom

doors had people's name or a number on and we discussed with the registered manager the need for more pictures or other reminders for people living with dementia.

The registered manager told us they had developed links with local advocacy services. We saw people had been supported to use advocacy services to help them make important decisions.

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and supported people in an individual way, for example with their religious and cultural needs. One person's church group held their meetings at the service to support their spiritual needs. A number of people of Polish nationality resided at the service and Polish staff had been recruited to ensure effective communication and people's beliefs and preferences could be respected. The registered manager explained how they supported one person's relationship with their spouse who regularly stayed at the service to be with them.

Staff understood the need to respect people's confidentiality and not to discuss issues in public or disclose information to people who did not need to know. We found information was held securely within the service and access was restricted to ensure it was not viewed by unauthorised people.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. One person said, "Staff are very willing to get involved, they do go the extra mile here." Relatives said, "[Name of person] was ill a couple of weeks ago and the senior reacted really well to the problems, checked them out at hospital and rang me at home; it was very good" and "The standards of personal care are very good. Staff make time to do [Name of family member's] hair so they look pretty. When I bend down to kiss her, she always smells so nice."

A social care professional described how the management and staff had been very responsive and flexible to meet their client's complex psychological needs. They described how well the staff had adapted their approach to try and provide an individualised care and activity programme. They had always found staff responsive and proactive in contacting other professionals for advice, assessment and support. They also said, "[Name of registered manager] goes over and above. They have pulled out all the stops and done all they can do. I have nothing but praise for the support my client has received here."

People had assessments of their needs and risk assessments completed. The registered manager also ensured copies of the assessment completed by local authority staff was obtained prior to admission. People and their relatives had contributed to the information in care files and some people had detailed personal profiles to inform staff about their background, work and family history and interests. Most people had a list of preferences, likes and dislikes for food and fluids, which was shared with catering staff.

The information in assessments was used to formulate care plans. People had care plans in place to support all areas of need and these had been updated to reflect any changes. Some care plans contained more person-centred information than others, although in discussions with staff it was clear they knew people and their needs very well. We found the documentation format limited the amount of information staff recorded and discussed this issue with the registered manager. They acknowledged the care recording format required updating and confirmed they would look into this and implement new systems.

The care records showed that relatives had been involved in the assessment process and provided information about people's social history, family network and previous interests and hobbies. The relatives we spoke with all said they had seen, read or contributed to their family member's care plan and they felt involved in care and support decisions. We saw they were regularly contacted should people's care needs changed. One relative said, "The staff are very informative and consult with us about all aspects of their [family member's] care.

We found people received sensitive and compassionate end of life care and support from staff. One relative contacted us before the inspection to praise the care that had been provided to their family member who had died in the home last year. The relative wrote, "The staff are professional and incredibly caring. The management is top notch. All their needs are dealt with in a pro-active manner. The nurse manager predicts what medication etc. they will need and ensures all is ready so there is never a delay. We are kept informed of how they are on a daily basis and any queries are dealt with. My [name of family member] feels safe in their care. Well done Castlethorpe."

Other relatives we met praised the care provided to their family member who was approaching the end of their life. They also appreciated the support provided to them as a family. The service was working with the community palliative care team to pilot the end of care pathway documentation, which we saw in place. The registered manager was proud of the relationship they had fostered with this team, how the service had developed their approach to end of life care over the last 12 months and the number of referrals received.

The service employed an activities co-ordinator for 14 hours a week and people were encouraged to join in a range of social and leisure activities. The activity co-ordinator maintained a file which included a programme of activities and entertainment. Group activities and one-to-one sessions took place with people to ensure there was social stimulation and involvement. The range of activities included, gardening, craft work, bingo, manicures, dominoes and other games, reminiscence and chair based exercises. During the inspection we saw people completed jig-saws, games, listened to music, watched TV and a film. A singer visited and encouraged people to participate, which we observed they all enjoyed. The activity coordinator confirmed entertainers visited the service regularly and the singers were very popular with everyone. They explained how the entertainment was discussed at the resident's meetings and people decided on the bookings; recently they had chosen not to re-book the drumming group.

The provider had a complaints policy and procedure which was included in the service user guide and given to people when they were admitted; it was also on display in the service and included timescales for acknowledgement and completion. The registered manager maintained a log of complaints which showed how these were addressed. The minutes of resident's and relative's meetings showed people were encouraged to raise any concerns so they could be addressed. People and their relatives told us they felt able to complain and said, "No complaints at all, but the staff will always answer questions and I'm never fobbed off" and "We have never had to [make a complaint], but the staff are always on hand if we need any advice."

Good

Is the service well-led?

Our findings

People who used the service and their relatives told us they were happy with the care provided and how the home was run. Comments included, "The manager is so kind and caring and leads by example" and "Everything is organised. The home is well-run."

Comments from health and social care professionals included, "The service is welcoming and works well with our team to provide a positive collaborative approach" and "[Name of registered manager] is a good manager, it's a well-run home. The building needs some tender loving care but the care is exceptional."

The service had a quality monitoring system in place, with some audits completed on areas such as care records, medicines, infection prevention and control, accidents and incidents and weights. We found the format of the audit tools to be limited and minimal in content. There were no audits of Deprivation of Liberty applications, which would prompt the registered manager to complete re-applications in a timely way. Nor were there audits of the environment which checked the quality of the décor, furniture and fittings in the service. Although the registered manager described the improvements made since his appointment, there was no formal renewal programme in place. We also found some of the information recording systems were over complex and required updating to support a more thorough yet simpler approach for the registered manager. For example, the registered manager completed many different training records, yet there was no overview record, to provide a clear picture of what training each member of staff had completed and what was in date.

Many of the files contained a lot of old records, which required archiving and would support easier access to the information. We discussed with the registered manager the need to improve and develop the audit programme, which would help identify and drive service improvement. The registered manager acknowledged the limitations with the current programme and confirmed they had recently obtained a new more comprehensive medicines audit tool, which they planned to use. Following the inspection visit, the registered manager told us they had contacted representatives from the local authority and other care services in the area for support. Through this networking, they had arranged visits to review the established quality monitoring and recording systems in place, to gain ideas to implement and support improvements at Castlethorpe Nursing Home.

We sampled a range of key policies and procedures such as equality and diversity, consent, health and safety and medicines. We found some required review to reflect current good practice and the registered manager confirmed they would address this.

We recommend that the service obtains a more up to date and comprehensive recording system and audit programme to support continued service development.

There was an open and inclusive approach to running the home. The registered manager and the two deputy managers were fully accessible to people and visible within the service throughout the inspection. They took time to speak with people who lived there, staff and visitors. They demonstrated a clear

understanding of people's needs. Staff spoke positively about the management team and said they listened well and were effective in dealing with any concerns raised. Comments included, "The manager has made a lot of difference, he is pro-active and forward thinking. The service runs very smoothly", "You can go to them with anything and not worry. The manager is all about professionalism and being fair" and "It's a good place to work. We have a good team and we are all very proud of the care we deliver. The management are supportive and value our opinions."

Staff were provided with the leadership they needed to develop good team working. We saw there were regular team meetings in which staff could share views and discuss ways to improve the services provided.

The registered manager had a range of knowledge and experience to manage the home and took their role seriously. The service worked closely with other professionals from outside agencies and sought interventions when required. The management team attended local network meetings and links with the community palliative care team were strong. We saw the provider and registered manager were aware of their responsibilities in notifying the Care Quality Commission and other agencies when incidents occurred that affected the safety and wellbeing of people who used the service.

We spoke with the registered manager about the culture and values of the organisation. They told us, "My primary aim is to deliver a first-class service and enable a smooth transition from independence to dependence as people's needs change." The registered manager considered they had made improvements since they had been in post in relation to care delivery, staffing levels, management of the shifts and the premises. The registered manager had also spent time with people who used the service, their friends and families promoting a more visible management approach and effective communication systems.

People who used the service and their relatives were encouraged and supported to make their views known about the care provided at the service. For example, there were regular meetings which gave people the opportunity to be involved in the running of the service and share their ideas. The registered manager also sent out regular quality questionnaires to seek people's views. We sampled a number of completed questionnaires, which contained positive feedback overall. The registered manager shared the findings of the surveys with people who used and visited the service.