HC-One Limited

Hinckley Park Nursing Home

Inspection report

67 London Road
Hinckley
Leicestershire
LE10 1HH

Tel: 01455615252
Website: www.hc-one.co.uk/homes/hinckley-park/

Date of inspection visit:
17 February 2016

Date of publication:
22 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 17 February 2016.

Hinckley Park Nursing Home provides care for up to 35 older people. At the time of our inspection 34 people were using the service. Accommodation is on two floors, accessible by stairs and a lift. People's rooms have an en-suite and are spacious. Facilities include communal lounges and dining areas and an enclosed garden. Since our last inspection in September 2014 the home had undergone extensive internal refurbishment.

The service was managed by a manager who was in the process of applying to be a registered manager. 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 were protected from abuse. Staff understood their responsibilities to identify and report any sign of abuse using the provider's safeguarding procedures. Staff knew they could report any concerns about people's safety directly to the Care Quality Commission. People were protected from avoidable harm through risk assessments. These included information for staff about how to support people safely and without undue restrictions.

Staffing deployment was based on needs of people using the service. If people's needs increased, additional staff were deployed. Relatives of people using the service felt that staff were `stretched' but this coincided with a period when the service was experiencing higher than normal staff absences. Additional staff were being recruited. The provider's recruitment procedures ensured as far as possible that only people suited to work at Hinckley Park Nursing Home were employed.

The provider's arrangements for the storage of medicines were safe. Only staff who successfully completed training in management of medicines supported people with their medicines.

People using the service were supported by staff with the right skills and knowledge. Staff were supported through effective training and supervision. Staff understood and practised their responsibilities under the Mental Capacity Act 2005. They sought people's consent before they provided care and support. No person had restrictions on their liberty unless it had been authorised under the Deprivation of Liberty Safeguards.

People were supported with their nutritional needs. Not all staff completed fluid intake records accurately, but action was being taken to improve completion of those records.. People had a choice of nutritious food and were protected from the risks of malnutrition and dehydration. People were supported to access health services when they needed them. The service arranged for health professionals to visit the service to attend to people's health needs.

Staff developed caring relationships with people using the service. They were able to do this because they understood people's needs and their life stories. Staff were attentive to people's needs and supported them to be comfortable.

People using the service and their relatives had opportunities to be involved in decisions about their care and support. They had access to information about the service and their individual care plans.

Staff treated people with dignity and respect. People were able to spend their time the way they wanted and their choices were respected. People were able to spend private time alone or with relatives in their rooms.

People's care plans were focused on how their individual needs were met. Staff referred to people's care plans and understood their needs. People had opportunities to be involved in reviews of their care plans and to provide feedback about their care and support.

People using the service and their relatives had access to a complaints procedure.

The service was managed by a person who had applied to be a registered manager. They understood the CQC registration requirements.

The provider's quality assurance procedures kept up to date with changes in legislation and were used to monitor and assess the service's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Those procedures were used to drive improvement at the service.

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 understood and practiced their responsibilities to protect people from abuse and avoidable harm without restricting people's freedom.

The provider's recruitment procedures were robust. More staff were being recruited.

Arrangements for the management of medicines were safe.

Is the service effective?

Good

The service was effective.

People were supported by staff with the right knowledge and skills.

Staff were supported through effective training and supervision.

People were supported with their nutritional and health needs.

Is the service caring?

Good

The service was caring.

Staff developed caring relationships with the people they supported.

People using the service or their relatives were involved in decisions about their care and support.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People received care and support that was centred on their needs.

People were supported to participate in meaningful activities.

People's feedback was encouraged and acted upon.

Is the service well-led?

Good

The service was well led.

The provider promoted an open culture where people, relatives and staff were encouraged to raise concerns and make suggestions.

Management and staff shared the provider's aims and objectives.

The service operated effective procedures for monitoring and assessing the quality of the service.

Hinckley Park 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 17 February 2016 and was unannounced.

The inspection team consisted of two inspectors 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. Our expert-by-experience had expertise in caring for older people.

Before our inspection we reviewed information we had about the service. This included notifications we had received from the provider about notifiable incidents that had taken place at Hinckley Park Nursing Home. We also reviewed information we had received from relatives of a person who used the service in the form of a complaint about the service. We used that information to help plan our inspection though our regulatory powers do not include investigating complaints.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

We spoke with 14 of the 34 people using the service on the day of our inspection, one of their relatives and six relatives of people we did not speak with. We looked at six people's care records. We observed how staff interacted with and supported people using the service. We spoke with the manager, two nurses, four care workers and a cleaner.

We looked at records about the training and support staff received; and looked at staff recruitment file to see how the provider recruited people to work at Hinckley Park Nursing Home. We looked at records of staff meetings, `residents' meetings and a summary of the most recent satisfaction survey carried out by the provider. We looked at records associated with the provider's procedures for monitoring and assessing the quality of the service and the management of complaints.

Good

Is the service safe?

Our findings

When we asked people whether they felt safe they all told us they did. Some expressed themselves with evident confidence. A person said, "Oh good heavens yes." Another said, "Safe? Yes, oh yes." People using the service told us that they felt safe when staff provided care and support. A person told us, "I feel safe when being hoisted." A person who was not able to communicate verbally nodded their head and held both thumbs up when we asked if they felt safe.

The provider had policies and procedures for protecting people from abuse. Staff we spoke with were familiar with those procedures and knew how to identify and report any signs that a person was either at risk or had experienced abuse. They described how they looked for changes in people's mood, sleeping and eating patterns and appearance as possible indicators of abuse. They knew how to report abuse and told us they were confident that any safeguarding concerns they raised would be taken seriously. A care worker told us, "I'm definitely confident that any concerns I raised would be taken seriously. If not I would use the whistle-blowing procedures or contact the Care Quality Commission." Training records we looked at showed that staff had attended training about safeguarding vulnerable people. Visitors we spoke with had no concerns about their relative's safety. One told us, "I haven't seen any unsafe practice." Another told us, "Yes I do think [person using the service] is safe here."

People's care plans included assessments of risks associated with their care routines. These risk assessments included information about how to support people safely to minimise the risk of harm or injury. People told us they felt safe when staff used equipment during personal care routines. One person told us they didn't feel as safe when they were supported by agency staff. Where people were at risk of falls they had low beds in their rooms and chairs with sensors that alerted staff if a person had left their bed or seating. People had fall mats in their rooms that limited the extent of injury that could be caused by a fall.

The provider had procedures for the internal reporting and investigation of accidents and injuries occurring at Hinckley Park Nursing Home. After incidents were reported by staff steps were taken to reduce the risk of further falls or associated injuries. For example, the provider arranged for support from physiotherapists or involved a person's doctor in discussions about how to reduce the risk of falls and prevent injury. People's risk assessments were reviewed and amended to include information about changes in how people were supported to reduce risk of similar accidents happening again. These measures worked because only one person was reported to have suffered a serious injury as a result of a fall in the last 12 months.

Another factor contributing to people's safety was that the premises were clean and well maintained. A relative told us, "Everywhere is so clean." People using the service were protected from risks of harm from accidents because the provider had effective maintenance procedures. For example, water temperatures were regularly checked to prevent a risk of people scalding themselves when washing. The home had undergone a major refurbishment since our last inspection in September 2014. Communal areas were tidy and free of clutter which meant people were protected from the risk of trips and falls. Corridors, lounges and people's rooms had sufficient space to manoeuvre people in hoists and mobile chairs safely. People using the service had individual fire evacuation plans. Throughout the day of our inspection we observed people

being safely supported with transfers, for example from armchair to wheelchair. Several people had mobile armchairs which limited the amount of times a hoist was required because they could stay in those chairs when being supported to different areas of the home. Care workers explained how they were supporting a person throughout the manoeuvre to help them feel safe. A person using the service told us that they felt safe when they were supported by permanent staff. They told us, "I feel safe when being hoisted, but agency staff don't always know how to use the hoist."

The provider had robust arrangements for recruiting new staff. People applying to work at Hinckley Park Nursing Home had to provide evidence of their suitability in their application forms. Successful applicants did not start working with people using the service until all the required pre-employment checks were carried out. These included Disclosure and Barring Service (DBS) checks. These checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce. The provider required potential recruits to provide two suitable references. People using the service could be confident that the provider sought to ensure as far as possible that only people suited to work at Hinckley Park Nursing Home were employed.

Staffing levels were decided by the manager. They based their decisions on the needs of people using the service. If people's level of dependency increased, extra staff were deployed. Staff rotas were planned six weeks in advance. A person told us, "The last couple of months the changeover in staff has been more stable than in the past." Another person told us, "When there are three staff it is fine, but when they are short it's not so good." The manager told us that three care workers and a nurse were on duty on each of the two floors every day. Staff we spoke with confirmed that to be the case. One told us, "Three care workers per floor is enough. It's only difficult when a care worker reports sick and a replacement has to be arranged. It's more important that we have the right skills mix than numbers."

When we spoke with relatives of people using the service they felt that staff were `over stretched' at times. They said was that at times people waited longer for staff to respond to requests for support. We witnessed that a person waited nearly 40 minutes for a response to a verbal request they made of a care worker, though this had no adverse impact on the person's personal care. We heard another person call out for ten minutes before a member of staff attended to them. A relative told us, "The care is very good when it is fully staffed. Sometimes, I carry out a lot of [person's] care when I visit. If [person] is asleep I help out sometimes. I feed other residents and help with the activities." We spoke with the manager about visitors helping people other than their relatives, but it was not something they were aware happened and they told us they would look into this.

We saw on-line feedback from people which included a comment about staffing. It said, `Adequate staffing. Care maintained to high standard.' We saw that staff were particularly busy in the build up to and during the lunch period when we counted 19 people who required support with eating their meal with three care workers to support them. During that period staff interactions were more task orientated than person centred. We saw that apart from the two occasions we witnessed, care workers responded without undue delay when people requested support.

At the time of our inspection the service was experiencing higher than normal sickness absence amongst staff. The manager and care workers told us that agency staff were used only to cover staff absences and that they were told about how to support people. The arrangement the provider had with an agency was that only staff with the correct skills and knowledge would be supplied. The manager preferred that only agency staff who had been at the service before were sent. More permanent staff were being recruited to reduce the use of agency staff.

The service's arrangements for the management of people's medicines were safe. Only staff trained in medicines management supported people with their medicines. We observed a `medications round'. We saw that the medications administrator checked they were giving people the right medicines. They explained to people what their medicines were for.

Arrangements for the storage of medicines were safe. This included storing medicines securely and at the right temperature. Arrangements for disposal of medicines that were no longer required were effective.

Good

Is the service effective?

Our findings

Results from the provider's most recent satisfaction survey showed that 92% of people using the service felt that staff were capable of providing the care and support they needed. A comment made on-line by a relative said, `staff were all professional.' A visitor we spoke with told us that staff were knowledgeable about their relative's needs and added "Overall, [person using the service] is well looked after."

Providers are required by regulation to induct, support and train their staff appropriately. In our guidance for providers we expect them to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction. The Care Certificate was introduced in April 2015. It covers 15 standards of care. The provider enrolled new staff to the Care Certificate.

Staff we spoke with told us they felt that the training they received equipped them to carry out their roles and refreshed and updated their skills and knowledge. A care worker told us, "My training has helped me to do my job." Another care worker told us, "The training is good, though I'd prefer more face to face training rather than on-line training. But I do feel well supported through training." A recent staff survey showed that 88% of staff felt they were supported with their learning and 96% said they were given time to attend training. Staff had opportunities to develop their skills. Care workers, for example, were able to enrol for a `nursing assistance programme' where they were taught additional skills such as medicines administration and other skills that enabled them to support the nurses at the home.

Staff were supported through regular, usually monthly, supervision meetings with their line-manager. A care worker told us, "I feel supported. I can talk to the nurses and managers about my role and I'm able to propose training I'd like to do." Staff were kept informed about people's latest needs at daily `flash meetings'. These were daily fifteen minute meetings at which essential information about people's needs was shared. This contributed to staff understanding about any changes in a person's needs and the way they needed to be supported.

People using the service could be confident that they were supported by staff with the necessary skills and knowledge.

The Mental Capacity Act (MCA) 2005 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 who lack mental capacity 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.

The manager understood their responsibilities under the MCA. They followed the DoLS procedures when necessary. A care worker we spoke with told us they had recently had training about the MCA. Staff we spoke

with showed awareness of the MCA and understood they could provide a person with care and support only if the person gave consent. We saw care workers requesting and obtaining people's consent before they provided support. Staff we spoke with understood that people had to be presumed to have mental capacity unless there was evidence to the contrary.

People using the service did not speak enthusiastically about the meals they had at Hinckley Park Nursing Home. A person told us, "The food is alright." Relatives were more complimentary. Comments from relatives included, "The food is good" and "My mother enjoys her meals. There is always a good selection of meals. Her nutritional needs are met." People with cultural dietary preferences were supported. Relatives were able to bring food that people could have in small refrigerators in their rooms.

We saw from menus we looked at that people had a choice of nutritious meals that were prepared by a cook. People with dietary requirements or preferences were able to have meals of their choice. People with special dietary needs, for example people requiring soft or pureed food, had their needs met. The cook and kitchen staff had information about people's dietary preferences which ensured that people had meals they liked. People could have their meals in their rooms or in communal dining areas. Relatives were able to join their family members for meals. When we observed a lunch-time meal in a dining area we saw that people were supported to have an enjoyable and sociable experience with other people using the service, relatives and staff.

We saw that. staff provided people with drinks of their choice throughout the day. However, we saw that `fluid intake charts' were not always completed. In one set of charts we saw that on 14 consecutive days in February 2016 a person's fluid intake fell far below their recommended target. The charts had a space for an explanation of a shortfall and a note of action taken, but neither were completed. Nor were the charts signed by the person completing them. We looked at another set of charts for a different person and found similar omissions. Both sets appeared to have been completed by the same care worker. We discussed this with the manager who showed us other care records which did record the action taken. The issue here was that the charts we looked at were, by themselves, not a reliable record of monitoring people's fluid intake because they were not properly completed. The manager was aware that not all staff consistently completed the charts and told us that staff would be reminded about accurate completion of fluid intake charts and where necessary staff would receive training.

Most people we spoke with felt they were supported with their health needs. Two relatives felt otherwise. We discussed this with the manager and looked at the people's care records. The records showed that the people were being supported in line with advice from health professionals but that changes in care routines had not been communicated to relatives. Care workers we spoke with told us how they identified changes in people's health. They looked for signs that people were unwell, for example changes in mood, behaviour, sleeping and eating patterns. Any concerns were acted upon by referrals to health professionals. For example, people with unplanned weight loss who were assessed at risk of malnutrition were referred to specialist dietary services. Staff acted upon the advice those services gave and supported people to achieve a weight considered to be healthy for them. People were supported to access health services such as dentists, opticians and chiropodists. A GP from a local health centre visited the home very Thursday.

Good

Is the service caring?

Our findings

People we spoke with told us they felt staff were caring. A person told us, "The staff are really caring" We saw feedback that relatives had made on-line. Comments included `Staff are all professional, caring and treated [person using service] with utmost dignity', "Staff are fantastic' and `Staff were all very friendly and helpful and took the time to get to know[person].'

Staff we spoke with told us about how they developed caring relationships with people using the service. They used the information in people's care plans to get to know them, this included information about what was important to them, their likes and dislikes. A care worker told us, "My main source of information is a person's care plan. I look at care plans often and learn how people want to be supported." They added, "I also talk with people and their relatives to understand more about their life history and the jobs they had. I use that information when I have conversations with people." Relatives confirmed to us that staff spoke with them along those lines.

People had access to information about their care and support through their involvement in reviews of their care plans. The service had an administrator who provided relatives with information they needed before and after they began to use the service. A relative told us, "The administrator was brilliant, she provided loads of information. She was really helpful. We saw during our inspection that the administrator was a source of information to relatives, staff and ourselves.

Staff paid attention to detail to help people feel they mattered. They helped people choose colour coordinated clothing and supported people to use a hairdressing service at the home. A relative told us, "My mother always looks well presented. She looks nice every day."

We saw and heard staff engaging in conversations with people and being attentive to their needs. Staff asked people if they were comfortable and helped people to adjust their posture. When staff supported people they explained to people how they would assist them and continued to talk to people and offer encouragement and reassurance whilst they supported them.

Throughout the day of our inspection we observed many positive interactions between staff, people using the service and relatives. Staff displayed a caring and compassionate nature and an understanding of the needs of people they supported. Staff helped people to be comfortable. They explained how they were supporting people, for example when they supported people to walk to other areas of the home. A relative told us, "The care staff seem to always have smiley faces when they come into mum's room." The manager, care workers and the administrator dealt sympathetically with relatives when an upsetting event happened during the late afternoon of our inspection.

People had opportunities to be involved in decisions about their care and support. One day each month a person using the service was a `resident of the month'. On that day their care plan was reviewed with their and their relative's involvement. These reviews helped staff to get to know a person better because staff who were involved in a person's support took part in the review. A relative told us, "I'm involved in

discussions about care. I have found that beneficial." Another relative told us, "Oh yes they discuss his care plan with me every so often."

People were able to have private time to themselves either in `quiet' areas at the home or in their rooms. We saw relatives spend time with people in different areas of the home, example in dining area visitors, lounges and people's rooms. Relatives had uninterrupted time with people they visited. Relatives told us they felt `at home' when they visited. They were able to visit the home without undue restrictions. The results of a survey showed that all people said they could have visitors when they wanted. We saw from the entries in the visitor's signing-in book that relatives came throughout the day and early evening.

A person using the service told us, "Staff are all very good they do respect my dignity and respect. "We saw and heard staff treating people using the service with dignity and respect. They used people's preferred names when they spoke with them or referred to them. Staff respected people's choices, for example how they spent their time and when they retired to their bedrooms. Staff did not go into people's rooms without being invited unless it was in response to a call for assistance using a call alarm. People had a choice of the gender of care workers who supported them with personal care. A female using the service told us, "I don't feel embarrassed about male carers helping me, they are all trained and are respectful".

All bedroom doors had signs that were used to inform staff and visitors when a person was receiving personal care in their bedroom. This prevented people's privacy being interrupted at those times. People told us they liked their rooms because they could spend time in them. When we walked around the home we saw that rooms were clean, spacious and personalised to people's taste to make them places where people could enjoy comfort and privacy.

People using the service and their relatives could be confident that they were supported by staff who understood how to treat people with kindness, dignity and respect.

Good

Is the service responsive?

Our findings

People using the service and their relatives contributed to the assessments of their needs. People told us they felt listened to and that their needs were met. A person told us, "I have always been looked after." A relative of a person using the service told us they felt they and their parent had been treated very much as individuals. They told us, "The staff have been more than helpful. The manager dealt with a very difficult situation and managed to achieve a positive outcome for us." Another relative told us, I can bring mum's dog in to visit and children are welcome, which is really good."

People's care plans we looked at were personalised and included information about what was important to people, things they liked or were interested in and how they wanted to be supported. We saw that care workers put their knowledge of people's care requirements into practice when they supported people. When we looked at people's daily care records we found that these provided assurance that people were supported in line with their plans. For example, where people required support with personal care, we saw from records that they had that support. However, we noted that relatives were not always informed of changes in the frequency of personal care routines which left some relatives feeling that their family member may not have always had the care they expected.

People's care plans were reviewed regularly, usually monthly. Each month a person was a `resident of the day'. On that day, their care plan was reviewed by staff who were involved in their care and support. The person using the service and their relatives were involved in the review. Using this approach, each person's care plan was reviewed up to 12 times a year.

The service had two `activities coordinators', who supported people to follow their interests and hobbies, and participate in social events and one-to-one activities. They knew about people's interests because these were detailed in people's care plans. An activities coordinator we spoke with told us that one-to-one activities took place twice a week and lasted 15 to 30 minutes. These activities included reminiscence activities where they spoke with a person about things that were of interest to them. People were able to spend as much time as they wanted reading or using `mindfulness colouring books' which are known to be of therapeutic value. People had tactile dolls and other objects which were recommended in research about activities for people with dementia. Relatives also told us about music and `sing-a-long' activities that took place. Relatives were encouraged to participate in activities if they wanted to because that also encouraged people using the service to participate. Other activities for people using the service included outings to places people wanted to see, for example a new shopping centre complex in Hinckley they had heard about. People with faith needs were supported to attend faith services.

The service had links with local community projects, schools and colleges. Activities included meetings with students where both groups talked about their lives.

People using the service and their relatives had opportunities to provide feedback at `residents meetings'. There were expected to take place monthly but had not done so. When they took place they were attended by few people – only six people attended the last meeting in September 2015. The manager was reviewing

the arrangements for these meetings with a view to encourage more people to participate. People's views were also sought through an annual survey that was organised by the provider's head office. A person told us they had attended residents meetings and participated in the survey. The provider had recently installed an electronic `touch pad' for people using the service and visitors to provide feedback. That facility had been used 49 times but because the feedback went directly to the provider's head office we were unable to see what people had said.

People using the service and their relatives knew how they could raise any concerns. Information about the complaints procedure was available in the reception area at the home. The complaints procedure allowed people to raise concerns directly with the manager or, if they wanted, with the provider's head office. The procedure required all complaints to be investigated and areas for improvements identified and acted upon. People were advised they could refer their complaint to the local government if they were not satisfied with the provider's response.

Good

Is the service well-led?

Our findings

People using the service, their relatives or representatives had opportunities to be involved in developing the service. They had those opportunities at reviews of care plans when they could make suggestions about how their care and support was provided. Other opportunities arose at residents meetings and, more recently, people using the service and relatives were able to use a electronic touch pad to provide feedback. Relatives told us that they were able to speak with the manager if they wanted to make suggestions or provide feedback and they were confident they would be listened to.

People using the service and relatives also had opportunities to provide feedback and ideas through an annual survey. The results of the most recent survey were positive and people reported they felt well cared for. The surveys were commissioned by the provider who carried out the surveys, produced reports of findings and made recommendations. These were incorporated into the provider's quality assurance reports for each of the services and action plans for individual homes were developed.

Staff had opportunities to be involved in developing the service. Those opportunities formally occurred during one-to-one supervision meetings they had with their line manager, staff meetings and `flash meetings'. Staff told us they could make suggestions at any time. Staff also had opportunities to express their views anonymously in a staff survey. Their feedback was generally positive. They felt well supported to be able to carry out their roles. A care worker we spoke with told us, "Morale is much better. The refurbishment of the home has helped."

The management and staff shared a clear vision about what they wanted to achieve for people using the service. This was set out in the service user guide and statement of purpose which was available for people using the service and relatives to read.

The provider promoted an open and transparent culture at the home. This was promoted at staff meetings, in newsletters and the provider's website. The provider had whistle-blowing procedures which staff could use to report concerns without fear of repercussions. Staff were therefore supported to question practice and they did that by using the provider's incident reporting and whistle-blowing procedures.

The manager was accessible to people as was the home's administrative officer who was able to provide information and advise people about the service. A person using the service told us, "The manager is easy to talk to." Another said, "The manager here is very good she comes to see me." A relative told us, "I do think the home is well run. I am well happy with mum's care."

The service was managed by a registered manager until they moved to another service in September 2015. Since then the service was being managed by a person who was in the process of applying to be the registered manager. They understood the responsibilities under CQC registration requirements to report events at the home such as deaths and serious injuries. Effective arrangements were in place to submit those reports in a timely manner. The provider had procedures for monitoring and assessing the quality of the service. These were based on the requirements of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. The manager carried out a series of scheduled checks on whether the service was complaint with the regulations. They reported their findings to an area operations director who then carried out their own checks and verified the manager's reports. Both sets of checks were thorough and each report included a plan of actions that had to be taken to bring about improvements. Each month managers of different services overseen by the area operations director met to discuss the findings of monitoring activity. The area operations director reported findings to the provider's board of directors.

The manager's monitoring activity included daily `walk rounds' when they observed staff care practice and how they interacted with people using the service. The manager took that opportunity to assess whether staff were putting their training about supporting people with dignity and respect into practice.

The quality assurance procedures were used to identify what the service did well and what could be improved. For example, if performance targets were not met, the manager submitted action plans which were monitored by the area operations director. The monitoring procedures took account of our guidance for providers about how they can meet the requirements of regulations.

Staff received feedback about the performance of the service at staff meetings and supervision meetings. Staff we spoke with told us they felt well informed.

We found that the provider arrangements for monitoring and assessing the service reflected effective governance arrangements. People using the service could be confident that their and their relative's views mattered to the provider.