Bethesda Healthcare Ltd

Westhampnett Nursing Home

Inspection report

Westhampnett House
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09 April 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 and 9 April 2018 and was unannounced.

Westhampnett Nursing home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation, for up to 32 older people, who are living with dementia and who require support with their personal care or nursing care needs. On the day of our inspection there were 26 people living at the home. The home is a large property situated in Westhampnett, West Sussex. A combination of single or double bedrooms were available for people. Shared bedrooms were only used when two people, such as a married couple, or partners, chose to share. There was a communal lounge and dining room as well as a conservatory which people could use. The home had attractive gardens. There is a passenger lift so people can access the first and second floors and there is ramped access on the ground floor for those with mobility needs.

At the last inspection on 18 August 2015 we found the service was in breach of a regulation as the staff recruitment process did not ensure adequate checks were made that staff were suitable to work in a care setting. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection we found the provider carried out the required checks on newly appointed staff and this regulation was now met.

At this inspection we found risks to people were assessed and actions put in place to mitigate people coming to harm. These, however were not always consistently applied and we found sufficient action had not been taken regarding those people assessed of being at risk of developing pressure injuries to their skin. We have made a recommendation about this.

Where people did not have capacity to consent to their care and treatment this was assessed. Where these people had their liberty restricted an application for a Deprivation of Liberty Safeguards (DoLS) had been made to the local authority. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

There service did not have a registered manager in post but the current manager had submitted an application to register with the Commission. 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 and their relatives were satisfied with the standard and safety of the care provided. Staff had a good awareness of the principles and procedures for safeguarding people in their care.

Sufficient numbers of registered nurses (RGNs) and care staff were employed to ensure people were looked

after well.

Medicines were safely managed.

The home was found to be clean and hygienic and there were no offensive odours.

The premises were safe and well maintained. Adaptations had been made so people with mobility needs could move around the home. People were able to personalise their rooms.

There were systems to review people's care and when incidents or accidents had occurred.

People's health and social care needs were assessed. There was evidence staff were trained in current guidance such as in palliative care and in supporting people who had needs regarding problems when swallowing food. Staff had access to a range of training courses including nationally recognised qualifications in care. Staff were also supported with supervision and their performance was monitored by regular appraisals.

People were provided with varied and nutritious meals. There was a choice of nutritious meals.

Staff supported people to access health care services such as their GP as well as when needing more specialist assessment and treatment for a dietician or the community nursing team.

People were observed to receive care from kind and caring staff. People's rights to privacy and choice was promoted. People were consulted about their care and how they liked to be supported.

People received personalised care that was responsive to their needs. Care plans reflected people's needs and preferences. Improvements had been made regarding the provision of activities and to engaging with people about this.

The provider had a complaints procedure and records were made of any complaint or concern raised. These records showed complaints were looked into and a response made to the complainant.

Whilst there were no people in receipt of palliative care staff were trained in this and there were plans to extend this to more staff. Advanced care plans had been devised with people regarding how they would like to be treated at the end of their life.

There were opportunities for people and their relatives to express their views which the provider responded to. The quality assurance and compliance manager had a clear plan of where improvements could be made and had put some of these into place. The staff and management worked well with other agencies such as the community nursing team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were assessed but action had not always been taken to mitigate these.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Sufficient numbers of staff were provided to meet people's needs. Checks were made that newly appointed staff were suitable to work in care.

Medicines were safely managed.

The home was found to be clean, hygienic and free from any offensive odours.

People's care was reviewed and incidents were monitored and action taken to make improvements.

Is the service effective?

Good

The service was not always effective.

The service adhered to the requirements of the Mental Capacity Act 2005 Code of Practice by carrying out capacity assessments and making applications to the local authority where people's liberty was restricted for their own safety.

People's physical health and social care needs were assessed and staff were supported to complete training in care and nursing practices.

People had varied and nutritious meals.

People had access to health care services.

Adaptations had been made to the environment and people were able to personalise their rooms.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind and caring. Staff promoted people's rights to choice, privacy and independence.

People were consulted and involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs. Activities were provided and people had opportunities to make suggestions about this.

People's views and concerns were listened to and acted on. The service had a complaints procedure and complaints were acted on and complainants responded to.

Whilst there were no people in receipt of end of life care staff training and care records showed the service had policies for palliative care.

Is the service well-led?

Good

The service was well-led.

The provider's management team had introduced improvements and had plans for the future direction of the service.

A number of audits and checks were carried out regarding the quality of the service.

People and staff had opportunities to express their views about the service and these were acted on.

Staff worked well with other agencies to meet people's needs.

Westhampnett 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 was 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 5 and 9 April 2018 and was unannounced. The inspection was carried out by 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 service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. 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 reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us.

During the inspection we spoke with 6 people and two visiting relatives or friends of people who lived at the home. We spoke with three care staff, a registered nurse, the chef, the manager, the provider's group quality assurance and compliance manager, the auditor whom was responsible for some of the training and the provider's group general manager.
We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for seven people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of medicines administered to people and complaints. We looked at staff training records and staff supervision records. We also spoke with a Tissue Viability Nurse from the community nursing team and a visitor who provided religious services to people.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 16 October 2015 we found the provider was in breach of Regulation 19 as adequate checks had not been carried out to ensure newly appointed staff were suitable to work in a care setting. This included a lack of references for some staff and a lack of checks that nurses employed by the provider were registered with the Nursing and Midwifery Council (NMC). The provider submitted an action plan to confirm that action was being taken to address this. At this inspection we found adequate checks were made before staff started work including references from previous employers, checks that nurses were registered with the NMC and checks with the Disclosure and Barring Service (DBS). Providers are required to obtain a Disclosure and Barring Service (DBS) check on staff before they start work. The DBS maintains records of any people who are deemed as not being suitable to work in a care setting. We judged the requirement made at the last inspection regarding staff recruitment was now met.

At the time of the inspection we were informed by the provider there were no people at the home who had any pressure injuries and that the staff had been successful in treating pressure injuries where people were admitted to the home with them. The staff liaised with the tissue viability nurse regarding any treatment and prevention of pressure injuries. The tissue viability nurse told us the staff had made a referral to them and had followed their advice which resulted in the staff successfully treating the pressure injury. However, we found measures taken to assess and manage the risk of pressures areas were found to be in need of improvement. The National Institute for Health and Clinical Excellence (NICE) issued guidelines in 2014 which outlined that because pressure wounds, once developed take an extended period to heal, can be very painful and may be a source of infection, the emphasis must always be on their prevention, before they occur. The importance of accurate assessment of risk and consistent care provision is outlined as a key area. The service was not consistently doing this.

The risk of pressure areas developing was assessed using a recognised assessment tool. There was a corresponding care plan called a 'skin integrity care plan,' which gave staff guidance on action to take to prevent pressure areas. However, we found these were inconsistently completed. For example, one person who was identified as being a high risk of developing pressure areas on their skin did not have a skin integrity care plan, but there were records to show the person was repositioned on a regular basis to help prevent pressure injuries. This was discussed with the manager and quality assurance and compliance manager who agreed a skin integrity care plan should have been completed and that the person should have a specialist air flow mattress which was not in place. The care plan was completed by the second day of the inspection and arrangements made for an air flow mattress to be provided. There was reference to the management and prevention of pressure areas in another part of the care plans which the provider sent to us following the inspection. This also did not reflect the actions staff were taking to prevent pressure areas developing, namely how often the person needed to be repositioned.

From the sample of records we looked at we also identified one person had a care plan to show how often they should be repositioned but two other people's did not when staff were completing a record to monitor this was being done. The quality assurance and compliance manager took action to update these details.

We asked the manager and quality assurance and compliance manager if the air flow mattresses were set at the right pressure and they did not know how this was ascertained and had difficulty in finding any guidance on this as the mattresses were of different models. Following the inspection, the provider contacted us to say the guidance had been located and the mattresses would be set at the correct setting. We were, however, unable to check this. We recommend the provider ensures recognised procedures regarding the management of risks associated for those people identified at risk of developing pressure injuries to their skin.

We looked at how other risks to people were managed. There were assessments regarding the risk of falls to people, risks for using bed rails as well as assessments of mobility and for supporting people to safely move. There were corresponding care plans to show how staff should support people when they moved and these included details such as equipment and numbers of staff. Risks of choking on food were assessed and arrangements were made for people to have softened food where this was an issue. We observed staff monitored people when they ate and intervened to ask if assess someone who coughed for a short time whilst they ate.

Staff were trained in the safeguarding of people and knew what to do if they needed to raise any concerns regarding the safety of people. Staff said they were encouraged to raise any concerns they had and added that they were provided with telephone numbers of the local authority safeguarding team and the Care Quality Commission if they felt the need to contact them. This reflected a service which promoted the safety of people by being open and transparent. Staff also said they were committed to protecting people and treating people equally irrespective of their age or disability.

We looked at the provision of staffing levels. The quality assurance and compliance manager informed us that a staff dependency assessment tool was not used to calculate staffing levels to meet people's needs but that this was done by looking at the assessed needs of people. We were also informed staffing levels were flexible and could be increased to meet people's changing needs. At the time of the inspection there were 26 people living at the service. The staff roster showed five care staff and one Registered General Nurse (RGN) on duty from 8am to 2pm each weekday. From 2pm to 8pm there were four care staff and one RGN on duty. In addition to this were the hours worked by the manager and deputy manager both of whom were RGNs. Night time staff consisted of one RGN and two care staff. We observed there were enough staff to meet people's needs and that staff responded when people asked for assistance. Staff said they considered there were enough staff on duty to meet people's needs. For example, one staff member said there was enough staff so they had time to spend time with people rather than just enough time to complete care tasks. A health care professional considered the service provided adequate staffing levels.

We looked at the service's medicines' procedures. Medicines were administered by the RGNs who were trained in the handling and administration of medicines and this included a competency assessment to ensure they administered medicines correctly. Medicines administration records (MARs) showed staff recorded their signature each time medicines were administered. The MARs showed people received their medicines as prescribed. We observed staff supporting people to take their medicines. People said they were satisfied with the support they received regarding their medicines.

We noted medicines were stored in metal trolleys fixed to the wall for security in corridors. The temperature of the medication storage was not monitored. When we raised this with the provider action was taken to address this immediately. Medicines may need to be stored at certain temperatures as high temperatures can affect the potency and effectiveness of medicines. Medicines needing to be stored in a refrigerator were stored correctly.

At the previous inspection we identified that care plan guidance regarding the 'as required' administration of rectal diazepam was not in place; at this inspection we found this had been addressed. However, adequate guidance was not in place regarding 'as required' medicines for laxatives and pain relief although we observed people were asked by staff if they needed any pain relief medicine. The manager and quality assurance and compliance manager took action to update these during the two day inspection and confirmed all the care plans regarding 'as required' medicines would be reviewed.

There were weekly audit checks to ensure people received their medicines safely and as prescribed.

The home was found to be clean and hygienic as well as free from any offensive odours. Staff wore personal protective equipment to prevent the spread of infection. Hand sanitisers and paper towels were in place for staff and visitors to use so the risk of infection was decreased. Staff were trained in infection control. The kitchen was clean and well maintained and had been awarded five stars for food hygiene by the environmental health department.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical wiring, the heating system, electrical appliances, hoists and passenger lift. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked each week. Radiators had covers in order to prevent the risk of people being burnt and first floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. There were health and safety risk assessments regarding the environment. There were contingency plans in place in the event of a fire or need to evacuate the premises. On the first day of our inspection we found a fire exit route was blocked by a resident's bed; this was rectified once we raised it with the provider.

On the first day of the inspection we noted bed rails did not all have appropriate cushioning to protect people from injury and that some cleaning chemicals were not securely stored. These were rectified by the second day of the inspection and bed rail cushioning was in place and cleaning substances securely stored.

The provider used a number of systems for reviewing care and where incidents had occurred in order that lessons were learnt. These included quality assurance audits and reports regarding areas such as any falls to people and the monitoring of weights. The quality assurance and compliance manager informed us of improvements regarding arrangements for people to have the correct support where there is a risk they may choke on food. The reviews of care had not effectively identified where action was needed regarding the assessment and care where people were at risk of pressure injuries to their skin.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people had capacity to consent to their care and treatment their care records showed they were consulted about their care and had signed a record to acknowledge they were in agreement with their care plan.

Staff had received training the MCA and knew the principles of the legislation and the need to obtain people's consent. Staff were observed to ask people how they wanted to be supported and asked their agreement before helping them.

Mental capacity assessments had been carried out where people were unable to consent to their care and treatment. DoLS applications had been made to the local authority for 12 people who did not have capacity to consent to their care and treatment and who were not free to leave the home unless accompanied by staff for reasons of their safety.

Care records showed people's physical, mental health and social care needs were assessed and covered psychological needs, daily lifestyle and emotional well-being. People and their relatives said staff were skilled in providing care. For example a relative commented about staff, "Satisfied with the level of training they had to support individual needs." Staff had a good awareness of people's right to services and good care irrespective of their age, sex or disability. The provider had policies and procedures on equality and diversity. The staff worked with other agencies such as the tissue viability service regarding support and guidance for the care and treatment of pressure areas on people's skin and the community nursing team for advice and guidance on current care and nursing procedures.

Staff were well trained and had access to a number of relevant training courses based on the current legislation regarding subjects such as the Mental Capacity Act 2005 and moving and handling of people. The service employed 13 health care assistants and seven RGNs. Nine of the health care assistants had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2, 3 or 4. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff said they were encouraged to complete training and completed courses considered mandatory to their role such as fire safety, health and safety, moving and handling, and infection control. Records of this were maintained on a

spreadsheet called a matrix so the training could be monitored. The quality assurance and compliance manager stated that additional training had been introduced in dysphagia (a condition where people have difficulty swallowing food) and in dementia. The quality assurance and compliance manager recognised the need to improve and develop the staff training and supervision and had future plans to introduce further training. RGNs were supported to update their training in areas such as the use of syringe drivers for pain relief. One staff member stated they did not receive moving and handling training but this was contested by the moving and handling trainer who showed us a record of the training. We noted this did not specify that the moving and handling training included both a theory and practical element. The trainer amended this at the time of the inspection.

Newly appointed staff had an induction which they said involved a period of shadowing more experienced staff and enrolment on the Care Certificate. Records of staff induction were maintained and showed staff had registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff also said they were able to ask for a longer induction period if they did not feel ready to work unsupervised.

Staff said they received supervision and felt supported in their work. The quality assurance and compliance manager said staff supervision had lapsed in the last year due to management changes and had introduced a plan to ensure all staff were supervised and had an appraisal of their work. The supervision was now taking place on a regular basis.

People's nutritional needs were assessed and care records gave staff guidance on how to support people to eat. We observed staff monitored people at meal times to ensure support could be given when needed. The meal time was calm and people enjoyed the meal which looked appetising. People were asked if they wanted additional servings of food. Care records included details of people's like and dislikes. There was a menu plan showing varied and nutritious meals. People were offered a choice of what to eat. There was good communication between the care and nursing staff and the kitchen staff. The kitchen staff had a record of people's individual weight, nutritional assessments. Information such as the need for nutritional supplements and the provision of softened food was available for kitchen staff to see. There was a system of numbered trays to ensure people got the right meal. The quality assurance and compliance manager informed us that staff had received training in dysphagia, which is the condition where people are at risk of choking as they have difficulties swallowing food or liquids.

Records showed the staff worked with other agencies such as health care and community nursing teams so people had access to health care services and ongoing support. For example, people's records included details of liaison with the tissue viability nursing team and the dietician service. A health care professional commented that the RGNs and care staff followed advice and guidance given. Records also showed other agencies and services were contacted such as social services staff, optician services, physiotherapy services and GP services. The assessment and care plan process showed health care needs were monitored such as blood pressure, body temperature, respiration and other relevant health care needs such as cardiac needs. Details about mental health care needs such as dementia were assessed recorded as well as psychological and emotional well-being.

The quality assurance and compliance manager told us people were consulted about any changes to the environment and that people were able to personalise their bedrooms. We observed people had brought their own belongings to the home. People were observed using communal areas for activities and for sitting in the garden. A conservatory area was also available which people and visitors could use for meeting in private or for activities. The home had a passenger lift and ramped access for people with mobility needs.

People were observed to be able to move around the home either without support or with the help of mobility aids. Signage was used to help those living with dementia to find their way around; this included signs on bedroom doors so people could tell which room was theirs.

Good

Is the service caring?

Our findings

The staff and provider treated people with kindness and respect. We observed staff spoke to people in a friendly and caring way. This included smiling to people as they asked them how they were, asking them how they wished to be assisted and intervening when people were in discomfort. People and their relatives confirmed staff were kind and caring. Each person we spoke to said staff treated them with respect and promoted their privacy. For example one person said, "I am always treated with respect and kindness. The staff always ask my permission before entering if my door is closed giving me my space and privacy." A visitor to the home said of the staff, "You can see the love for the residents. There is more interaction. This has improved tremendously."

People's care plans showed each person was treated as an individual. Communication needs had been assessed and there was evidence to show people's rights to leading a lifestyle of their choice was promoted as well as their religious needs. Details about the times people preferred to get up and go to bed were recorded along with other daily lifestyle choices. The care plans were personalised and showed how people liked to be supported with personal care and those areas of care they could do themselves so they could maintain their independence.

Whilst people were not fully aware that they had a care plan there was evidence that people were consulted and their preferences taken account of. We observed people were consulted when staff assisted them with daily routines.

Staff said there were enough staff on duty to enable them to spend time with people as opposed to only having enough time to complete set tasks. Staff demonstrated they had values of treating people as individuals who had a right to a good standard of care. For example, one staff member said, "I treat people how I would like to be treated – with kindness – and as I would like my parents to be treated." This same staff member said their training emphasised the importance of privacy and of treating people with respect. Another staff member said they treated people in the way they would like their mother and father treated and as they would like to be treated themselves.

We observed staff knocked and waited before entering people's rooms. The provider confirmed people were able to have a key to their bedroom door if they wished. Staff spoke to people politely. The provider's quality assurance and compliance manager and the manager said people were able to choose the gender of the care staff who would be providing personal care to them; a record of this preference was made on people's care records.

A health care professional said the staff were friendly and had good relationships with people in the home and their families. The provider confirmed people's relatives are supported to be involved in the home with no restrictions on visiting times.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. Care records demonstrated people's needs were assessed before they were admitted to the service. The care plans were individualised and showed people's physical health, personal care and social as well as psychological needs had been taken account of. There was a, 'At a Glance' care plan, which gave staff a summary of the person's needs. Care records included a social life history of the person so staff knew about the person's background. Staff considered the care plans to be of a good standard and provided them with the information to provide effective care. The care plans were reviewed with people and their relatives and staff confirmed they discussed people's ongoing care needs at regular staff shift handover meetings so they were updated on any changes to people's needs.

The provider's quality assurance and compliance manager said a number of improvements have been made to the provision of activities for people. There was an activity programme which was displayed for people to see and was given to each person. A range of activities were provided including gentle exercise, a gardening club, an art class, coffee mornings and musical entertainment. These were provided by either staff from the home or by staff external to the home. An activities folder was maintained of events attended by people and people were asked to give their views on each activity session using an evaluation form. We observed activities taking place in the home which people responded to and enjoyed. Some of those who chose to spend time in their rooms commented that the activities were not to their liking. The provider responded to this feedback by saying each person was asked what activities they would like to do which is then used to plan events for.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Care records included details about people's communication needs. For those with communication needs staff used a laptop computer to engage people with activities when they wished to remain in their rooms. There were examples of signage in the home to assist those people who were living with dementia. The manager was looking to extend this by the use of other visual aids and communication aids. The manager and the provider's quality assurance and compliance manager were not fully aware of the AIS and the provider did not have any policies or procedures regarding this. This was something the provider's quality assurance and compliance manager said would be explored.

The provider listened to and responded to any complaints. The quality assurance and compliance manager informed us that the complaints procedure was given to each person or their relative in an information pack. Relatives and people said they felt comfortable raising any concerns or complaints if they had them; they said they would speak to a member of staff or the manager. For example, one person told us, "I feel very comfortable approaching the manger if there were any problems knowing that she would respond straight away and try to resolve the issue." Where any complaints or concerns had been raised with the provider there was a record of the complaint along with a record of how it was looked into and any findings. There was a record of a written response to the complainant. Where applicable there was an apology from the

provider. The provider had a Duty of Candour policy which is required by Regulation 20 of the Health and Social Care Act 2008 and outlines what providers must do when things go wrong and an apology when applicable.

At the time of the inspection there were no people in receipt of end of life care. People's care plans included details of their wishes for their future care and how they would like to be treated at the end of their life. The quality assurance and compliance manager had completed a nationally recognised qualification in end of life care called, The Six Steps Programme and there were plans for further staff to complete this. Two staff had completed training in palliative care at a local hospice.

Good

Is the service well-led?

Our findings

At the time of the inspection the service did not have a registered manager. However, the manager confirmed they had applied to the Commission to be 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.

The provider used a number of methods for auditing and checking the quality and safety of the service. These included checks on any incidents, falls and the weight of people. Monthly visits and a report by the provider regarding the safety, premises, staff performance and complaints were carried out.

The provider had employed a quality assurance and compliance manager to oversee the quality and performance of the service. We found the quality assurance and compliance manager had a strategy for developing the service and for promoting a person centred culture. The quality assurance and compliance manager outlined a number of improvements made to the service such as developing the activities for people and adding more dining tables so people could sit and eat together. Additional equipment had been made available for people to interact with as advised by the community mental health team and included the use of laptops so staff could engage with people in a creative way.

Resident meetings had been introduced and there was evidence people's views were sought and then acted on. For example, comments made by people at the residents' meetings were listed on a notice along with an action plan of what the provider was doing to meet people comments; the notice was tilted, 'You said. We did.' There were records of relatives' meetings where relatives could raise any issue about the home. There were also plans to introduce more informal meetings such as coffee mornings so relatives could discuss anything they wanted. Surveys were used to obtain the views of people and relatives regarding the standard of service provided. People and their relatives said they were asked to give their views on the service they received and that any suggestions were acted on. For example, changes to the menus were made following feedback form people as well as additional activities. A visitor who provided religious services to people said they spoke to people on a one to one basis and fed back any concerns to the manager who was always receptive. This visitor spoke favourably about the culture of the staff team who were said to all be focussed on listening and interacting with people.

The quality assurance and compliance manager also made us aware of the changes made regarding supporting people with their food and fluid such as the introduction of a nutritional notice board in the kitchen so staff had guidance on people getting the correct meals as well as regular meetings with the chef.

Staff performance was now more closely monitored. The quality assurance and compliance manager said there had been a lapse in staff supervision and appraisal which had been addressed and all staff now received regular supervision. Additional checks were made by a member of the management team by carrying out unannounced night visits to check on staff performance. There was system of operational responsibility in the service with RGNs having a role in making decisions regarding the care and treatment of

people. There were staff meetings which included discussions of people's daily needs and monthly staff meetings. Staff told us they felt able to raise any issues or concerns which were listened to and acted on. Staff reported they worked well as a team.

The provider supported staff to develop their skills and management staff had completed qualifications in management in health and social care. Staff demonstrated a value base of respecting people and their rights to good care as well as treating them equally.

The provider and staff worked well with other agencies such as community health teams who told us the staff liaised well with them and followed any advice given; this included joint working to meet people's health care needs.