

The Royal Masonic Benevolent Institution Care Company

Ecclesholme

Inspection report

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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

This unannounced inspection took place on 16 and 20 November 2017.

Ecclesholme is a residential care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This was the first time this home had been inspected since registering under the current provider on 18 March 2016.

Ecclesholme is situated in the Eccles area of Manchester and accommodates up to 50 adults. Some people are living with dementia. There are three floors that are accessible by lift and stairs. Each floor provides a variety of communal areas to meet the different needs and preferences of individuals. People living in the home are able to move between the different floors according to their wishes. At the time of the inspection 43 people were living at the home.

There was 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 living at the home told us they felt safe. The staff we spoke with demonstrated a good understanding of how to recognise and protect people from harm or abuse. Staff were aware of safeguarding and whistleblowing policies and procedures and their responsibilities to report concerns.

People living at the home had up to date care plans that reflected their needs, wishes and preferences. These plans were reviewed and updated regularly to reflect any changes. People living at the home told us they felt cared for. Staff supporting them appeared kind and unhurried.

Staff had been recruited safely and had received training and guidance to ensure they were able to support people effectively. The staff we spoke with confirmed this. Staff told us they were happy to be working at the home some of whom had been there for over 20 years. We saw positive interactions between staff, people using the service and their visitors. People visiting the home praised the staff working there.

The home was aware of the importance of consent and their obligations under the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. We found the home was meeting their obligations.

Medication was seen to be stored and administered safely and effectively. Records were accurate and staff were suitably trained. Staff received regular medication training. Regular spot checks by senior staff maintained good practice in relation to medication. Infection control policies were clear and staff were observed to follow them throughout the two days of inspection.

Two GP surgeries visited weekly, district nurses visited as required which currently was every day. A visiting GP and district nurse praised the quality of communication from the home which they felt made their input more effective. The home is also skilled in supporting people with end of life care that reflects their wishes and ensured this was provided consistently.

People living at and visiting the home spoke highly of the food. The cook was enthusiastic and knowledgeable and ensured a variety of appetising food and drink was available throughout the day. The kitchen is also open during the night in case people were hungry. The home had changed when they had the main meal to later in the day in response to some people not feeling hungry enough to eat at lunch time. We saw where people were at risk nutritionally the home had effective systems in place to manage this.

An electronic record system was in place with paper records used for daily updates of food and drinks, pressure care and personal care. The home monitored the quality of care provided using audits and spot checks of care delivery. The home sought people's views on the service provided from people using the service their relatives and staff. Satisfaction surveys showed people were mostly satisfied. We saw complaints and concerns were responded to effectively.

The registered manager was committed and effective. Everyone we spoke with was aware who the manager was and felt the service was well led and managed. People, relatives and staff told us they found the manager to be approachable, caring and responsive.

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

People living at the home told us they felt safe.

Staff demonstrated a good understanding of Safeguarding procedures, which protect people from harm and abuse.

People were supported to manage the risks inherent in their daily lives.

Medication was stored and administered safely.

Is the service effective?

Good ●

The service is effective

People's needs and wishes were properly assessed and support plans developed to meet them.

Staff received sufficient training and regular supervision to enable them to fulfil their professional roles.

People's nutritional needs were clearly identified and met appropriately.

Is the service caring?

Good ●

The service was caring

People using the service and their visitors said they felt the staff were caring.

People were supported in ways that protected their dignity and respect.

People were supported to manage their emotional needs in a respectful manner.

Staff were skilled in promoting independence.

Is the service responsive?

Good ●

The home was responsive.

People living at the home received care that is personalised to their needs and preferences.

People's concerns and complaints had been recorded and responded to.

The home had skill and experience supporting people at the end of life and worked closely with health staff to meet people's wishes and needs.

Is the service well-led?

Good ●

The service was well led.

People living at and visiting the home felt the home was well managed.

Staff told us they had confidence in the management team and their leadership.

The home has robust auditing procedures in place to maintain quality and identify improvements.

The home had contingency plans in place to deal with any unexpected emergencies and impact on service provision.

Ecclesholme

Detailed findings

Background to this inspection

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

The inspection took place on 16 and 20 November 2017. The first day was unannounced, which meant the provider did not know we would be visiting on that day. The second day was announced.

The inspection team consisted of two adult social care inspectors and an Expert by Experience (ExE) an ExE is a person with personal experience of using or caring for someone who uses this type of care service. The ExE at this inspection had expertise in caring for older people, people with dementia and people who used care services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Prior to the inspection we looked at information contained in the PIR and reviewed all the information we held about the service including statutory notifications, safeguarding referrals and complaints. We also liaised with external stakeholders including the local safeguarding team.

As part of the inspection we spoke with the registered manager and 10 members of staff including: night staff; shift leaders; care workers and a cook; three visiting professionals; four visiting relatives and 13 people who lived at the home. We looked in detail at seven care plans along with other documentation held by the service including: policies and procedures and a range of records the home kept in relation to the running of the home.

Is the service safe?

Our findings

People who lived in the home reported feeling safe. One person said "I couldn't have ended up in a nicer place than here. They really look after me and I feel very settled and safe." Another person said "I thank God for what I've got here" whilst a third said "It's a lovely place this. I feel very safe and I'm very lucky to be here." One of the relatives we spoke with said, "I feel mum is safe, I have peace of mind now. I visit two or three times a week at different times and it is always good", another stated, "I feel that (person) is safe and feel the care is very good" A third relative said, "Mum's been here 12 months...It's just amazing here....It's not like coming into a care home here, it never smells and her room's immaculate."

We found there were systems in place to safeguard people from the risk of harm and abuse. This included having clear policies around safeguarding and whistleblowing in place. The staff we spoke with were able to identify what might indicate abuse, for example, changes in mood, unexplained marks or bruising or increased distress and were aware of their responsibilities in reporting concerns. One staff member said, "If I had any concern I would raise it with the shift manager, I would also contact the Safeguarding team or other professional if needed." Another said, "If I saw bruising I would report it to the manager. I can go higher if needed like to Social Services or CQC" Another said, "For whistleblowing, we have documents on the laptops which are password protected", "If I suspected or saw any abuse I would go to the senior or manager. If they were involved I would go higher." We saw there were effective systems in place to record and report any accidents or incidents and that staff were aware of the process to follow.

The home is part of the Safer Care Homes Programmes, run by Haelo an innovation and improvement science centre at Salford Royal NHS Foundation Trust. This included using software to look at when and where falls were happening and how risks could be reduced. The home promoted the use of people's mobility aids by making them more personal and recognisable, known as 'Pimp my Zimmer' People who had used this method reported positive outcomes and the practice was adopted by more people in the home when they had seen the benefits others experienced. This showed the home were proactive in their management of the risks associated with people not using their mobility aids. We saw a 'near miss' reporting tool was in place to record and review incidents that might not be captured on other documents either because of the nature of the incident or because no injury was sustained. This demonstrated the home was actively seeking to understand and minimise the risk and frequency of accidents.

We looked at the employee records for six staff and noted recruitment procedures were safe and robust. Each file contained references, details of qualifications and employment history. Disclosure and Barring (DBS) checks had also been carried out with the DBS number clearly documented. A DBS check is undertaken to determine that staff are of suitable character to work with vulnerable people. The registered manager said they had recently started using an 'Analysis for Suitability' assessment which helped determine an individual's suitability for working in the home.

We saw the home had a robust disciplinary policy which they had followed recently. This had been in response to unsafe practices by one member of staff which had resulted in their dismissal. This demonstrated a commitment to safe practices.

During the inspection there was 11 care staff on duty, including the shift leaders. In addition there was a registered manager, deputy manager, maintenance, and domestic and kitchen staff. The registered manager explained they were looking at a new dependency tool within the larger organisation to consider staffing levels though this was not being used yet. We saw how staffing levels might fluctuate in response to changing needs. For example a person receiving end of life care recently had a dedicated team of staff to ensure consistency for the person and their family. We saw that staff were able to support people with patience and kindness and did not appear to be rushed or hurried.

We looked at medication management overall and in particular for seven people living at the home. Medicines were managed safely. There was a medication policy and medicines were stored and administered appropriately. Each person had their own medication cabinet in their bedroom. The records of medication administered were electronic (eMAR) and would alert staff to any late medication. We found there were no gaps in the seven eMAR records viewed.

Controlled drugs were stored separately in the clinic room and were checked and secured appropriately. People who might need medication on an 'as required (PRN) basis' such as pain relief had clear guidelines in their care plans detailing when to administer and we saw these were followed correctly. Staff followed clear policies in relation to covert medication or medication given by alternative methods such as crushed and that this was done in conjunction with the GP and pharmacist. The home had a robust system for ensuring topical creams were administered including barrier creams to protect skin or pain relieving gel. We saw application had been accurately recorded on charts in people's rooms and body maps used to ensure care staff knew where to apply these treatments. There were systems in place to monitor and respond to on-going risks, food and fluid charts, and turning charts.

The home had an infection control policy, which staff and visitors were aware of. We saw personal protective equipment - (PPE), such as gloves, aprons and hand cleansing equipment was available in the communal areas, bathrooms and people's bedrooms. We observed staff using these. Staff spoken with said "We do infection control training, read policy and procedures, wash hands regularly, use coloured bags. PPE is provided to us and used all the time."

There were risk assessments in care plans in relation to moving and handling, falls, skin integrity, nutrition and choking. Risk management plans were tailored to the individual. There was a facilities manager based at the home with overall responsibility for the safety and suitability of the premises. We looked at the home's safety documentation to ensure the service was appropriately maintained and safe. Gas and electrical safety certificates were in place and up to date, all hoists, lifts and fire equipment were serviced within regulatory timeframes with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers had all been checked regularly to ensure they were in working order.

Is the service effective?

Our findings

People's needs and wishes had been assessed and support plans developed to meet their individual needs. The methods used reflected good practice and were person centred.

An electronic recording system was being used. We saw some of the previous paper records had been scanned into this, however, this task was still on-going. Where we needed help to access records the home were able to provide this promptly.

We looked in detail at the care records of seven people living in the home. We saw each person had an assessment of their needs and wishes and where it had not been possible to establish the individuals wishes directly, the home had consulted with family or significant others. The corresponding support plans which described how to meet each person's assessed needs and wishes were clear and up to date, any changes to needs were reported during the shift handovers. Written updates on the handover sheet were completed four times in 24 hours. This ensured all staff were aware of any specific changes at the start of each shift.

There was a comprehensive induction programme for new staff which had been developed to provide a broad range of knowledge and engender the home's core values and culture. Staff had received training and were knowledgeable about the needs of people using the service. The home had a training co-ordinator who provided support to the home along with other homes within the organisation. One staff member told us, "I get regular training and have recently done moving and handling and managing risks". Another said, "Training is good, I can also learn from others and ask anything at any time". There was a training schedule that included mandatory training for all staff. Training completion was monitored using a spread sheet which enabled the home to accurately identify training needs and when 'refresher' training might be needed. There were five training days scheduled in November 2017 that included some repetition to allow staff more flexibility to attend. Training topics included; mental capacity, deprivation of liberty safeguards, care certificate, customer service, falls awareness, nutrition, data protection, first aid and infection control. Staff we spoke with felt they had enough training and knowledge to carry out their role and were able to access some learning 'on-line' which increased accessibility. Staff also reported being able to seek advice and guidance whenever they felt they needed it from colleagues and shift leaders.

Staff received regular supervision and appraisal in line with the provider's policies and procedures. Staff we spoke with valued the supervision they received, one person said, "I get supervision about four times a year which is ok plus I get on-going support". Another said, "I get regular supervision but also on-going support from senior staff". The home kept a record of when supervisions took place and when they were due. We noted of the 54 staff only four supervisions were overdue however these had been scheduled. This showed a commitment to providing regular one to one support and guidance to staff working at the home.

People's nutritional and hydration needs were recorded and there were systems in place to ensure staff were aware of any specific recommendations, including colour coded lists for people needing, thickened fluids or specialist diets. This information was kept in the kitchen and communal dining rooms on the different floors. The recording of food and fluid intake was not always consistent with people's needs. For

example on one person's fluid monitoring sheet who required thickened fluids, some staff had written 'juice' whilst others had written 'thickened juice'. Each staff member we spoke with was able to tell us this person required thickened fluids and said this was purely a recording issue, rather than the person being given the wrong fluids. One member of staff told us "To be honest what people eat is not always recorded as it should; sometimes I have just put fish, mash and veg and only afterwards remembered I did not specify it was pureed. People always get what they should eat though" We raised this anomaly with the registered manager who took immediate steps to reinforce the importance of accurate recording and robust auditing by shift leaders and senior staff.

Staff were aware of the importance of good nutrition. One said "I like to ensure people have eaten well." Another said "We check what people want to eat, provide alternatives if they don't like what's on offer. We offer snacks during the day." People had enough to eat and drink and there was a wide variety of food available. The cook was enthusiastic and knowledgeable about the nutritional needs of the people living in the home. Food was well made and looked appetising. Food was made available at any time during the day and night and when people were reluctant to eat, we saw that snacking plates were provided to encourage them. People praised the quality of the food. One person said, "The food's lovely and there's always plenty". Another person said, "I still have a good appetite, not as good as it was but I still like my food, and the food's very good here." A visitor said, "The food's great and we can eat too when we visit if we want to. My sister in law came to visit and they made an afternoon tea." We saw that people could choose where they ate one person said, "I prefer to eat in the dining room on this floor and the food is very nice. You can always have what you want"

The home worked closely with other professionals to ensure care was effective. Good relationships were in place with the local GP surgeries and the district nursing teams attached to them. Two surgeries visited the home each week and the district nurses visited as often as required, which was currently daily for one person. One of the GPs who visited the home every week felt they had a very good relationship with the home. The GP also reported having access to other professionals such as a Geriatric Consultant. The home and the GP regularly reviewed health plans and ensured 'Do not attempt CPR' (DNACPR) records and end of life plans were updated. We spoke to a district nurse visiting at the time of inspection they also praised the communication between the home and themselves as being effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making a particular decision 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 interest and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Eleven applications for Deprivation of Liberty authorisation had been sought by the home in the last 12 months. There was a system in place for monitoring renewals. We saw the home were aware of their obligations in relation to the Mental Capacity Act 2005 in seeking consent for care and support. We saw the home had sought consent from individuals to receive care and where they were unable to give consent the home had consulted with relatives or significant others to ensure they understood the views of the person. The staff we spoke with were aware of the importance of consent and were kind and patient when seeking this. One member of staff told us "I ask them and wait for a response. If they become distressed or are not comfortable then I know consent may have changed so would stop and check." Another staff member said

"Ask the resident. If they have communication problems, ensure I know how they provide this. If people refuse support I will leave it and go back later and ask again."

The home was equipped to meet the needs of people living there and had been designed and decorated to create a stimulating environment. People were supported to engage in activities which reflected their interests and backgrounds. Activities included a workshop with tools where people made bird boxes, a potting shed for planting up baskets and a bar area for social activities. The home had been audited by Dementia Care Matters and achieved a rating of level two on a scale where nine was the lowest and one the highest. Observations during the inspection showed how some consideration had been given to ensuring the environment was dementia friendly. We saw themed seating areas, memory boxes, pictorial signs on some doors and the use of contrasting handrails which would assist some people living with dementia. We noted that some areas of the home would benefit from cosmetic updating. We saw the home had a maintenance schedule, which included the decoration of these areas.

Is the service caring?

Our findings

People living at the home told us they felt cared for. Comments included "The staff are so nice and it's thanks to them that I'm doing so well." "I like it here, they are all very nice." and "The staff are very nice and they're helpful." During both days of the inspection we observed staff were unhurried, kind, patient and responsive to people living at and visiting the home.

Staff were able to describe how they sought to maintain people's dignity. One staff member told us, "When providing personal care ensure doors are closed." Another said "Ensure curtains and doors are closed; explain what you are going to do and that they are happy with this." Staff also talked about ensuring people were kept covered up as much as possible when supporting with personal care. This showed staff cared about how people felt when receiving personal care.

Staff were able to describe individuals' backgrounds and interests and clearly knew the people they supported answering questions about specific needs and preferences. On the second day of inspection, people living at the home and staff were attending a funeral. One person was concerned about the colour of their clothing and voiced this to a staff member. The staff member reassured the person what they were wearing was appropriate, however also offered to go and get them a different coloured cardigan to put on, if this would make them feel more comfortable. The person was much more settled following this positive interaction.

People were supported to manage their feelings and responses in a respectful manner. Guidance in care plans informed staff how to respond when a person experienced distress and became upset. There were guidelines about speaking briefly and clearly for some people, or withdrawing for others. We observed staff took time to respond to and reassure people throughout the day.

We saw staff were skilled in respecting and promoting independence. One staff member told us, "I encourage residents to do things for themselves, just do what they can't manage." Another told us, "Help and support them, don't take their independence away. Help them to do whatever they can for themselves." Whilst a third stated, "If getting someone ready, involve them in the process, let them make choices about what they want to do or wear."

Choice was actively offered although staff were mindful to avoid confusing people with too much choice. Staff described how they did this one said, "Don't give too many options. For example ask what colour top they may want to wear, then lift out a couple of options, so not overloaded. Use short sentences, keep things simple. Also make sure you ask people to make a choice even if you know the answer, such as if they want tea or coffee or want sugar in it."

Is the service responsive?

Our findings

People received care that was personalised and responsive to their individual needs and preferences. Prior to admission a pre-assessment was carried out with the person and/or their relative(s). People's support needs were clearly described within their care plans so staff knew exactly what tasks to undertake and how best to support each person. People's care files evidenced individuals and their relatives had been involved in care planning and personal preferences had been discussed.

We asked staff about their understanding of person centred care and how they knew what was important to people. One told us, "Treat everyone as an individual, be aware they are not all the same and like the same things. There is information in the care plan, plus we speak to families and the person themselves." Another said, "It's all about people, each is an individual and their needs and choices can change daily, we do what they want us to do. I speak to them or their families and ask what they like. I also read the care plan, see what they used to do and enjoy. This provides topics we can chat about."

The home utilised an electronic care planning system. Care plans, risk assessments and monitoring charts were all completed on laptops, which were readily available to staff. We looked at seven electronic care files and saw these included a personal profile, daily notes, care plans, forms and monitoring charts. Each care file contained a range of person centred information. The personal profile section captured details of the person's needs, preferences, hobbies and interests. This document was written in first person and provided staff with everything they needed to know to provide personalised care to each individual.

As part of the inspection we looked at whether people were having their care and support needs met. This process involves cross referencing the information within care plans against actual practice. We found the service to be providing care in line with people's assessed needs and preferences. For example, one person had indicated they did not like to wear skirts, but preferred to wear trousers and a jumper. They also wished to be able to walk around the building during the day. We checked and on both days of the inspection the person was dressed according to their preference and was freely moving around the floor they resided on. We saw other care needs for this person were provided as per their care plan including dietary management, personal care and skin integrity.

Each person's detailed care plan had been condensed into a summary document. This listed each care plan area followed by a few sentences which clearly explained the person's needs and the interventions or support required to meet these. For example, one person had some issues with communicating and understanding information. The summary stated, 'use simple language and give time to express their needs. Another person's nutritional summary, included specific information such as drink preference and how many sugars they liked to have.

Within each care plan, we saw where specific issues had been identified further documentation and/or other assessments had been completed to ensure the person was safe and their needs were being met.

We asked staff we spoke with for their opinions. One told us, "The music man comes in on Friday. Staff here

are quite jolly and will regularly engage in sing-alongs. We have various people come in and do activities, we also have a hairdresser and we do people's nails." Another stated, "Activities have gotten much better. We used to have an organiser who left, so staff now do this. We try to follow the schedule as much as we can, but some people are happy to do their own thing. The residents have options to go out to Barton Hub and other places."

The home had received mixed feedback via surveys and meetings about the quality and frequency of activities. We spoke with the registered manager, who told us they had taken on board this feedback and acknowledged the need to re-employ an activities co-ordinator, so had included this resource in the proposed budget they had submitted to head office for 2018. In the mean time we saw staff had completed training in how best to engage people in activities, investment in new items such as games, puzzles and tactile equipment had been made and external resources arranged to supplement the activities provided internally by the staff.

A music therapist and a fitness trainer attended the home each week and on a monthly basis the home facilitated outings to go dancing, to a local community centre and Barton farm. During the course of the inspection we observed a reminiscence session being held discussing people's memories of Christmas time, people being supported to play games and puzzles and the visit from the fitness trainer, who ran a session for over 20 people, promoting co-ordination, gentle exercise and movement. One person who was cared for in bed said the music person came to them and they sang which they really enjoyed. Another person was making lavender bags for gifts using lavender they collected from the garden.

We looked at how the home managed complaints. A complaints, concerns and compliments file was in place, which contained guidance on managing and responding to complaints, a monitoring form and complaints log. We saw all complaints received had been addressed as per company policy, including meeting with the complainant where appropriate and providing a written response detailing findings and action taken.

We noted a recent complaint we had been copied into was not listed on the log. We spoke to the registered manager who explained that this complaint had been made directly to head office, and therefore had been recorded on their documentation. Once the complaint had been dealt with, a copy of all documentation would be sent to the home, and stored within the complaints file. During the inspection, the registered manager requested the information collated to date from head office, to show us. Within the complaints file we saw the registered manager had recorded detailed outcomes of each complaint along with any lessons learned, in order to inform future practice.

The home followed the 'Six Steps to Success – Northwest End of Life Care Programme for Care Homes'. The Six Steps Programme was originally developed in the North West as a programme of learning for care homes to develop awareness and knowledge of end of life care. The programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles in this area. A visiting district nurse praised the home's end of life care.

A designated file had been set up with sections for each floor within the home. Within these sections, we saw individual registers were in place for all people living at the home, along with a checklist to determine at what end of life care phase they were currently at. The six steps programme starts at phase one which is for people with an advancing disease. We noted anyone who did not meet this criterion, still had a sheet in place but had been recorded as a zero.

We saw monthly six steps register meetings had been held to discuss each person on the register, any

changes to presentation and any actions required. The six steps file also contained evidence of advanced care planning discussions, with people who had wanted to do so, with their end of life wishes clearly documented. These had also been transferred to the person's care files.

Despite not providing nursing care, the home strove to meet people's end of life wishes should they have included remaining at Ecclesholme, rather than go into hospital or to another residential facility. We spoke with a district nurse who confirmed the home was supportive of people's wishes and worked alongside the district nursing team to facilitate this safely and effectively.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 home had a clear management structure in place, with the registered manager being supported by a deputy manager and shift leaders. At the time of inspection the deputy manager was supporting another one of the provider's homes and so one of the senior carers had stepped into the role, to ensure continuity. We found the registered manager was very approachable and open and facilitated our requests throughout the inspection, as did the rest of the staff and administration team.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One told us, "I enjoy working here, the management are approachable and you can speak to them about anything." Another said, "I love it here. Best place I have worked, all the staff are interested and I've received lots of support. I can talk to the senior or shift leader about things and they will listen."

The home had a meetings and feedback file in place, which contained sections for staff, resident and relatives' meetings as well as survey information and feedback. We noted staff meetings had been held with different designations of staff including day staff, night staff and shift leaders. Meetings were scheduled to be held quarterly and whilst the amount of required meetings had been facilitated, the gap between meetings had fluctuated rather than being consistent.

We saw resident meetings were held quarterly and relative meetings annually. Relatives told us the home had an open door policy and they could discuss any issues or concerns as soon as they arose, therefore the frequency of meetings was satisfactory. Minutes from the latest residents' meeting were displayed throughout the home on notice boards. We saw the agenda had included activities, what was coming up, refurbishments of the home, food/menus, if people were happy with everything and had any concerns.

As part of the inspection we sat in the weekly senior carers meeting run by the registered manager, which also included representatives from the kitchen and maintenance teams. The meeting covered a range of topics and provided an overview of how the home was working. This included staff attendance and sickness, updates of people using the service, maintenance issues, nutrition and hydration and training needs.

In order to capture the views of people who used the service and their relatives, the home had taken part in surveys carried out by Your Care Rating Limited. This is a 'not for profit organisation' who carry out annual surveys at care homes nationwide conducted via a market research organisation. Results of the survey were provided to the home and were also available online via the Your Care Rating website. The last survey had been completed at the end of 2016, with results published in January 2017. We noted 46 people had taken part along with 33 relatives. We looked at the results and noted 100% of people who had taken part stated they were satisfied with the care provided and were treated with kindness, dignity and respect.

Relatives' ratings had been slightly lower and some of their comments focussed on concerns with staff turnover, staffing levels, the need for refurbishment and activity completion. We saw the issues raised had been added to the home's improvement plan with the action taken to date documented. A refurbishment plan, including dates for completion, had been drafted, staffing levels had been increased and plans made to recruit an activity co-ordinator, with alternative arrangements made in the interim, including investment in new equipment and provision of staff training.

The home's policy and procedures were updated at provider level and stored electronically. We were told staff had access to these policies via the internet. Each staff member we spoke with confirmed this was the case. We saw the home had a wide range of policies including key ones in areas such as: medicines, safeguarding, MCA, DoLS, moving and handling and dementia care.

The home had a detailed contingency plan in place, which covered the actions to be taken in the event of an unexpected event which could affect the running of the home, such as an electrical failure or flood. Safe haven partners had been identified in case people needed to be evacuated for any length of time. This ensured alternative accommodation was available.

We saw a range of systems in place to monitor the quality and effectiveness of the service, which were carried out on a daily, weekly, monthly or less frequent basis. These included audits of medicines management, care plans and the environment. Alongside internal quality monitoring checks, audits had also been carried out at provider level and by external organisations, to assess either the service provision as a whole or specific areas such as meal provision and kitchen management.

We saw a weekly health and safety audit was completed to check for potential hazards and detail measures in place to address these concerns.

The regional manager completed bi-annual audits, which covered all aspects of service provision, including capturing people and relative's views. Other areas covered included medicine management, complaints, safeguarding, care files, culture and staffing. A detailed report along with action points had been generated, which we saw had been added to the homes 'continuous improvement plan'. The improvement plan was an on-going list of all action points generated via the auditing and quality monitoring processes in place, along with details of how each point was to be addressed and the date of completion. This ensured the home 'continually improved' and was responsive to issues or concerns noted.

We also saw a quarterly compliance audit was completed by the provider. This audit was conducted similar to an inspection and was linked to CQC's key lines of enquiry (KLOEs), with the intention of ensuring the service was meeting all required standards and regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This process also involved a review of the homes auditing and quality monitoring systems, to ensure they had been done and were effective.

We looked at whether the home worked in partnership with other agencies. We saw the home had positive links with both the district nursing service and local general practitioners who all spoke positively about their involvement with the service. The home was also involved in local apprenticeship schemes and employed apprentices at the home some of whom have gone on to take up full time posts at the home. The registered manager had received an internal award in recognition of this work at the organisations annual conference the previous year.

Additionally we saw the home was a member of the Research Ready Care Home network, who worked with the National Institute for Health Research. The home was in the process of commencing involvement in a

research project by an academic from Manchester University, into people who present with behavioural difficulties. This would entail staff member's taking part in structured interviews.

The home was also part of the Safer Care Homes programme, run by Haelo which is the Innovation and Improvement Science Centre founded at Salford Royal NHS Foundation Trust (SRFT). The programme is commissioned by the SFRT, Salford CCG and Salford Council, with the aim of having the safest health and social care system in the country. Participants in the programme meet regularly to share experiences and complete peer exchange visits to assess and ensure quality.

We noted the home had also been awarded 'The Butterfly Household Model of Care Quality of Life National Accreditation Award' by Dementia Care Matters, a leading international dementia care culture change organisation.