Tameng Care Limited

Shawcross Care Home

Inspection report

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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

We carried out an inspection of Shawcross Care Home on 10 and 11 October 2018. The first day of the inspection was unannounced.

Shawcross Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is located in Ashton in Makerfield and provides residential and nursing care. The home is divided into two separate units, one for nursing care and one for people living with a diagnosis of dementia. The home can accommodate up to 50 people. At the time of the inspection there were 48 people living at Shawcross Care Home.

The home was last inspected on 19 July 2017, when a focussed inspection was carried out, which looked at the key questions of safe and well-led. This was because during the last comprehensive inspection carried out on the 20 and 22 March 2017, we identified two minor breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the management of medicines and good governance. We returned on the 19 July 2017, to check the progress the provider had made. During the focussed inspection, we found the provider had made the necessary improvements and was meeting all the regulations. As a result, we improved the ratings in the key questions safe and well-led, as well as the overall rating from requires improvement to good.

At this inspection we found the evidence continued to support the overall rating of good. However, we received mixed feedback about staffing levels and noted some discrepancy between the number of staff deployed each day and the amount the home indicated was required to meet peoples needs. As a result we had made a recommendation for the home to look at the allocation of staff on each unit, to ensure people's needs are met both timely and safely.

At the time of the inspection the home had 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 and staff provided mixed feedback about the number of staff deployed to meet needs. The home used a system to work out the number of staff required to safely meet needs based on people's dependency levels, these are sometimes called dependency tools. We noted staff numbers allocated on the nursing unit were less than had been recommended by the dependency tool. Observations during inspection also showed staff struggled at times to meet needs, including their own need for a break, due to the number of staff deployed..

People we spoke with told us they were happy living at Shawcross Care Home, and aside from some

concerns with staffing levels, felt safe. Checks had been carried out to ensure staff were suitable to work in a care setting with vulnerable people.

Staff were knowledgeable about the different types of abuse, how to identify these and report any concerns. The home had appropriate safeguarding policies and reporting procedures in place, which had been followed consistently. Accidents and incidents had also been logged, with actions completed to minimise the risk of reoccurrence.

The home was clean, well maintained with appropriate infection control processes in place. Staff had access to and wore personal protective equipment (PPE) to prevent the spread of infection. Checks and servicing of equipment, such as for the gas, electricity, fire safety, passenger lift and hoists were up-to-date.

Medicines were stored, handled and administered safely and effectively. Staff responsible for administering medicines were trained and had their competency assessed annually.

Staff completed both e-learning and practical training sessions. Staff spoke positively about the training provided, confirming they completed regular sessions. Staff also received supervision, albeit we found some inconsistencies in the frequency of completion. We saw the registered manager was taking steps to address this and ensure all staff were up to date.

The home was adhering to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. Where people lacked capacity to consent to care and treatment and did not have a legal representative to make decisions on their behalf, best interest meetings and decisions had been completed.

People spoke positively about the food and drink provided, with choices offered and people's preferences catered for. Meal times were observed to be a positive experience, with people being supported to eat where they chose. People who required a modified diet, such as soft or pureed, received this in line with guidance from professionals, such as dieticians or speech and language therapists.

Staff were reported and observed to be patient, caring and kind. They knew the people they supported and how they wanted to be cared for. People told us they were treated with dignity and respect and offered choice within the daily lives. Staff were aware of the importance of promoting independence and encouraged people to do as much as they could for themselves.

Care files contained detailed care plans and risk assessments, which described how people wished to be cared for and helped ensure their needs were being met and their safety maintained.

The home provided a range of daily activities and events for people to participate in, facilitated by two activity coordinators. Activities were advertised on noticeboards throughout the home and people were asked and encouraged to join in. Involvement was captured within personal activity records.

People and their relatives were involved in the running of the home, through attendance of resident and relative meetings and completion of questionnaires. The home encouraged feedback both through internal processes and also via an external care home review website.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly, monthly or quarterly basis, depending on the area being assessed and covered a range of topics including medication, accidents and incidents, infection control and

training. Provider level audits had also been completed, to provide further oversight of all aspects of service provision.

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

Not all aspects of the service were safe.

Staffing levels were not always appropriate to meet people's needs.

People we spoke with told us they felt safe living at Shawcross Care Home.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed annually.

Is the service effective?

Good

The service was effective.

The service was meeting the requirements of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

Staff reported sufficient and regular training and supervision was provided to enable them to carry out their roles successfully.

The dining experience was positive and we saw nutritional needs were being assessed and provided as per professional recommendations.

Is the service caring?

Good

The service was caring.

People living at the home and their relatives were positive about the care and support provided. They told us staff were kind, respectful and treated people with dignity.

People's preferences were captured within care files and care was provided in line with their wishes.

Staff had a good understanding of the people they cared for and were actively involved in promoting people's independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person-centred way.

The home had an activities programme in place. People we spoke with were positive about the activities and outings available.

People told us they knew how to complain and would feel comfortable doing so, but had not yet needed to.

Is the service well-led?

Good

Not all aspects of the service were well-led.

Audits and monitoring tools were in place and used to assess the quality of the service, although had not identified the issues noted with staffing levels.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported.

People and staff's views were captured through the completion of questionnaires. Feedback about the home was welcomed and encouraged.

Shawcross Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 and 11 October 2018. The first day of the inspection was unannounced. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC) and an Expert by Experience (ExE). An Expert by Experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Before commencing the inspection, we looked at any information we held about the service. This included any notifications that had been received; notifications are changes, events or incidents that the provider is legally obliged to send to us, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality performance officers at Wigan Council to ask for their views of the home and any other pertinent information, to help with inspection planning. Feedback received was positive and highlighted no current concerns.

We had not asked the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the course of the inspection we spoke to the registered manager and six staff members. We also spoke with eight people living at the home and one visiting relative.

We looked around the home and viewed a variety of documentation and records. This included six care files, eight staff files, eight medication administration record (MAR) charts, policies and procedures and audit documentation.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Shawcross Care Home. Comments included, "Yes, the staff more than anything make me feel safe", "As far as the environment goes, yes. I also trust the people and the staff are here to help me" and "Yes, I can walk around safely and the staff are very good too."

We received mixed feedback about staffing levels, from the people and staff we spoke with. This was specifically in relation to the nursing unit. Three people told us there seemed to be enough staff around, whereas another three people felt more staff were needed, both during the day and at night. One told us, "Definitely not enough staff, though the manager would say otherwise. If I ring my buzzer it varies how long it takes them [to respond]." Another said, "There should be more staff. They tell you will be back in a minute, but can be up to 20 minutes. If the staff were not running about so much would be better."

Similarly, two staff felt that staffing on the dementia unit was okay at present, whereas three more told us additional staff were required on the nursing unit to meet people's needs. Comments included, "Really we need three on each floor, they count the CHAP (care home advanced practitioner) in the numbers, but they have their own role to do, so have little time to help with care" and "We need more; when [there's] just two of us on and you're supporting someone who needs two staff, [it] leaves everyone else uncovered until you've finished."

The home used a system called the Care Home Equation for Safe Staffing (CHESS), to determine the number of staff needed to meet people's needs. We were told by the registered manager during inspection there was currently an issue with CHESS and the data produced was incorrect. We were sent a copy following the inspection which indicated 7.7 staff were required on the nursing unit to meet needs.

We looked at rotas for the four weeks prior to this inspection and noted some occasions when only six staff had been allocated to the nursing unit. During the first day of inspection we spent time observing care on the nursing unit, when only six staff were on shift, and noted the two carers allocated to the upstairs section of the unit did not have any breaks nor ate lunch, as they were too busy supporting people. When people required both carers to assist, such as for getting up or going to the toilet, this left only the CHAP, who was responsible for administering medicines amongst other tasks and so was not always able to respond to requests for assistance.

The registered manager told us recruitment was ongoing and seven new staff were awaiting start dates, which would increase the numbers available.

We recommend the home reviews its staffing levels and how they are allocated, especially on the nursing unit, to ensure these reflect the needs and dependency levels of people living at the home.

Care files contained a range of personalised risk assessments, to ensure potential risks had been considered and action taken to minimise these. Where specific issues had been noted or equipment was required, such as bed rails or hoists, individual risk assessments had been completed.

Staff had received training in safeguarding which was regularly refreshed and knew how to report concerns. The safeguarding file contained guidance on identifying and reporting safeguarding concerns, along with a lessons learned document, which had been completed following any referrals, to review the issue and consider what could be done to prevent a future occurrence.

Safe recruitment procedures were in place, to ensure staff employed were suitable for the role and people were kept safe. We looked at eight staff files and noted references, proof of identification, full work histories and Disclosure and Baring Service (DBS) checks had been sought. DBS checks help employers make safe recruitment decisions as they identify if a person has had any criminal convictions or cautions. Regular checks of nurses' registrations had also been completed, to ensure these were in date.

Accidents and incidents had been recorded correctly and consistently. As well as completing accident forms, any incidents had been inputted into 'datix,' the company's web-based reporting and risk management software programme. This allowed incidents to be captured and disseminated throughout the organisation and analysis of trends completed to enable proactive risk management. We noted regular reports had been generated, to enable the registered manager to analyse accidents, incidents and falls, with action plans completed to address any issues noted.

Both units of the home were clean with appropriate cleaning and infection control processes in place. Bathrooms and toilets contained hand hygiene guidance, liquid soap and paper towels and staff had access to and used personal protective equipment (PPE) such as gloves and aprons. Infection control audits had been completed each month to ensure standards had been maintained.

The home had effective systems in place to ensure the premises and equipment was fit for purpose. Gas and electricity safety certificates were in place and up to date. Hoists, the lift and fire equipment had been serviced in line with legislation with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order. Each person had a personal emergency evacuation plan (PEEP), which explained how they should be evacuated from the building in the event of an emergency.

A maintenance board was located within the home, which listed the tasks done each week throughout the month. This included checks of bedrails, wheelchairs, sensor mats as well as tasks linked to the management of legionella, including flushing of water outlets and cleaning of showerheads.

Medicines were being managed safely and effectively, albeit we found some inconsistencies between the nursing and dementia units. Staff authorised to administer medicines had received training and had their competency assessed annually. Audits had been completed to check stock levels and ensure medicines had been stored, administered and recorded correctly. We saw a daily audit had been completed on the nursing unit, which was not being used on the dementia unit. This provided an additional level of oversight and ensured any issues had been picked up quickly. The registered manager told us this would be completed across the whole home moving forwards.

Each person's medicine administration records (MAR's) contained their name, a photograph to aid with identification at the time of administration and allergy information. Each clinic room, where medicines were stored, contained a list of people who took early morning medicines and what they were, which acted as a reminder to staff to give these before breakfast. We checked eight MAR charts across both units and found these had been completed accurately and consistently. Where people had been prescribed 'as required' (PRN) medicines, such as paracetamol, we saw protocols were in place to guide staff on when to administer and signs to look for, however we did note three different formats in use across the home, with some more

detailed than others. We suggested the registered manager looked into formalising the system by using one format, to improve consistency.

Where people lacked capacity and had been refusing their medicines, authorisation had been sought from the GP to administer medicines covertly, which is without their knowledge. Each person who was, or may be administered their medicines covertly had a care plan which explained this process. We did note guidance from the pharmacist had not been sought consistently, which is best practice, to ensure medicines are safe to be crushed or given with food.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found CD's had been administered as per guidance, with the register completed correctly and consistently.

Good

Is the service effective?

Our findings

Staff told us they received sufficient training and support to carry out their roles. Comments included, "Training is quite good. If there's a course you want to do, the manager will sort it for you" and "Yes, training is good and there's enough. We have to do e-learning plus other practical courses. We have to re-do some every year." Staff training records confirmed staff had received required training, which was in date.

Feedback on the completion of supervision was more mixed. Two of the staff we spoke with told us these had not been done as consistently of late, which was linked to the departure of the deputy manager, who used to complete these, whereas the rest told us these were completed regularly and these staff were happy with the support provided. One stated, "Yes, I have supervision, [I] am happy with it. It's done quite regularly with the unit manager" and "Yes, the unit manager or registered manager do these every few months or so."

Both supervisions and training were monitored via separate matrices. The supervision matrix confirmed what staff had told us, with some having received these in line with policy, whereas others were behind schedule. The registered manager had identified this issue and was taking steps to rectify the situation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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).

The home was always acting in accordance with MCA. Staff confirmed they had received training in MCA and DoLS and had a good understanding of the principles. Comments included, "DoLS stand for deprivation of liberty; we do training in this and information is in care files" and "These are used for people who lack capacity and can't make decisions for themselves. Makes sure we do things in their best interest."

We found DoLS applications had been submitted where necessary, with re-applications submitted prior to expiration. Our reviews of care files, demonstrated best interest meetings and decision making had taken place where people lacked capacity to consent and did not have a legal representative, such as a Lasting Power of Attorney (LPA) for health and welfare in place. For those who had capacity, signed consent forms had been completed agreeing to the care provided.

People we spoke with told us the food was good and they received enough to eat and drink. Comments included, "You get a choice, it is very good. If you don't like one thing, there's an alternative", "The food is very good, they have everything, fish and chips, roasted potatoes, everything", and, "You get plenty to eat and they bring me jugs of juice and brews throughout the day."

We saw people who required a modified diet, such as soft or pureed meals, received these in line with the

professional guidance recorded in their care plan. Food and fluid charts had been used when people had an identified need, such as recent weight loss or were on a fluid restriction programme due to a specific medical condition. Signs had been put up in people's rooms to request visitors inform staff if they had brought or were giving any food or drink to people. This was to ensure dietary guidance was followed and an accurate recording of any intake kept.

Care staff monitored people's weight in line with their care plan, with advice sought from healthcare professionals when required. Weights were recorded either in a weights file or in people's care files, however not consistently in both. To remedy this, the registered manager removed the weights file during the inspection. The home completed a formal nutritional monitoring system, the Malnutrition Universal Scoring Tool (MUST), which is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. This was done monthly; however, we did note some issues with the consistency in how thoroughly it had been completed. We raised this with the registered manager, who circulated a reminder for all staff to follow the provided guidance.

People's pressure care needs were being met. The Waterlow was being completed each month, this is a formal prevention and monitoring tool, used to assess people's risk of skin breakdown. Care files clearly detailed people's pressure care needs, including any equipment in use and frequency or repositioning. For people with airflow mattresses, the setting was also documented, which ensured it was consistently inflated to the correct pressure. Repositioning charts had been completed daily and we saw repositioning had been completed as per guidance.

Records showed that people were supported to maintain their health and were referred to healthcare professionals such as GPs, chiropodists and speech and language therapists (SaLT) where necessary. Each person's care file contained a section for professional involvement, where who had visited, along with any feedback and recommendations had been recorded.

We saw steps had been taken to ensure the environment was suitable for people living with dementia. A 1950's style living room had been created in the communal area between the two units. This contained items from the era and had music from the 1950's playing in the background. We were told the room was used for remembrance as well as somewhere for people to just sit and relax. We did not see the room being used during the inspection, although one person we spoke with told us they had done so and enjoyed it.

Pictorial signage had been used on all bedroom, bathroom and toilet doors, to make them easier to identify. Corridors were light and airy, with LED lighting used on the EMI unit, to ensure it was correctly illuminated. Information boards were present in each unit, which included the day, date, time and weather.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the care provided and the caring nature of the staff who supported them. Comments included, "I think they are very, very good" and "Yes, I have no problems; one is nominated internally for carer of the year; they would do anything for you."

People living at the home were treated with dignity and respect by staff. One person told us, "They do it [personal care] in private so I am not embarrassed." Another said, "They shut the door, close the curtains and always wear gloves and aprons." Staff told us they respected people's views and ensured they received support the way they wanted it. This information was contained in people's care plans and confirmed by asking prior to providing care. When providing personal care, staff told us they ensured dignity was maintained by closing doors, using a towel as a covering and making sure people were comfortable with what they were doing.

We saw staff treating people with dignity and respect during the inspection, for example knocking on doors before entering, asking people whether they wanted to wear a tabard to protect their clothes at meal time and being discreet when supporting people with personal care and toileting.

New personal care monitoring charts were introduced during the inspection. This was because whilst the dementia unit had detailed records to document when people had received a bath, shower or body wash, on the nursing unit the records were not as clear and a specific template had not been used. The new sheets captured what people had received, or if they had refused support to shower or bathe.

People were encouraged to maintain their independence. One told us, "I try and undress myself at night and change my slippers. I also go to the toilet myself." Another stated, "They encourage you to wash yourself if you can, if not they will help you." A third stated, "I wash myself, but if there is an area I can't get to, like my back, they ask if I would like them to do it." Staff were knowledgeable about the importance of promoting independence. One told us, "[Person's name] doesn't like making decisions. R, rather than do this for her, we pick some options and encourage her to choose, such as what to wear and eat." Another said, "If I know someone is able to do something, I will prompt and encourage them to do so. Sometimes they would prefer you to do it, as it's easier, but that's not helping them stay independent."

People we spoke with confirmed staff knew them, their likes, dislikes and what was important to them, however two people also commented on staff not having time to chat, which they would have liked. One told us, "They know about me and my family. My [relative] is unwell, which upsets me; the staff know and have been so kind me." Another said, "They come and have a chat with me. I call them redcoats, the ones that come and ask if I want to have a singsong." Whereas a third stated, "I don't have that type of conversation with them as they are always in a hurry."

Observations over both days of the inspection, showed staff spoke with people in a kind and friendly manner, were patient when asking questions, giving people time to respond. We observed the appropriate use of physical contact such as hand holding for reassurance and people looked comfortable and at ease

within staff's presence.

There was a positive culture at the service and people were provided with care that was sensitive to their needs and non-discriminatory. Staff were mindful of the importance of catering for people's diverse needs, whether these be spiritual or cultural. At the time of inspection nobody living at the home had any specific requirements, however staff told us these would be catered for. We saw care files contained sections which captured cultural or spiritual needs and wishes.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. Care files contained information about people's communication ability, including and aids required, such glasses or hearing aids and how best to communicate with them.

Good

Is the service responsive?

Our findings

The home provided care which was personalised and responsive to people's individual needs and preferences. Pre-admission assessments had been completed, which captured key information about the person, to ensure the home had an understanding of their needs prior to admission.

People's care files contained a 'my choices' booklet, that contained by staff information about things which were important to the person and how they wished to be supported. People could choose how much or how little information they wished to share, with a tick box on each page to indicate they had chosen not to complete that particular section. In some bedrooms, we noted scrapbooks had been completed by staff, which provided additional information about people's lives, background, family and friends.

Each care file contained a range of care plans, which clearly explained people's needs and how support should be provided to meet the need safely and in line with people's wishes. We found some inconsistencies with the way in which changes to people's needs had been captured. Each care plan had a review section, which was completed each month, when the care plan was reviewed. For some people, changes had only been documented here, rather than the care plan be rewritten. This meant staff would have to ensure they read the review section of each care file, to check they knew the person's current needs. We saw other examples, where following a change, such as to someone's diet, a new care plan had been completed. This ensured the most up to date information was readily available. The registered manager told us new care plans should always be written and would remind the staff responsible for completing these to do so.

We saw care plans were regularly reviewed, although documentation within care files did not capture people or their relative's involvement in this process. Involvement had been captured via best interest meetings and the collation of personalised information. Relatives we spoke with also told us they were involved in all decisions about the care provided and happy with communication.

People told us they were happy with the activity programme provided by the home. One person said, "They have bingo, a singer, Tuesday they have a church service, have a visiting dog, do craft work." Another stated, "I like doing crafts and Tai Chi. We do games on the floor like snakes and ladders;, they take us to St. Luke's Church every other Sunday." A third told us, "Every other Sunday they take you over to the church in a wheelchair and we have a cup of tea. We do Bingo and games and the activities coordinator comes and cuts my nails. Sometimes the lady vicar comes and plays her guitar whilst we sing along."

During the inspection one of the activities co-ordinators showed us a mural people had been involved in creating. This was an underwater seascape on a wall in the activity room, which those involved in were very proud of. We saw a schedule of weekly activities and events were advertised on each floor of the home. During the week of inspection these included a meal out, fun and play games, bingo, art and craft, Tai Chi, pamper session, film afternoon and reminiscence. Each person had a 'journal' in which activity engagement had been recorded.

We did note people in the dementia unit, which is where the activity room was based, were much more

engaged in activities than those on the nursing unit. People in the nursing unit were asked if they wished to take part in the activities, however the majority of people declined. We did discuss with the registered manager, rather than working together, whether the co-ordinators had considered basing themselves on each unit during the day, which may increase people's willingness to participate. They said this was something that had been discussed and would be looked at further. We will check on this at the next inspection.

The was an effective system in place to deal with complaints. The complaints procedure was clearly displayed on noticeboards within the home. People we spoke with knew how to complain, telling us they would speak to a carer, nurse or the registered manager. However, none of those we spoke with had needed to raise a formal complaint.

The home's complaint's file contained a copy of the provider's policy and procedure, along with a flowchart which explained the complaints process step by step. We noted three complaints had been submitted within the last 12 months, each of which had been dealt with as per the flowchart, with written responses provided.

The home was meeting people's end of life needs. Care plans detailed people's needs and wishes for this time of their life. We saw the home worked closely with the local Hospice in your Care Come (HiyCH) team, who provided training and also supported the home with end of life care. We were told there had been some issues with staff not turning up for planned training sessions, however we saw this had been dealt with via the home's disciplinary process. The registered manger also told us nine care staff had been nominated for Wigan and Leigh Hospice awards, in relation to the provision of end of life care.

Good

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 registered manager was present during both days of inspection.

There was a clear management structure within the home, albeit the deputy manager had left earlier in the year and their replacement, although identified, had yet to start. The registered manager told us they had found it difficult to recruit to the post, so had instead decided to advertise for a clinical lead, which had proven more successful. The clinical lead would be based predominantly on the nursing unit. Since the last inspection a new unit manager had been appointed to the dementia unit. They oversaw all aspects of the running of the unit under the supervision of the registered manager. Staff spoke positively about the unit manager, commenting on the positive changes they had seen since the manager had been in post.

Staff told us they enjoyed working at the home and felt supported. They felt comfortable raising issues and felt listened to when they did. Comments included, "I love working here and feel supported. You can bring anything up with [registered manager]" and "Yes, I feel supported by both of them [unit and registered manager]; if you have any issues, you are always helped and supported with these."

People we spoke with all knew who the manager was, referring to them by name and said they were approachable. One person told us, "The manager is [name], he's a grand chap. If he sees you in the corridor, he will stop and have a chat with you." A second said, "When I first met him, he said ask either him or the girls if I needed anything. If he is passing, he will bob in and say hello. If you ask for anything, he will sort it for you."

The home used a range of systems to assess the quality of the service provided. An electronic feedback device was located in reception, which people were actively encouraged to complete. People and relatives were also encouraged to provide feedback via a care home ratings website, with forms for doing this readily available. We noted the home had a current score of 9.5 out of 10, based on 46 ratings received.

A 'You said…We did' board was located in the home, which provided feedback on the actions taken to address comments, concerns or suggestions made by people, relatives and staff. Some recent suggestions from people and relatives had been for a new shower room on the nursing unit and a pet for the home. We saw funding had been secured and a new shower room provided and the home had acquired a pet dog, which had proven very successful. Although staff were responsible for looking after the dog, people we spoke with told us they enjoyed seeing the dog, stroking it and the company it provided.

The home completed a wide range of audits covering all aspects of service provision. The majority of these were done via the Thematic Resident Care Audit (TRaCA), which is a system designed by the provider. TRaCA's were carried out in a number of areas including health and safety, food safety, dining experience,

housekeeping, pressure care and resident care. All TRaCA's were reviewed by the registered manager who provided action points and ensured these were followed through. Provider level audits had also been completed, looking at service provision as a whole. Action points and areas for improvement had been generated and were followed up on, during the next audit.

We received mixed feedback from staff about the frequency of staff meetings. Two told us meetings only took place a few times a year, whilst the others we spoke with said these occurred every two months or so. One said, "Yes, we have staff meetings. These are every two months or so for everyone on the unit. We also have little flash meetings as well if anything needs discussing." We noted there was no clear schedule in place for meetings. Minutes we saw showed these had been held quarterly, although it was apparent from speaking to staff additional meetings had been held but were not formally minuted. The registered manager told us they would introduce a schedule and ensure all meetings were recorded moving forwards.

We saw a number of examples of partnership working. The home was in discussions with Salford University to became a 'teaching care home' and work with them on 'research led innovations in care'. The home had also been selected to take part in a thesis study by Manchester University, researching pet therapy in care homes.

The home's policies and procedures were stored online and updated at provider level, which ensured the home always had the most up to date guidance available. A policy of the month programme had been introduced, which involved staff having to read up on one key policy per month and sign to confirm this had been read.

We found accidents, incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file. The last inspection report was displayed within the home and on the website as per requirements.