Prime Life Limited

St Georges

Inspection report

Ratcliffe Road
Leicester
Leicestershire
LE2 3TE

Tel: 01162745115
Website: www.prime-life.co.uk

Date of inspection visit:
06 March 2018

Date of publication:
18 April 2018

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

The inspection took place on 6 March 2018, and the visit was unannounced.

St. Georges provides residential care to older people including people recovering from health issues and some who are living with dementia. St. Georges is registered to provide care for up to 36 people. At the time of our inspection there were 30 people living at the 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.

There was a registered manager was 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.

St. Georges Care Homes 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 provider used a wide range of quality monitoring checks. Quality monitoring had been carried out effectively. The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours if an emergency arose, or an equipment repair was necessary. Staff had access to the maintenance diary to manage any emergency repairs. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service and their relatives.

We found that applications had been made to the local authority to legally deprive people of their liberty. The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. They were also aware of best interests meetings to ensure peoples treatment was in line with the MCA and Deprivation of Liberty Safeguards. People were asked for their written consent to care following their admission to the home. This was in addition to staff agreeing their actions prior to each caring intervention.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. Following their recruitment staff received on-going training for their particular job role. Staff were able to explain how they kept people safe from abuse, and were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

People were provided with a choice of meals that met their dietary and cultural needs. The catering staff were aware of people's dietary needs, and sought people's opinions about the menu choices to meet their individual needs and preferences. Staff and external agencies regularly provided a range of activities that were tailored to people's interests. Staff had access to information and through this, developed a good

understanding of people's care needs. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

Relatives we spoke with were complimentary about the provider, registered manager and staff, and the care offered to their relations. People or their relatives were involved in the review of their care plan. Staff had access to people's care plans and received regular updates about their care needs. Care plans were updated to include changes to peoples care and treatment. People were offered and attended routine health checks, with health professionals both in the home and externally.

We observed staff interacted positively with people throughout the inspection, people were offered choices and their decisions were respected.

We received positive feedback from the staff at the local authority with regard to the improved care and services offered to people at St. Georges Care Homes.

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 were protected from the potential of cross infection.

Care plans included risk assessments and informed staff of areas where people required care to ensure their safety. Staff understood their responsibility to report any observed or suspected abuse. Staff were recruited and employed in numbers to protect people. Medicines were ordered administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff had completed essential training to meet people's needs safely and to a suitable standard. People received appropriate food choices that provided a well-balanced diet and met their nutritional and cultural needs. Staff understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care before it was offered.

Is the service caring?

Good

The service was caring.

Staff were caring and kind, treated people as individuals and recognised their privacy and dignity at all times. Staff understood the importance of caring for people in a dignified way, and people and their relatives were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People

and their relatives were confident to raise concerns or make a formal complaint if necessary. People were supported to have a dignified and pain free death.

Is the service well-led?

Good

The service was well led.

People using the service and their relatives had regular opportunities to share their views and influence the development of the service. The provider uses quality audits to check people were being provided with good care.

St Georges

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 was a follow up to the last inspection in December 2016 and to ensure the provider has addressed the issues we saw at that time.

Inspection site visit activity started on 6 March 2018 and ended on the same day. It included direct observations of the staff group and how they offered care to people, speaking with the people and their relatives and the management and staff. We visited the location on 6 March 2018 to speak with the area manager, registered manager and office staff; and to review care records and policies and procedures.

This unannounced inspection was carried out by one inspector and expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we held about St. Georges including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) and other observations to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with six people who lived at the home and two visiting relatives to gain their experiences of St. Georges. We were assisted on the inspection by the registered manager and senior carer. We asked them to

supply us with information that showed how they managed the service, some of which we received following the inspection visit. We also spoke with an admin assistant, a senior carer, three care staff, a catering assistant, handyperson and domestic assistant.

We looked at four people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily records and risk assessments. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Good

Is the service safe?

Our findings

People are now protected from the potential of acquired infection.

One person told us, "My room is kept clean and they are always changing the sheets, even when they are not dirty." A second person said, "I think it's a nice place to live and it's always nice and clean here."

At the last inspection of this service we saw that infection control was not well ordered and placed people at risk. At this inspection we saw there had been improvements and the registered manager had put an action plan in place to address this. There was a planned programme in place to ensure areas of risk were painted regularly to aid the cleaning and disinfection process and the display of materials and sporting memorabilia was removed, as we could not be sure they could be disinfected properly. The programme also included regular disinfection of shower heads and flushing of water outlets that were not used regularly. We saw that staff performed an annual infection control audit to ensure people were cared for safely. People told us they felt the home was kept clean. We saw the cleaning materials on the domestic assistant's trolley were not left unattended. There were dangerous chemicals on the trolley which could endanger a person's health if consumed accidentally.

Most people and their relatives told us they felt safe in the home. One person said, "I feel safe here and I know there is always someone downstairs if I need them." A second person said, "There is always someone [staff member] around to help if you need it." A relative said, "They [staff] have been absolutely amazing. Dad is well looked after, I couldn't ask for more."

People told us there were a couple of people who wandered into their bedrooms. One person said, "I wasn't happy about other residents wandering into my room when I wasn't here so I asked for a key and they have given me one." However a second person said, "I have complained (to staff) a couple of times about another resident going into my room and going through my drawers." We spoke with the registered manager who said all people were offered a bedroom door key, and he would prompt people and their relatives with the offer again.

Staff we spoke with understood their responsibilities to keep people safe. Staff confirmed they had received training and were enabled to recognise when people may be at risk of harm. Staff were able to explain what they would do if they suspected or witnessed abuse of any person who used the service. They told us they would share their concerns with the registered manager or the staff member in charge. A staff member said, "I know we can report any issues to [named staff], but we have the internal whistle blowing number as well."

People's needs were assessed which ensured staff had the appropriate information to care for them safely. Staff demonstrated they were aware of the support people required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. We observed two people when they were assisted by staff. One person was helped to stand and the other was hoisted from their lounge chair. Staff undertook these safely, and we later confirmed in line with the information in their care plan and related to their health, safety, care and welfare.

Care plans and associated risk assessments identified the risks to people's health and wellbeing and were regularly updated. The care plans provided clear guidance for staff in respect of minimising risk. We observed people were relaxed when staff offered assistance and support to them.

We saw from records and staff confirmed that they attended regular fire drills, and records listed the staff who attended the training. In the event of a fire or emergency and if an evacuation was required, personal evacuation plans (PEEP's) were in place, and kept in the reception area of the home.

We found that staff were employed in sufficient numbers to care for people safely. One person said, "I think the staff do a good job, even though they are busy." A second person said, "I think there are enough staff. People [who use the service] don't need to wait long for help."

We observed staff responded to people's requests for assistance promptly. We spoke with the registered manager who explained the staffing numbers were adjusted in line with people's dependencies, to ensure there was enough staff to provide a safe environment for people.

We found staff were employed in numbers that ensured people's safety. Staff confirmed the number of staff on duty each day. The registered manager or deputy manager was being assisted by a senior carer and five care staff in a morning, afternoon and evening, and a senior carer and two care staff at night. In addition there were catering and domestic staff and a handy person. We confirmed the number of staff was consistent with the current and previous staffing rotas.

People's safety was supported by the provider's recruitment practices, which demonstrated a balanced staff team that reflected people's cultural diversity and gender balance. We looked at recruitment records for four staff, and found that the relevant background checks had been completed before staff commenced work at the service. Staff we spoke with confirmed that they did not commence employment until they had the required pre-employment checks in place. This included a disclosure and barring check (DBS) and references. A DBS disclosure can help employers make safer employment decisions.

We found that medicines were administered with people's safety in mind. One person told us, "I get my pills in a pot but they trust me to take them." We later ascertained the person was usually in their bedroom when being given their medicines and so was less of a risk to other people in the home.

Medicines were stored securely and remained active as they were stored in a room at an appropriate temperature. Staff kept records of the room and fridge temperatures; however they were unaware what to do if the recorded temperatures were above or below the recommended storage temperatures.
We viewed the fridge temperatures for the eight weeks prior to the inspection. They were recorded at below freezing each time, but there was no information on the record to guide staff what to do if they were above or below the recommended limits.

We spoke to the registered manager who had a new thermometer purchased which recorded the temperature was within the recommended limits. They also amended the recording sheet to ensure staff were aware of what to do when temperatures exceeded normal limits.

We looked at the medication administration records (MARs) for five people. All the MARs were signed appropriately, and information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely.

We observed how staff administered medicines to people. People were being offered pain relief which was

prescribed on an 'as required' basis. Staff stayed with people to ensure their medicines were taken, which demonstrated that staff understood safety around how medicines were administered. People who were prescribed 'as required' or PRN medicines had instructions along with the MARs which detailed under what circumstances they should be administered and the maximum dose the person should have in any 24 hour period. Staff understood the signs and symptoms that some people may display when they may require PRN medicines to be administered.

Medicines are audited once a month by the deputy manager; we saw a number of audits that had been completed. As these were mid-way through the medicine 'month' they did not reveal an accounting error, where medicines brought forward from one month to another had been counted incorrectly. We spoke to the registered manager who said extra audits would be put in place to ensure issues such as this were picked up.

We spoke with the staff who supported people with their medicines. They told us they had updated training in this area and were subject to regular competency assessments which helped to ensure their practice reflected the training they had received. We viewed the training matrix which confirmed staff had undertaken regular medication updates.

The changes that have been introduced since our last inspection have been documented and any lessons learnt fed back to staff. We saw from the minutes of staff meetings where the reasons behind any failings were explained and staff were encouraged to change their practice to ensure people were cared for safely.

Good

Is the service effective?

Our findings

At the last inspection we found that catering service did not effectively meet people's needs.
At this visit we found people were provided with a balanced and varied diet that met their cultural needs and helped maintain their weight.

One person said, "I am happy to ask if I don't like what I'm offered, but I have never gone hungry." You can't beat the food here. I even get offered seconds." A second person said, "The food is good and there is plenty of variety."

People were offered positive meal choices, and were provided with food and drinks throughout the day. Breakfast in the morning was followed by a mid-morning drink and biscuit, lunch and mid-afternoon drink and tea around 5.00pm, all offering culturally appropriate choices. People had flexibility and choice to eat their meals in a room of their choice. We saw that people at risk of losing weight were offered fortified drinks and meal supplements throughout the day. Where people's diets required to be adjusted in line with their health needs, people had been referred to their GP or specialist for advice. Specialised diets, for example diabetic diets were provided for people who required them. Staff had begun to use yellow and orange plates and different coloured cups to assist people living with dementia and improve their mealtime experience. These have been developed for use with people with dementia, and were introduced following the training course staff attended. Care staff now include 'Dementia champions', these are care staff who have had further training in living with dementia and can act as a point of reference for staff.

At the last inspection we found that some bathing and shower rooms were not adequately heated to ensure people's comfort. On this visit we found there had been a number of adaptions and changes that have improved the building. An improvement plan was developed following our last inspection and this is now nearly completed. The corridors and some bedrooms / lounges have been decorated and inappropriately designed toilet seats have been replaced. Other improvements have included a 1960's style working kitchenette, which staff use for activities, though we didn't see anyone using it on the day of our inspection.

People's needs and choices were assessed and provided effective information for staff. This provided staff with information that guided them to providing effective information that met people's cultural needs. The registered manager explained how people's needs were assessed prior to them moving into the home, and that was used as the basis of the care plan, which was developed as the person's stay lengthened.

Staff were trained and provided effective support to people. Since our last inspection 30% of care staff have attended a specialised dementia course and all staff have completed the 'virtual dementia training', which has resulted in changes to how meals are served and how staff should approach people living with dementia.

Records we viewed demonstrated that staff had received the training and supervision that they needed and provided a good effective service. Staff supervision is used to advance staffs' knowledge, training and development by regular meetings between the management and staff group. Supervision sessions included

observations by the management team. The registered manager told us this was to ensure staff were adhering to the training that had been provided, and to ensure their continued development. For example the senior staffs' competency when administering medicines was repeated annually.

One person said, "I can see people [medical professionals] when I need to, I just ask." A second person said, "I see the chiropodist regularly, they just turn up." There was evidence where people's additional health needs had been responded to by staff as they arose. For example referrals to: GP's, a dietician the speech and language therapist (SALT) and community psychiatric nurse, had been made on people's behalf.

The building has recently undergone a period of transformation. Corridors and public rooms had been redecorated, and people were consulted for their opinions on the choice of colours used. Paintings and framed photographs had also been erected, again to enhance people living with dementias' experience. Following specialist dementia training for staff, other adaptations had been made to the environment, for example the toilet seats had been replaced with a 'user friendly' type in keeping with the current understanding of people's perception when living with dementia.

People's consent to care and treatment was sought in line with legislation and guidance. We heard people being asked by staff if they agreed to their clothes being covering before lunch, and others if they wanted a hot drink and choice of snacks were also offered. That demonstrated the staff group were aware of communicating effectively and seeking people's consent before offering care or assistance.

We observed people were offered the support detailed in their care plan and risk assessments, which met their cultural and individual needs and choices. People were relaxed when staff approached them to offer care and support. That demonstrated staffs' approach was effective and did not cause people concern or anxiety.

Records showed that where necessary people had mental capacity assessments completed on their behalf, with regard to making certain choices and decisions. When people lacked capacity to give their informed consent, the law required registered persons to ensure that important decisions were taken in their best interests. A part of this process involved consulting closely with relatives and with health and social care professionals who have known a person and have an interest in their wellbeing.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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 are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager had ensured that nine people were protected by the DoLS. Records showed that the registered manager had applied for the necessary authorisation from the relevant local authority. Some people had been represented by a family member. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person, adhere to the main principles of the MCA and act as a safeguard for the person's rights.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by a caring staff group. One person said, "I have to use the lift because I can't do the stairs, but a carer always comes with me because I really hate lifts." A second person said, "They [staff] are nice here, they always listen to you." One relative said, "Staff are very kind to everyone and always respectful. I have never heard a raised voice (from staff)."

People and their relatives told us the staff group were compassionate and caring. We observed interactions with people throughout the inspection which showed that staff were caring and people were treated respectfully.

We observed staff who assisted some people, and saw where others were prompted to eat their lunch time meal. We asked a member of staff why there was a difference, and they told us some people just needed a gentle reminder to complete their meal. We saw staff ensured that when necessary people's clothes were protected from food spillages, which assured their dignity. Staff were heard asking them if they agreed to the covering being placed and again before it was removed. That demonstrated staff took steps to promote people's dignity.

People or their relatives were involved in making decisions about their or their relations care. The registered manager told us care plans reflected people's needs and were being reviewed regularly. For those people who were unable to express their views and opinions. Records confirmed that family members had been involved in care plan reviews, where the person was unable to take part.

We observed that staff checked on people's well-being throughout the day. Individual choices, preferences and decisions made about people's care and support needs were recorded. These daily records included the care and support people received, and demonstrated that staff supported people's decisions about how they wanted to be cared for.

People's privacy and dignity was recognised. One person said, "Oh they (staff) always knock and wait for me to say before they come in (to their bedroom)." A second person said, "Staff are always kind and don't rush me." One relative said "Staff are really respectful to [named], they try and have a laugh with him if he gets anxious."

We observed staff respected people's privacy and dignity, and heard staff knocking on people's bedrooms and toilets before entering throughout our inspection. We also observed staff have a discreet word with a person who required personal care. That demonstrated staff were aware of the need to ensure people's privacy and dignity.

Good

Is the service responsive?

Our findings

At the last inspection we found that people received personalised care, however not all of their needs were included in their care plan. At this visit we saw that the provider had made improvements.

One relative said, "They keep me informed of what is going on, I couldn't have done this without them. I am included in his care planning and if anything happens, they let me know." A second relative said, "I can honestly say that [named] has never been looked after so well."

People received personalised care that was responsive to their individual needs. Care plans were person centred and each contained a detailed medical history and health needs of the person. Details of their family contacts and who was important to them, previous work history, hobbies and interests and their preferred gender of carer. One person said, "I don't mind who looks after me, they are all very kind and know their job."

Care plans also included an accident and emergency grab sheet which included details such as their medical history and activities of daily living and included a personal evacuation plan (PEEP). Care plan reviews took place regularly and there was evidence that relatives were involved where people were unable.

Where people required assistance with personal care, care plans were detailed how the support was to be provided, what the person's abilities were and what support they required.

We found there were adequate activities offered and most people were happy with the level of activities offered. One person said, "I have my hair done once a week now, that didn't happen when I was living on my own. I enjoy chatting to people here and I don't get lonely now." A relative said, "They [staff] organise interactive activities here and one carer works with Alzheimer's so knows about Dementia needs." A second relative said, "[Named] enjoys the activities, they do more now than they have ever done."

However one person said, "I enjoy the activities, but we don't do any exercise ones." A second person said, "I have been out on a couple of trips. I went to Skegness, that was good, but I would like to go out on more." We spoke to the registered manager about that, who said there were 1-2 trips a month out in the community and all the people in the home had equal opportunity to go. The registered manager also said there were 'chair-o-bics' sessions arranged every other week, with the staff also undertaking bean bag and ball throwing exercises.

We saw the activity co-ordinator maintained an individual record of activities people were interested in, how people were engaged and or where a person decided not to participate in any activities. We saw staff undertaking a game of scrabble when we visited.

Care planning reflected people's individualised needs and we saw evidence of information on allergies, likes, dislikes, wishes and aspirations, and past life histories completed by people and their families. We saw where the staff had responded to the changes in people's lives, and made application to the local authority

for DoLS restrictions.

Staff had access to people's care plans and received updates about their care needs through daily handover meetings. Staff told us handover's took place at the start of each shift, so staff could be updated about people's needs and if any changes in their care had been identified.

The provider had systems in place to record and deal with complaints. People and their relatives told us they were aware how to make a complaint. One relative said, "Staff are so approachable [named staff] always asks how we [family] are."

People and their relatives were aware they could visit anytime and if necessary speak with the registered manager or their deputy with any concerns, and were aware of the homes' open door policy where managers were available to deal with people's concerns. One person said, "I can have visitors whenever they want to come."

Staff felt they could raise concerns or issues with the registered manager and were confident these would be listened to and acted upon. The registered manager told us they were aware of three complaints in the last 12 months. An outcome had been provided for each, and where necessary changes were made to the service. Complaint information was fed back to staff though staff meetings or individual supervision sessions, so that staff were aware of any issues and any changes that had been required. Analysis by the registered manager did not reveal any patterns or themes with these or previous complaints. We looked at the complaints policy and procedure, which included details of the local authority, which are the appropriate body to investigate complaints.

We saw that staff had planned changes to some people's care plans, in advance for their end of life care. For example one expressed they did not wish to go to hospital, but to remain at St. Georges care home. Care plans also had information supplied by people's relatives where the person chose not to be, or was unable to be involved in these arrangements. Staff demonstrated that plans were in place for people and they had sought the assistance of people's GP's to supply medicine in anticipation of a person reaching the final stages of their life, and to give them a dignified and pain free death.

We saw people had advance decisions care plans in place and a do not attempt resuscitation (DNACPR) advance decision. These had been agreed with people when they had full capacity or their relatives where they were unable to assist. That meant staff were clear about the people's wishes, and could inform any other appropriate authority of this, for example if the person was admitted to hospital. That demonstrated people were supported to have a planned ending to their life that reflected their wishes.

Good

Is the service well-led?

Our findings

At the last inspection we found that provider's audit did not cover all of the areas or processes in the home. At this visit we found the processes to monitor the quality of the service provided had improved.

The registered manager demonstrated the quality assurance audits that had been introduced following our last inspection, and the corresponding records which demonstrated people are safe and well cared for. These included regular checks on the medicines system, care plans, risk assessments, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. These had resulted in follow up appointments being arranged for people at risk of malnutrition. That meant the registered manager and staff had undertaken audits that demonstrated how the service protected people.

The provider monitored and assessed the quality of the service directly as well as through other staff in the home and visits by the area manager. The registered and deputy managers' carried out a range of scheduled checks and monitoring activity to provide assurance that people had received the care and support they required. Further monitoring was performed by the area manager on their regular visits and other staff in the home including the kitchen staff and handyperson.

The provider and registered manager were regularly overseeing staff and speaking with people, visitors and staff whilst in the home to ascertain how effective the staff group were. They said to us they also operated an 'open door' policy, where any visitor or staff could speak with them at any time.

The registered manager provided a range of records of safety tests that were completed periodically. The testing of gas and electrical appliances and water safety tests were all in date. Regular tests of the fire alarm system, emergency lighting were also in place and tested by staff on a weekly basis. That demonstrated the registered manager ensured the home was safe and demonstrated good management skills. Staff were aware of the process for reporting faults and repairs, and had access to a list of on call contact telephone numbers if there was an interruption in the provision of service. Other information included instructions where the gas, electrical and water isolation points were located.

There was a clear vision to develop high quality care and support. One person said, "Staff and management are very approachable. I know I could ask them anything and they would do their best to help." One relative said, "The management here are very approachable. I don't have to worry about [named] now; they are well taken care of." A second relative said, "I can talk to them [management] anytime and they let me know if anything is going on that I need to know about."

We spoke with the registered manager about the visions and values of the provider. They told us these are explained in the 'manager's handbook', which is a development tool produced by the provider for use in all of their homes in the area. They said there was an emphasis on openness and honesty throughout the home. They told us about the open agenda at staff meetings where staff could add items for discussion.

We found people who lived in the home and their relatives were regularly asked to comment through the

quality questionnaires that were distributed. The most recent were distributed in October 2017 and covered (the now implemented) changes of décor and environment changes. The questionnaires were also used to inform people of the staff development and specialist courses around people living with dementia. The numbers returned were on average about eight of the thirty-two and outcomes were shared with the entire staff group at staff meetings and changes made where necessary. The registered manager said there were further questionnaires that would be circulated later in the year, but regarded the low number returned indicated that people were satisfied with the service provided. The provider added they and the managers' would continue to have an open door policy and meet with relatives to gauge people's opinions and ascertain the need for change.

Staff told us the management team regularly assisted in the day to day running of the home. One member of staff said, "[Named] is always around to speak with."

The registered manager understood their responsibilities and displayed a commitment to providing quality care. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required. Staff felt the registered manager was approachable, understanding and supportive.

The provider had also arranged 'sit and see' sessions which are a type of observation tool developed by the provider. This is where a senior manager or company director observes the interaction between people who used the service and staff and observe for care and compassion. The 'sit and see' system has been introduced to oversee, record and where required improve the compassionate caring of people. Any information gathered is communicated to people as a written report and we saw one such report in the foyer of the home for people to view.

The registered manager told us that staff were supported to improve their practice through individual supervision sessions. They said staff had responded positively through these and they were used to develop the staff and people's care plans. That demonstrated the registered manager used the staffs' long term knowledge of people to develop and improve their care plans and their experience of care.

The registered manager understood their responsibilities and ensured that we were notified of events that affected the people, staff and building. The registered manager had a clear understanding of what they wanted to achieve for the people at the home and they were supported by the deputy manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff were provided with detailed job descriptions and had regular supervision and staff meetings. The registered manager explained individual supervision was used to support staff to maintain and improve their performance. Staff confirmed they had attended supervision sessions and had access to copies of the provider's policies and procedures, which are updated regularly.

Prior to our inspection visit we contacted the local authority commissioners responsible for the care of people who used the service. They had positive comments about the registered manager, the staff and the quality of care provided.