Order of The Sisters of St Joseph of The Apparition

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Inspection report

Lady of the Vale Nursing Home
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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

The inspection took place on 25 October 2016 and was unannounced. We last inspected Order of The Sisters of St Joseph of The Apparition in April 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Order of The Sisters of St Joseph of The Apparition provides nursing and personal care for up to 39 older people, including people with dementia-related conditions. At the time of our inspection there were 34 people living at the home.

The service 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.

We found that people were cared for in a clean, comfortable and well-maintained environment. Risks to personal safety had been assessed and actions were taken to prevent people from coming to harm. The service had established systems for protecting people from abuse and responded appropriately to any safeguarding concerns.

A robust recruitment process was followed to check the suitability of new staff. Sufficient staff were employed to provide safe and consistent care. The staff team were supervised and given training to help develop their skills and care for people effectively.

The service worked with health care professionals to maintain and improve people's health and well-being. People were supported to receive their medicines as prescribed. A varied diet was provided and people told us they enjoyed the food. Nutritional needs were monitored and staff supported people with their eating and drinking needs.

People's rights under mental capacity law were understood and upheld. Formal processes were followed when necessary to make important decisions about people's care and treatment.

Staff had a good understanding of people's needs and treated them as individuals. They were kind, had caring attitudes and were respectful of people's privacy and dignity. Measures were in place to enable people and their families to express their opinions about their care and the service they received. Any complaints were taken seriously, though records did not always support how complaints had been addressed.

Care needs were assessed and work was in progress to embed electronic care recording, including making care plans more personalised to the individual. A variety of stimulating activities and events were offered to support people in meeting their social needs.

The management were committed to developing the service and promoting an open culture. Staff told us they were well supported, given leadership and could air their views. Methods to monitor the quality of the service were being better structured to ensure standards were maintained and improved.

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.

Appropriate systems were in place to minimise risks and safeguard people from being harmed or abused.

Enough staff were employed to safely meet people's needs.

Suitable arrangements had been made to ensure people received their medicines at the times they required them.

Is the service effective?

Good

The service was effective.

Staff were provided with training and were supported in their personal development.

The service worked within the principles of mental capacity law to make sure people's rights were protected.

People accessed a range of health care services and were given the necessary support to meet their health and nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring had formed good relationships with people living at the home and their families.

The service provided people with the information and support they needed to make choices about their care.

People were treated respectfully and cared for in a dignified way.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and care planning was being adapted to reflect person-centred care.

The service offered good opportunities for people to engage in various activities to prevent them from being social isolated.

Complaints about the service were suitably acted upon.

Is the service well-led?

Good

The service was well led.

A registered manager was in post who provided leadership and support to the staff team.

The management aimed to work inclusively with people, their families, staff and other professionals.

More robust systems had been introduced to maintain oversight of the quality of the service.

Order of The Sisters of St Joseph of The Apparition

Detailed findings

Background to this inspection

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

This inspection took place on 25 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, the provider had 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 improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted other stakeholders including commissioners of the service.

During the inspection we talked with six people living at the home and one person's relative. We observed how staff interacted with and supported people, including during a mealtime and a social activity. We spoke with the trustee director, the registered manager, the deputy manager, the support manager, the administrator, the bursar, the activities co-ordinator and eight nursing, care and ancillary staff. We reviewed five people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

The people we talked with described feeling safe living at the home. Their comments included, "I feel secure here", "The staff are polite and never rude" and "Everything is always locked up at night, so I do feel safe." A person who was sitting in their bedroom showed us their call system bell was tucked down the side of the chair, within easy reach. They told us, "The staff always check I've got access to it." This person also referred to the level of supervision provided in the communal areas, telling us, "The staff stay in the room when people are there."

Information was made available to people about their rights to be protected from harm and abuse. The provider's policies and procedures on safeguarding and 'duty of candour' were displayed in the home to refer to. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. Details of both policies were also being included in the guide to the service that was currently being updated.

The service had systems for safeguarding people against the risk of abuse and for responding to any alleged abuse. All staff had been trained in and had access to safeguarding and whistleblowing (exposing poor practice) procedures. This was confirmed by the staff we spoke with who told us safeguarding awareness was also discussed in their individual supervision sessions. The staff understood the different types of abuse that people might experience and their responsibilities for recognising and reporting abuse. The registered manager demonstrated that since they had been in post they had taken appropriate action in response to any safeguarding concerns raised.

Money was not held on behalf of people at the home. The bursar told us they had established where people had appointed representatives with power of attorney in relation to their finances. In these instances, purchases and payments for services, such as hairdressing, newspapers and toiletries, were made and representatives were invoiced on a monthly basis. Records were kept of all transactions, backed by corresponding receipts, and these were routinely checked by the provincial bursar. An annual external audit was also conducted to assure people their finances were handled safely.

Pre-admission assessments were carried out to determine whether the service was able to safely meet people's needs. Potential areas of risk, including moving and handling, skin integrity and nutrition, were also identified as part of the on-going assessment process. We observed measures to reduce risks were linked into care planning and guided staff on the methods and equipment required to protect people's personal safety.

Any accidents and incidents which occurred in the service were suitably reported. The reports were then thoroughly analysed each month to review risk factors and check for any trends. Actions taken included provision of safety aids and equipment, increasing frequency of staff observations for people identified as being at risk, and organising training in falls prevention.

One person we talked with told us their bedroom was very nice and that staff regularly came in and cleaned

it. They commented, "They do the work properly." We observed the home was clean, suitably equipped to provide people's care and treatment, and there were no obvious safety hazards. Personal protective equipment was readily available for staff to assist with control of infection. A range of checks and audits were undertaken to ensure standards of maintenance, health and safety, food safety and hygiene, and infection control were adhered to. Some staff had been designated particular responsibilities in relation to health and safety and monthly meetings to discuss issues were being planned.

An external company had been commissioned to do a full fire safety assessment of the service and we saw the action plan produced was in the process of nearing completion. The home had a business continuity plan that staff had been instructed on to make sure they understood the procedures to follow in emergency circumstances. Individual plans were in place for maintaining people's safety in the event of the home needing to be evacuated.

Our check of records indicated all necessary recruitment checks were undertaken before new staff started working at the home. Applicants' suitability was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. References, including one from the last employer had been sought. Application forms were completed, proof of identification was obtained, and interviews were recorded. The Personal Identification Numbers of qualified nurses were checked to ensure they maintained their professional registration.

During the inspection we observed that staff worked at a steady pace and there was enough staff deployed to meet people's needs. Staffing was calculated according to the numbers and dependencies of the people living at the home. The current levels had recently been increased and were two nurses and nine care staff during the day and one nurse and four care staff at night. The registered manager, who was a qualified nurse, was supernumerary to the roster. Separate ancillary staff were employed for housekeeping, catering, laundry and maintenance duties and the home had administrative support.

The registered manager had substantially reduced the extent of external agency staff deployed to cover absence in the home. Where this was needed, for example covering a vacancy on night duty, the same agency staff who were known to the service, were requested for continuity. Two bank care staff were employed and some existing staff also worked extra hours to maintain the staffing levels. An on-call system was operated which enabled staff to get advice and support at any time and to escalate any emergencies to the management team.

Suitable arrangements were made for people to receive their medicines safely. The service had started to use a new pharmacy that delivered supplies, including medicines prescribed outside of the usual ordering cycle. Medicines were stored securely in the treatment rooms and in trollies for use around the home. The nurses took responsibility for, and were trained in, the safe handling of medicines. Their competency was also assessed annually, including a knowledge test and observations of their practice. One person we talked with told us, "They (staff) make sure you get the correct medication."

Guidance for staff was readily available, including the home's medicines policies and procedures which were kept in the Medicine Administration Records (MARs) files. People's care plans also described their individual medicines regimes and, where applicable, the protocols for medicines prescribed on an 'as required' basis. Directions for how medicines were given covertly (disguised in food or drink) to one person were not clearly stated and this was rectified during our visit. The majority of MARs had been appropriately completed, confirming people were given their medicines at the times they required them. Some procedural and recording deficits had been identified through a recent audit, though we clarified that people had

received their medicines. Procedures had been reinforced with staff and further audits were being carried out to check improvements and ensure medicines were safely handled.

Good

Is the service effective?

Our findings

The registered manager informed us about the training and support provided to staff to enable them to perform their roles effectively. New staff received an induction that was specific to their job role and the staff we talked with confirmed this. They told us their induction had provided an opportunity to familiarise themselves with the home, get to know the people living here and to shadow existing members of staff. Where appropriate, new staff members were enrolled to complete the Care Certificate, a standardised approach to training for new staff working in health and social care.

The service had made changes to training provision in recent months and a new matrix had been created to give an overview of all courses undertaken by the staff team. This was in the process of being completed and we were provided with an updated version following our visit. The matrix showed that staff had undertaken mandatory areas of training in safe working practices, such as fire safety, moving and handling, and infection control. Other courses relevant to staff members' roles and the needs of the people they cared for had been completed. The topics included epilepsy, nutrition, diabetes, resuscitation, catheterisation, effective documentation and training on CareDocs (the electronic care recording system). Further training was being arranged for those staff who had been assigned lead roles, such as wound care, dementia, and end of life care. Some of the staff had achieved nationally recognised qualifications in care. Staff told us they received regular training, including support to gain qualifications.

The registered manager acknowledged staff had not previously been receiving regular supervision or annual appraisals. They had recognised this as an area that needed improving when they had taken up post earlier in the year and had implemented a delegated system. The aim was to provide staff with four supervision sessions across the year and agreements to this effect had been drawn up. However, the monitoring of supervisions had not been fully effective and we found some were either overdue or not forward planned. Following our visit we were provided with an updated schedule that indicated the majority of staff had been supervised, along with the dates of their next planned sessions. The supervision records we reviewed showed staff were given opportunities to reflect on their workload, performance and to identify any training and development needs. The staff we spoke with confirmed they had received supervision from either the registered manager or a senior member of the team.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the service worked within the principles of the MCA and relevant policies and procedures

were available for guidance. 18 of the staff to date had been given training to raise their awareness of the MCA and DoLS and the implications for their practice. The staff we spoke with were aware of the importance of gaining people's consent before providing any care or treatment. One staff member told us, "Consent is sought as part of the care planning process. If people don't have the capacity to consent, a best interest decision can be made on their behalf."

During our visit we observed staff asked people's permission and involved them in everyday decisions about their care. There was evidence in care records that formal processes were followed to assess capacity and, where applicable, make decisions in a person's best interests. For example, relevant people had been involved in a decision about administering medicines for a person unable to give their consent and the outcome was clearly documented. A number of people living at the home had DoLS authorised to enable them to receive the care and treatment they needed. Clear records were maintained to monitor DoLS applications, authorisations and renewal dates.

People's nutritional risks were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool that identifies if adults are malnourished or at risk of malnutrition. Care plans were devised for supporting people in meeting their dietary requirements and/or assistance required with eating and drinking. Referrals had also been made to dietetic services and speech and language therapists for further assessment and advice. Staff monitored people's weights and, where needed, food and fluid intake through the completion of daily charts.

The chef told us staff informed them about people's individual dietary needs, likes and dislikes and any allergies when they were admitted to the home. This information was kept in the kitchen for the catering staff to refer to. The chef reported they were also informed promptly of any changes to a person's needs. They told us they routinely spent time talking with people about the food and that this helped them to determine whether the menus needed to be adapted.

We saw the home had a varied menu which was displayed for information. People were asked to choose from the menu each day and the chef confirmed alternatives could always be provided on request. Our observations and people we spoke with confirmed this. People comments included, "They ask you what you want to eat, what you like and what you don't like. You don't go hungry" and "The food is good. There's always a choice." A relative told us they regularly took lunch with their family member and felt the food was of a good standard. We observed that drinks and snacks were provided between meals and people were encouraged to stay hydrated.

People living at the home had access to a full range of healthcare services. An on-going record was kept of each person's contact with external healthcare professionals. Advice or changes in treatment from professionals were incorporated into care plans. People we talked with were happy with how they were supported in meeting their health needs. A relative told us they had contributed information to help staff understand their family member's rare medical condition, and how this impacted on the care they needed.

Another relative had contacted the Care Quality Commission, giving positive feedback about the care their family member had received at the home at the end of their life. They told us, "The nursing and care staff displayed knowledge of the whole spectrum of end of life care, including excellent communication skills and a professional yet friendly and family compassionate approach at all times." The service was working towards achieving the 'six steps end of life programme' award and was supporting staff to develop their skills in this area. People had been consulted about their wishes in relation to their end of life care and treatment in order to formulate specific care plans. A sensitively written information leaflet had also been produced to support families and there were plans to convert a room to enable visitors to stay overnight.

Good

Is the service caring?

Our findings

People were complimentary about the caring nature of staff and the support they received. They told us, "The staff are very good, very nice", "I'm well cared for, in lovely surroundings, and have no worries", "I'm happy and settled and have everything I need", "They (staff) are very kind and patient" and "I'd recommend the place."

During our visit we found there was a warm, inclusive atmosphere in the home. Staff engaged with people, spending time sitting and talking with them, and were polite and friendly in their interactions. At all times we saw that staff were caring and respectful in their approach. Family and friends were free to visit when they wanted and were encouraged to get involved in activities and daily life in the home. We saw visitors were able to take meals and refreshments and some joined in an activity to design a Christmas card for the service. People confirmed their visitors were made to feel welcome and that they could meet with them in private. Some people also told us they appreciated the visits from the Sisters of the Order and the sense of community within the home. A relative who had contacted the Care Quality Commission told us, "Mother was not a Roman Catholic but gained comfort from the many visits from the resident nuns and helpers who were there to just hold her hand and be company in the absence of family members."

Where people were unable to tell us about their care, we observed they were relaxed in the company of staff and responded positively to them. Frailer people who were cared for in bed looked comfortable, well cared for and had aids and equipment for their safety and comfort. We saw that staff were attentive towards people in communal areas and checked in on people who stayed in their bedrooms. At lunch, people who needed assistance with eating and drinking were supported in a sensitive manner on a one-to-one basis. The mealtime was not rushed and was a pleasant and sociable experience.

Most of the staff we spoke with had worked at the home for a number of years and knew people well. They were knowledgeable about people's diverse needs and gave clear accounts of their individual preferences and the level of support they required. We observed they used their knowledge to good effect, including talking with people about their particular interests and where they had been born. Some staff described how they initially got to know people when they were admitted to the home. They explained they read the care plan so they were aware of the person's needs and lifestyle and would have topics for conversation when they introduced themselves. Staff felt the care plans were useful and they could use them in a meaningful way to start to build relationships with new people and their families.

Staff were aware of the importance of maintaining people's privacy and dignity and gave us examples of how they did this. For example, closing curtains, covering people over when providing personal care, and knocking on bedroom doors before entering. Some staff had recently been given designated lead roles for championing the rights of people with dementia and dignity in care. They were undertaking further training to support their responsibilities and it was planned that they would carry out checks in the home to ensure good practice was embedded. We noted all of the people who had completed the home's latest surveys had stated they felt they were treated with respect.

Staff understood the need to keep confidential personal information safe and told us this was held securely on the electronic system and in the nurse stations. One staff member told us they would only breach confidentiality where this might impact on a person's safety. For instance, if anyone confided in them about potential abuse, they would report it and be honest and explain the reason why this must be done.

We observed that people were able to exercise control over different aspects of their daily lives. For example, when to get up and go to bed, where and how they spent their day, where they took meals and being given choices of food and drinks. One person commented, "I like to be peaceful and prefer not to get involved with the activities. The staff respect this." A staff member told us they helped people who were unable to communicate verbally to make decisions, such as holding up clothes for them to choose from.

A range of information was displayed to keep people updated about what was happening in the home. This included details of the staff, their roles and who was on duty, and forthcoming social events. The provider's key policies and procedures were on display, along with numerous leaflets on care-related issues including advice on choosing care services, healthy eating, dementia, and bereavement. People were also given an informative guide that explained the mission and values of the service and what they could expect from living at the home.

The registered manager acknowledged that consulting people and their relatives through reviews of care had lapsed and provided us with evidence that these had been scheduled. They told us advocacy services could be arranged, if needed, to support people in representing their views. One person received support from an Independent Mental Capacity Advocate in making decisions about their care and treatment. Newsletters, surveys, resident and relative meetings and a suggestions box were also used to communicate news and seek feedback about the service.

Good

Is the service responsive?

Our findings

We observed that staff were responsive to needs and requests and there were no undue delays in people being attended to. This was confirmed by the people we talked with. Their comments included, "There's always staff present and they come straight away if you press the buzzer" and "The staff regularly check on me to make sure I'm alright." One person told us, "The staff were very good", when they had a fall late at night and had contacted their family straight away.

A new call system had been installed in the home which we were told could be adapted to suit people's needs. For instance, a person with a sensory impairment had been provided with a large emergency button that enabled them to summon assistance. There were plans to run reports from the system to evidence staff response times and how long they spent with people. The registered manager told us movement sensors were also being considered as an add-on to monitor people's safety in their bedrooms.

The care records we reviewed showed pre-admission assessments had been conducted. These provided details of the person's needs, their support network, and the healthcare professionals involved in their care and treatment. The information gathered was used to develop initial care plans for meeting the person's identified needs and any risks associated with their care. Further assessments were then routinely completed to check whether people's needs had changed and prompt staff to revise the care plans.

People's personal information was being transferred into CareDocs, an electronic care recording system, and paper records had been retained for staff to refer to, if necessary. Care plans were generated automatically from assessments for those people who had moved into the home since the system was introduced. We noted these care plans contained largely pre-populated statements and had not yet been tailored to the individual's routines and preferences. In some instances there was limited or vague information about the extent of support staff should provide and the person's independent skills. However, staff were able to accurately describe the support they gave and how they encouraged people to do as much for themselves as possible.

All care plans were evaluated monthly to keep checks on progress and ensure people's needs were being met. Daily reports were recorded on each person's welfare. Staff confirmed they received handovers at every shift which gave them an update about each person and any changes or incidents affecting their well-being.

The management told us they were still in the process of transitioning information into CareDocs and felt the system would ultimately improve record-keeping. They gave assurance that further efforts were being undertaken to make care plans more specific and personalised. This included gathering information about each person's background, what was important to them, and the ways they preferred to be supported. Dates had been arranged for named nurses to hold individual care review meetings, giving people and their relatives an opportunity to discuss and agree their care. Keyworkers were also being allocated to enable each person to have a named member of the care staff with particular responsibilities towards their care.

People told us they were able to continue to practice their faith, attend religious services and that the Sisters

of the Order would visit them individually if they wished. One person said, "I don't go to Mass now, but have Holy Communion in my room."

During our visit we observed social activities took place, including a crafts session, and those people we talked with spoke highly of the activities provided. One person told us, "We're baking cakes tomorrow and will be doing activities for Halloween." We saw posters were displayed and there was a noticeboard which informed people about the activities and events going on in the home. A board was also dedicated to reminiscence and there were photograph displays of recent events, such as a garden party, which people said they had enjoyed.

The activities co-ordinator told us before starting their role they had been given time to get to know people and their interests. They had since used questionnaires to find out about what kinds of activities people wanted. The activities co-ordinator explained they planned a different activities programme each week, worked flexibly to provide alternatives, and booked visiting entertainers. Activities were also themed around the seasons and world events to help keep people orientated and involved in what was happening outside of the home. Recent activities were themed around Autumn, planning for Christmas and there had been events held to coincide with national charity days, such as the Macmillan coffee morning. Health and well-being classes were incorporated into the programme, with regular visits from a physiotherapist. Further training was also being planned for the activities co-ordinator, including in Jabadao, a form of playful and fun exercises. Some events were used to raise funds for further activities resources and outings.

In addition to group activities, the activities co-ordinator said they aimed to provide meaningful individual sessions and support. For example, they had ordered newspapers from a person's country of birth so they could stay up to date with the news. The support manager told us keyworkers also supported one-to-one time, giving an example of a keyworker recently accompanying a person to go out shopping in the community. Overall, we found there was a good level of stimulation and activities provided to help people in meeting their social needs.

Information about the provider's complaints procedure was provided to people and displayed. The people we talked with had no complaints about the service. They told us, "I've absolutely no complaints" and "If I wasn't happy I'd tell them." A relative said they had raised concerns on behalf of their family member and these were being dealt with by the registered manager.

A log and individual records were maintained for each complaint received, though the records were variable. We noted two complaints had been made by the same family earlier in the year and were informed about how these had been responded to. However, the records were incomplete and did not demonstrate the actions taken and whether the complaints had been resolved. We highlighted this with the registered manager to remind them of the need to consistently follow the provider's procedure. A number of compliments about the service had been received, including praise from a relative who had contacted us to say they were, "Impressed by the calm, peaceful atmosphere and the family was impressed by all aspects of the care provided. The family would feel confident to recommend Lady of The Vale to anyone needing a loved one cared for."

Good

Is the service well-led?

Our findings

The service had a manager who had registered with the Care Quality Commission (CQC) in July 2016. They understood their management responsibilities and registration requirements, including notifying the CQC of events which affected the service and their obligations under the duty of candour regulation.

The registered manager was an experienced nurse who was qualified in leadership and management and had won the North West 'Good Nurse Award' in 2014. They were supported in their role by the trustee director, the deputy manager, and the support manager who they felt had strengthened the management team. Support was also provided by the home's administrator and the bursar. We observed the registered manager had a visible presence and knew the people living at the home, taking time to greet and chat with them. The people we talked with were happy with the management of the home. Their comments included, "The manager runs the home very well" and "They do their very best for us."

Staff felt they worked well as a team to care for people and spoke positively about the support and leadership provided. They told us, "The manager comes round the floors and checks on people and staff", "The manager if very approachable", "There's an open door policy", and "They (the manager) has been very supportive." The staff we spoke with said that supervisions and staff meetings provided them with forums to voice any concerns or request additional support. We saw meetings were held with nurses and care staff on day and night shifts. A full staff meeting had recently taken place during which issues about staffing, communication and clarification of roles had been openly discussed.

Staff told us they felt the registered manager actively listened to and acted on their suggestions. For example, a device that enabled frailer people to have their hair washed whilst in bed had been suggested. The registered manager had agreed this was a good idea and quickly arranged to have one purchased. Some staff commented on the changes the registered manager had made. They told us, "The manager is good, has high standards and is improving the home" and "There's been lots of improvement over the last year. The service has come on leaps and bounds."

Systems had been implemented to promote working inclusively with people and their families. Quarterly newsletters were produced which included details of upcoming events, photographs, congratulations, and welcoming new staff and residents. News about the running of the home was featured, such as the progress of the refurbishment and the kitchen being given a five star food hygiene rating by the local authority. The registered manager reported they were looking to further improve the information available about the service on the provider's website and by updating the guide to the service.

A 'resident and relative' meeting had been in held in May 2016 to introduce the registered manager and discuss changes in the home including new menus, activities and computerised care planning. Surveys had been issued in Spring 2016, asking people for their feedback about particular areas of their care and the service in general. The findings were predominantly positive and had been published along with the actions that would be taken to further improve satisfaction. Individual care reviews had started to be brought up to date to ensure people and their representatives were fully consulted about their care and treatment.

A Sister from the Order had recently taken on the role of trustee director and was in the process of introducing themselves to people and their relatives. On the day of our visit they were spending time at the home, giving people the opportunity to meet and talk with them privately. They told us they had met with the management and staff, including attending the last staff meeting and had reinforced the chain of command within the service. We were shown the previous trustee director had completed extensive reports following their visits to review the quality of the service. The new trustee director was currently devising a format for the quality checks they would be conducting.

An independent infection control audit had been carried out in August 2016 and the home had achieved 95% compliance. The management and staff carried out audits to keep checks on the standards at the home. Areas covered included care records, medicines, wound management, mattress checks, health and safety, food safety/hygiene, infection control, and maintenance of the environment and grounds. Any remedial actions required as a result of audits were set out in action plans and, where applicable, were discussed with the staff responsible to address. The management were aware some audits had been sporadic to date and had produced a more structured plan to assess and monitor the quality of the service.

Since taking up post, the registered manager had prioritised improving areas of the service which would directly benefit people living at the home and the staff team. This had included reducing the use of agency staff, providing more robust training, and introducing greater accountability for different aspects of service delivery. They had evaluated where improvements and resources were needed within the environment and a refurbishment programme was on-going.

The registered manager was keen to continue their own and other staff's personal development and told us they kept abreast of legislative changes and initiatives in care. They were committed to working in partnership with other professionals, such as links with a palliative care group as part of the six steps end of life programme. Further developments in progress at the service included embedding the care planning system, enhancing support for staff with lead roles and introducing awards for staff to recognise best practice.