Ms Mary B Rushe

Rushes House Care Home

Inspection report

2 St Martin's Road
Marple
Cheshire
SK6 7BY
Tel: 0161 427 7332
Website:

Date of inspection visit: 19 and 21 January 2016.
Date of publication: 04/03/2016

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

Overall summary

This inspection was carried out over two days on the 19 and 21 January 2016. Our visit on 19 January was unannounced.

We last inspection Rushes House Care Home in September 2014. At that inspection we found that action was needed to improve assessing and monitoring the quality of service provision.

At our last inspection of the service in June 2014 we found that action needed to be taken to ensure an effective system was in place to identify, assess and manage the quality of service provision in the home. During this inspection we found that appropriate action had been taken and maintained to address those concerns identified in our last report.

Rushes House Care Home provides care and accommodation for up to 17 older people. Accommodation is provided over four floors with a lift servicing each area. Only people with good mobility are accommodated on the top floor. Single and double

Summary of findings

bedrooms are available. The home has a no-smoking policy and is situated in the village of Marple, close to local shops, parks and canals. There is also a private car park to the rear of the property.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff we spoke with had a clear understanding of their role in protecting people and making sure people remained safe and free from harm.

Risk assessments were in place and provided guidance for staff to follow about how to manage identified risk(s) in order to promote and maintain people's independence wherever possible.

Staffing rotas showed that there was consistently enough care staff on duty with the right competencies, experience and skills to keep people safe.

Only members of staff who had received appropriate training were responsible for the management and administration of medicines at the home. A policy and procedure was in place for the safe handling of medication in an adult care setting and the registered manager carried out annual competency checks of those staff with the responsibility for administering medicines in the home.

Suitable arrangements were in place for the prevention and control of infection. All bathrooms and toilet areas were extremely clean and hygienic and all contained a wall mounted liquid soap dispenser and paper towel dispenser.

We saw that people's healthcare needs were reflected within their care plans, based on a full assessment of their individual needs which were reviewed on a regular basis. Staff also undertook a range of training which staff told us was good and 'met their needs' to carry out their job roles effectively and enabled them to meet people's needs safely and appropriately.

Staff gained people's consent and cooperation before any care or support was offered or given. Where people were unable to give verbal consent, staff knew by the person's facial expression or body language if they did not agree with the action being suggested and did not force the person, but tried again later.

We spoke with the cook who was very knowledgeable about providing well balanced and meals and told us about the different types of meals provided and how nutritional values were monitored for each person using the service. The cook also explained how those people with varying dietary needs due to medical conditions had their nutritional needs met.

We saw that good relationships were had with visiting healthcare professionals such as doctors and the district nursing service.

Wherever possible, people using the service would be involved in discussions about their care and treatment and the decision would then be recorded in their care plan. Where people were unable to be involved we saw representatives participated in the care planning process. We spoke with a relative who confirmed such discussions had been held with them about their relatives care needs.

People's private space was respected by staff and permission was asked before staff entered a person's room.

We were told that wherever possible, people using the service would be involved in discussions and the decision making process about their end of life care and this would then be recorded in their care plan. Staff we spoke with understood their role when dealing with such a sensitive matter, but still needed to complete end of life care training.

The individualised approach to people's needs meant that both registered manager and staff provided a flexible and responsive approach to meeting the individual care needs of people using the service.

Staff we spoke with told us that they had regular conversations with people who used the service, or their representatives, to see if they had any worries or concerns.

We saw that the registered manager worked much of the time 'on the floor' which provided them with

Summary of findings

opportunities to assess and monitor the culture and openness of the service being offered to people. Staff we spoke with told us that the registered manager 'led by example' and gave the staff team confidence.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

People who used the service told us that Rushes House was a safe place to live.

Staff working in the home had been recruited following an appropriate recruitment process.

Arrangements were in place to safeguard people from harm and abuse.

Medicines were managed safely.

Prevention and control of infection was well managed.

Is the service effective?
The service was effective.

Good

Staff received regular support, supervision and training.

We observed staff gaining people's consent and cooperation before any care or support was offered or given.

Staff had completed basic training in MCA and DoLS and all new staff received such training as part of their induction to the service.

Staff supported people to make choices about their food and drink. Nutritional and fluid intake was monitored where necessary.

Is the service caring?
The service was caring.

Good

The atmosphere in the home was calm and relaxed and we observed positive interaction taking place between the staff and people who used the service and their visitors.

Staff encouraged people to make choices about their daily life style.

Care staff on duty demonstrated that they knew and understood the needs of the people they were supporting and caring for.

Is the service responsive?
The service was responsive.

Good

Meaningful activities were supported to take place on a day to day basis, according to the wishes of the people using the service.

People's changing needs were responded to quickly.

Care plans, risk assessments and associated care documentation were regularly reviewed and updated where necessary.

A system was in place for receiving, handling and responding appropriately to concerns and complaints.

Summary of findings

Is the service well-led?

Good

The service was well-led.

A manager registered with the Care Quality Commission was managing the service and systems were in place to monitor and assess the quality of the service being provided.

People who used the service and their visitor's told us that the management of the home were always available, approachable and supportive.

The registered manager had a clear vision and set values for the service and led the staff by example.

Rushes House 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.'

This inspection was carried out over two days on the 19 and 21 January 2016. Our visit on 19 January was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection reports about the service and notifications that we had received from the service. We also contacted the local authority commissioners and the local Healthwatch team to seek their views about the service. No concerns were received about the service.

Part of our information gathering includes a request to the provider to complete and return to us a Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. On this occasion, we did not request a PIR before our visit.

During our visit we spoke with the registered manager, who is also the provider of the service, two care workers, the cook, the administrator and four people who used the service and a person who visited the home regularly.

We looked around the building, watched staff interacting with and supporting people, examined three people's care records, six medicine administration records, four staff personnel files, staff training records and records about the management of the home such as auditing records.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe and secure living in Rushes House Care Home. One person said, "I feel absolutely safe living in this house, especially at the night time. That's when I used to worry most when I was living at home but the staff here are fantastic." Another person told us, "I've no reason not to feel safe living here; we are like one big happy family." We also spoke with a relative who visited the home on a daily basis who said, "[relative] is well looked after and I know they are safe and comfortable living here."

We looked at four staff personnel files and saw that staff had been recruited following an appropriate recruitment process. This process required the applicant to complete an application form and attend a face to face interview with the registered manager / provider of the service. Each file we examined contained a completed application form, job description, two appropriate references and terms and conditions of employment. Pre-employment checks had been carried out including an enhanced check by the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring checks on applicants who intend to work with vulnerable people. Such checks help employers to make safer recruitment decisions and to minimise the risk of someone unsuitable being employed to work in the home.

Staff we spoke with had a clear understanding of their role in protecting people and making sure people remained safe and free from harm. All confirmed they had received appropriate training in safeguarding and we were provided with copies of the training records to show this training had taken place. Staff had access to a safeguarding policy, which included details on the action to take, use of the local authority's multi-agency safeguarding procedure and how to record information accurately. The staff team also had access to a 'Whistle Blowing' policy and when asked, told us they would be confident should they need to disclose any issues of concern to other appropriate authorities such as the local authority safeguarding team or the Care Quality Commission (CQC).

Specific care plans had been developed to provide person centred information and guidance to staff so that they could support and manage care in a consistent and positive way, which protected people's dignity and rights. These plans were being reviewed regularly and where people's health or individual needs deteriorated we saw that referrals were made for professional interventions and assessments at the earliest opportunity. Risk assessments were also in place and identified guidance for staff to follow about how to manage the risk(s) in order to promote and maintain people's independence wherever possible. We spoke with two members of staff about care plan records. They told us they provided them with enough appropriate and relevant information to meet people's needs.

People who used the service and a visitor confirmed there were enough staff on duty at any one time and our observations of staff supporting people in a timely manner confirmed this. One person told us, "Staff see to your needs straight away, you don't wait for anything in this home. They [staff] understand what each of us need and know us all like family." Staffing rotas showed that there was consistently enough care staff on duty with the right competencies, experience and skills to keep people safe. The consistency of the staff team meant this helped staff to know people, understand their needs and to provide consistency of care. Daily handover information was provided by the manager to care staff at shift changes where updates to people's needs would be discussed. We were invited to sit in on one handover meeting and found the information shared was relevant and appropriate to maintain people's individual needs in a consistent manner.

Records were available to demonstrate that equipment used in the home such as hoists, lift, electrical equipment and fire prevention equipment were regularly serviced and maintained in accordance with the manufacturers' instructions. We saw that fire procedures were in place and an up to date Fire Risk Assessment had been completed. Personal evacuation plans were in place for each individual person. This included the type of evacuation required, any special or complex needs and the number of staff required. A colour coded system was used to show the level or risk for example, a person recorded as "green" would require very little assistance, "amber" would mean the person could mobilise with assistance and "red" would mean the person was immobile and would require full assistance. This provided an effective, coordinated and controlled way to evacuate the building in an emergency. The fire alarm and nurse call system were regularly checked and serviced. This meant that good systems were in place to make sure the home was as safe as possible and was adequately maintained. An appropriate and up to date insurance certificate for the service was displayed in the home.

Good

Is the service safe?

Suitable arrangements were in place for the prevention and control of infection. During our tour of the building no unpleasant odours were detectable and all areas were found to be clean and hygienic. Cleaning schedules were in place for both domestic and kitchen staff and were designed to be followed on a daily, weekly and monthly basis. All bathrooms and toilet areas were extremely clean and hygienic and all contained a wall mounted liquid soap dispenser and paper towel dispenser. Such equipment was also supplied in people's bedrooms and in en-suite facilities.

We asked two staff to describe the arrangements in place for the safe administration of medication in the home. We were told that medication was checked by two members of staff following delivery from the supplying pharmacy and signatures seen on the Medication Administration Records (MAR) confirmed this. In addition the staff were able to describe the arrangements in place for ordering and disposal of medication and records seen confirmed this. Only members of staff who had received appropriate training were responsible for the management and administration of medicines at the home and we saw that medicines, including Controlled Drugs (CD's) were stored securely.

A policy and procedure was in place for the safe handling of medication in an adult care setting. There was also information and guidance from Stockport Clinical Governance Group (CCG) entitled "Guidance for Managing Medicines in Care Homes", updated in November 2015 and based on current National Institute for Clinical Excellence (NICE) guidelines. Medication was delivered to the service by a local pharmacy on a monthly basis and was double checked on delivery against the copies kept of the prescriptions. There was a list of staff signatures available for those staff with responsibility for administering medication.

Each person who required medication to be administered to them had a MAR and all had a recent photograph of the person in place. We checked six MAR and found them to be correctly recorded with no unaccounted gaps or omissions and each record was clear and legible. Where hand written MAR's had to be put in place, for example, when medication was received from a hospital stay or visit, hand written entries would have two staffs' signatures to witness the information was transcribed from the medication details to the MAR correctly. No person was self-administering medication at the time of our inspection.

We found no excessive stocks of medication being stored and we saw evidence that the registered manager carried out annual competency checks of those staff with the responsibility for administering medicines in the home.

Regular reviews of people's medication was carried out by a visiting General Practitioner (GP) who visited the home on a weekly basis.

Good

Is the service effective?

Our findings

People and their relatives were very complimentary about the staff. One person commented, "The staff are very kind and caring and look after us all well." One relative told us, "I can't say enough good things about this home and the staff and manager. The care my [relative] receives is second to none, it is excellent, above and beyond expectations and nothing, absolutely nothing is too much trouble for any of the staff."

We saw that people's healthcare needs were reflected within their care plans. For example one person needed support with their mental health and contact had been made with a psychiatrist

who provided an assessment and ongoing treatment for the person. They also stated in a survey questionnaire they had completed, "I believe that the staff at Rushes are very effective. They go the extra mile to find out and meet the various needs of the residents. They are also very flexible, adaptive and creative when meeting resident needs."

There was evidence in the records we looked at, that people who used the service had access to the full range of medical support in the community. Information in records showed that doctors, district nurses and other healthcare specialists had been contacted and visited the person when requested. One person using the service told us they were supported by staff to visit the doctors when they needed to.

Regular visits to the service by General Practitioners (GP's), district nurses, opticians, physiotherapist and chiropodists showed that a range of healthcare needs were being monitored and provided for. The GP for the service held a "surgery" at the home on a weekly basis and kept up regular telephone communication with the registered manager to monitor individual people's health status. This helped the manager plan for 'non-urgent' appointments and reduced the amount of times that the GP had to be requested to visit the home.

Suitable arrangements were in place that ensured people received good nutrition and hydration. Care plans contained detailed information about people's dietary needs and the level of support they needed to make sure they received a balanced diet. We asked three people living in the home what they thought about the quality and standard of food served to them. One person said, "We have a great cook [named], he knows what we all like and don't like. He makes different things and you can choose what you want." Other comments included, "There is always plenty of food here, if you get hungry they will always make you a sandwich or get you some biscuits and a drink. The cook [name] always comes around before each meal and asks what you would like, he makes sure you get something you enjoy eating".

We spoke with the cook who told us about the different types of meals provided, including diabetic, pureed and soft diets. They also explained about butter, cream and full fat milk being added to meals to increase the nutritional value, especially where people were at risk of malnutrition. We were provided with evidence of daily temperature checks being taken of fridges and freezers and the cook confirmed that all hot foods were probed to ensure they were at the correct temperature before being served. We discreetly observed the lunch time meal being served and saw that the dining room was appropriately furnished and tables appropriately set for the meal being served. The atmosphere in the dining room was calm and relaxed and people were assisted to move to the dining room or could choose to eat in the lounge if they preferred. Staff were seen to sensitively encourage people to eat and allowed people to eat at their own pace. Staff, including the cook, stayed within the vicinity of the dining room and provided support to people where this was requested or needed.

The latest visit by the environmental health department had rated the kitchen '5' which meant good food hygiene standards had been achieved and kitchen staff were carrying out effective catering and hygiene practices.

We looked at how staff were supported to carry out their job roles effectively. All staff completed induction training when they commenced working at the home and this also included working closely with the registered manager, who also worked as part of the care staff team. Two members of staff told us about their induction training, including working with the registered manager who 'set the scene' and standards expected to be maintained by all staff. One person told us, "Our induction training was really, really good. We not only had training such as safeguarding and moving and handling, but also learnt all about each resident, the care plans and reporting concerns to [name] registered manager."

Good

Is the service effective?

One visitor we spoke with told us, "Staff know how to use the equipment like transferring [relative] from a hoist to wheelchair and from wheelchair to bed. I don't have any worries about the staff working here and their skills in looking after people."

Staff undertook a range of training which included moving and handling, safeguarding, fire safety, dementia awareness and infection control. Staff told us that the training was good and 'met their needs' to carry out their job roles effectively. We were provided with individual staff training records that identified the training staff had completed to date and could see that a number of training sessions had been planned and booked for staff during the early months of 2016. The planning of such training helped to make sure all members of staff were kept up to date with current best practice. Records we viewed also showed systems were in place to make sure staff received regular supervision and appraisal from the registered manager.

During our inspection we observed staff gaining people's consent and cooperation before any care or support was offered or given. Staff knew people very well and we could see that where people were unable to give verbal consent, staff knew by the person's facial expression or body language if they did not agree with the action being suggested, for example, one person did not want their meal when presented at lunch time and pushed the plate away. The carer spoke kindly to the person and took the plate away to keep the meal warm and brought it back later when the person accepted the meal from the carer.

We saw that people's healthcare needs were considered as part of the care planning process and from our discussion with the registered manager, staff and the records seen, it was apparent that staff had developed good professional links with other community health care professionals and specialists to help make sure people using the service received prompt and effective care.

Staff who we asked talked about good team work and communication. One said they were part of a staff team that "shared common values, remained positive and put the resident's at the centre of everything they do."

In our discussions with the registered manager they were able to tell us about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised un the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us that they would always involve the person's next of kin / representative and social worker if any decisions needed taking about capacity. Staff had completed basic training in MCA and DoLS and all new staff received such training as part of their induction to the service.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We were told by the registered manager that, at the time of our inspection, no DoLS applications had been made, but continuous reviews of each person would identify if an application needed to be made. A managing authority has responsibility for applying for authorisation of deprivation of liberty for any person who may come within scope of the deprivation of liberty safeguards. In the case of a care home, the managing authority will be the person registered, or required to be registered under part 2 of the Care Standard Act 2000 in respect of the care home.

We checked to see that the environment had been planned in a way that promoted people's wellbeing, independence and safety. Although some armchairs were showing signs of wear and tear they were not unsafe and we saw that a plan was in place to start renewing chairs on a rolling programme. New flooring and carpets had been laid in various rooms / areas of the home and ongoing re-decoration and refurbishment of the premises was taking place. Equipment, such as aids, adaptations to the premises and hoists were available in the home to promote people's independence and comfort.

Good

Is the service caring?

Our findings

People who used the service, and their relatives who we spoke with, expressed satisfaction with the care and support provided by the service. One person using the service said, "I love the staff in this home. They are all so caring and smashing and nothing is too much trouble." Another person told us, "I like living here, we're like one big family and they [staff] know how to look after me and the others properly." One visitor told us, "The care here is outstanding and I'm absolutely delighted that [registered manager] and staff go out of their way to provide an outstanding service. The doctor comes weekly and I've met with them and the staff to discuss my [relative] end of life care. [Relative] is well looked after, they encourage [name] to get up so [name] isn't lay in bed all day."

We also looked at comments recorded in recently returned survey questionnaires from relatives and visiting healthcare professionals. Relatives comments included, "My mother is well looked after, staff are very friendly and caring. My mother is always well dressed and does not complain", "We are so happy with the care my mum receives and are eternally grateful to all the staff" and "[Name] has received excellent care and guidance during their stay here. Their challenging behaviour has been dealt with in a compassionate manner whilst controlling their behaviour. Their stay here and the support they received has been invaluable." One visiting nurse recorded, "The service has a good name, well managed, caring staff, appropriate reviews and requests for visits", another visiting nurse recorded, "Extremely helpful and very efficient staff. The resident I visited received care that is amazing."

Discussion with the registered manager, care staff on duty and the cook demonstrated they knew and understood they needs of the people they were supporting and caring for. We observed staff caring for people with dignity and respect and attended to their needs discreetly and saw no evidence that people had to wait very long before staff responded to meeting their needs.

The atmosphere in the home was lively and we saw people being involved in making decisions about their daily lifestyles. People freely wandered around their home accessing their bedrooms and communal areas without being restricted. People's private space was respected by staff and permission was asked before staff entered a person's room. One person invited us to see their room and was proud to state "I clean and keep my room tidy". Such activities provided people with the opportunity to feel valued, encouraged independence and respected individuality.

All the staff we observed were motivated and caring and interacted with people in a caring and friendly manner. Where people seemed distressed or confused, a member of staff comforted them and listened to what they were saying. Such actions helped the person to become relaxed and settled again. Watching staff indicated they knew the needs of people well and the continuity of staff working in the home had led to people developing meaningful relationships with the staff and registered manager.

Care plans included a booklet called 'My Life Story' which gave a detailed biography of the person's life history so far, although not all stories had been fully maintained or completed. Such information would help staff have a better understanding of people's previous lifestyles and provide some key information to enhance a person's daily life. It would also help people celebrate significant and meaningful events and anniversaries and perhaps keep contact with those people important in their lives.

We asked the registered manager to tell us now staff cared for people who were nearing the end of their life. We were told that wherever possible, people using the service would be involved in discussions and the decision making process about their end of life care and this would then be recorded in their care plan. We had already spoken with a relative who confirmed such discussions had been held regarding his relatives wishes when the time came. Staff we spoke with understood their role when dealing with such a sensitive matter, but still needed to complete end of life care training.

Good

Is the service responsive?

Our findings

One person using the service told us that they felt their needs were being met and commented, "I have everything I need and I live my life to the full. I go out when I want and do what I want during the day and the staff help me to do that."

Prior to any person coming to live in Rushes House, the registered manager would carry out an assessment of the person's individual needs. We saw examples of assessments that had been carried out before the person had moved in to the home, to make sure their identified needs could be fully met by the service.

We looked at sample of three care records relating to care and the identified needs of individuals who used the service. Details in the records covered a range of needs and had been regularly review and updated when necessary. In one file we could see that the person had been involved in making decisions about their end of life care and had signed the documentation to confirm this. They had also asked one of their friends who visited them on a regular basis to sign the document as a 'witness' to the decisions they had made. This meant that people's right to be involved in planning their life was being supported to happen.

Care plans identified where a person had mental health needs or was living with dementia. Staff demonstrated a good awareness of how diminishing mental health and dementia could affect people's wellbeing and daily lifestyle. The individualised approach to people's needs meant that both registered manager and staff provided flexible and responsive care, whilst recognising that people with such needs could still live a happy and active life. Staff continued to encourage people to become involved in activities that would provide stimulation and maintain their wellbeing. For example, people were encouraged to read newspapers and participate in completing word search books and participate in quizzes to encourage mental stimulation. This meant that people's health and wellbeing was being considered on a day to day basis, according to the wishes of the individual. One relative we spoke with told us that both the registered manager and care staff involved him in all discussions about his relatives care and care plan.

Although no activities programme was displayed in the home, discussion with the registered manager, staff and people who used the service confirmed that activities took place on a daily basis according to what people decided they wanted to do. During our inspection three people using the service decided they wanted to visit a local coffee shop and 'people watch' and staff supported them to get ready to go out. We were told that this was a regular weekly occurrence for these three people who enjoyed each other's company and their time out in the community. We saw other people enjoying one to one chats with the staff, reading books and newspapers or knitting. This meant that, where people had capacity, their right to choose how they spent their time was respected. Where people lacked capacity, staff spent one to one time providing encouragement to try and get the person involved in things like reminiscence or just holding their hand and chatting.

To support the religious wellbeing of individuals, people were supported and encouraged to attend church of their chosen denomination in the community. One person using the service told us, "I usually go to church every Sunday but I didn't go last week because it was too snowy." Visiting clergy provided opportunities for those people unable to visit church in the community to attend a service held in the home.

We saw that the home had a written complaints policy which included the option for people to take their complaint outside the service if they were dissatisfied with the response received from the registered manager / provider. The complaints procedure was displayed in the main hallway and the registered manager told us they were not currently dealing with any formal complaints and there had been no formal complaints made since our last inspection of the service. It was explained that regular conversations and checks with people who used the service, or their representatives, were held to see if they had any worries or concerns. We were told if verbal concerns were raised, these would be resolved before they escalated.

People using the service, who we asked, told us they had no concerns and had not had cause to make a complaint. One person using the service told us, "Believe me, if I had a concern or a complaint I would go straight to [name] and

Good

Is the service responsive?

tell them. We see and chat with [name] every day so there is always a chance to speak with them if you are worried. I can't imagine anyone having a complaint about this home or any of the staff."

Good

Is the service well-led?

Our findings

At our last inspection of the service in June 2014 we found that action needed to be taken to ensure an effective system was in place to identify, assess and manage the quality of service provision in the home. During this inspection we found that appropriate action had been taken and maintained to address those concerns identified in our last report.

At the time of this inspection visit there was a registered manager in post. The manager was registered with the Care Quality Commission (CQC) on 1 October 2010. People who used the service told us that the registered manager, administrator, cook and care staff were very approachable and 'had time for them every day'. One person using the service told us, "We are like one big family. I find it easy to talk with any other them [staff]; they all listen to what you have to say." Another person said, "I often chat with [name] and [name] but I know I can speak with any of the staff, they are also my friends."

There was a relatively stable staff team. The registered manager, who was also the owner of the home, told us that they had a very skilled and highly motivated staff team and being a small home meant that the staff team worked well together and took direction from the examples set by the registered manager. Those staff we spoke with told us about a well led service with a "good team" and "good communication" within the team. Staff told us of their daily handover meetings that included updating information about every person living in the home and discussions about matters relevant to make sure people remained safe and comfortable during every shift. Both the care staff and administrator who we spoke with said that "good ideas and the use of initiative" were always received positively by the registered manager.

The administrator of the service had the responsibility for making sure all documentation was kept up to date, such as policies and procedures, as well as monitoring and arranging staff training, carrying out audits of personnel files, staffing rotas and quality monitoring documentation. The administrator also worked closely with the registered manager to make sure the manager had time to spend working with care staff rather than being based in the office all the time. Throughout the inspection we saw that this management structure worked well. The registered manager told us that being 'on the floor' provided them with opportunities to assess and monitor the culture of the service, by making sure that people using the service were 'at the centre of everything we do'. Staff we spoke with told us that the registered manager 'led by example' and gave the staff team confidence.

The registered manager sought feedback about the service through surveys, formal meetings, such as individual service reviews with relatives and other health care professionals and informal feedback via day-to-day conversations and communication from the staff team. We saw that surveys were analysed and action plans drawn up to review any areas where improvements to the service could be made. For example, we saw that as a number of people had mentioned some of the armchairs were beginning to show signs of wear, and plans to replace some of those chairs had been incorporated into the business plan and budget for the next six months.

Since our last inspection of the service the registered manager and administrator of the service had developed a range of audits and checks to make sure the service was being maintained safely and that a good standard of care was being provided to everyone living in the home. These checks included a daily 'walkthrough' check of the premises, a monthly check of the premises, monthly reviews of any accidents and incidents, monthly checks on maintenance matters, monthly check on staff working practices and monthly check on manual handling practices.

A medicines audit/check was conducted on a monthly basis, with an annual audit being conducted by the supplying pharmacist. Records were available to demonstrate these audits had been consistently completed and action taken where needed. We could see that where action had been taken, improvements had then been maintained.

A full annual infection control audit of the premises was completed in January 2015 with an overall compliance rating of 98%. The annual infection control audit for 2016 was due to take place and advice and support was provided by an external health and protection nurse.

There was a Business Contingency Plan in place that looked at the systems used in the home and described the action to be taken should any of those systems fail and place people at risk. For example, if the heating failed, the

Good

Is the service well-led?

building was flooded or the building required to be fully vacated. Plans were in place to move people to a place of safety and emergency and essential telephone numbers and contact details were also included.