Maria Mallaband Care Homes Limited

Rosedale Nursing Home

Inspection report

The Old Vicarage
Catterick Road
Catterick Garrison
North Yorkshire
DL9 4DD
Tel: 01748 834948
Website: www.mmcgcarehomes.co.uk

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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

Overall summary

This inspection was unannounced and was carried out on 16 October 2015.

Rosedale Nursing Home is registered to provide accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening for up to 68 people. It is divided into three units; a general nursing unit; a unit for people living with dementia who required residential care and a unit for people living with dementia who require nursing care. There were 61 people living at Rosedale on the day we inspected.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

Summary of findings

and associated Regulations about how the service is run. The registered manager had also completed a Provider Information Return (PIR).The PIR 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.

Rosedale provided good care and support for the people that lived there. People we spoke with said they felt safe and they spoke positively about the care and support they received. Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people.

The home had safe systems in place to ensure people received their medication as prescribed; this included regular auditing by the home and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

New staff had received relevant training which was targeted and focussed on improving outcomes for people who used the service. This helped to ensure that the staff team had a good balance of skills, knowledge and experience to meet the needs of people who used the service.

Staff followed the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions.

People had their nutritional needs met. People were offered a varied diet and were provided with sufficient drinks and snacks. People who required special diets were catered for.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

People told us that they were well cared for and happy with the support they received. We found staff approached people in a caring manner and people's privacy and dignity was respected.

People looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

People were involved in activities they liked and were linked to previous life experience, interests and hobbies. Visitors were made welcome to the home and people were supported to maintain relationships with their friends and relatives.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

The provider actively sought the views of people using and visiting the service. They were asked to complete an annual survey to provide feedback on the service.This enabled the provider to address any shortfalls and improve the service.

The service had a quality assurance system, and records showed that identified problems and opportunities to change things for the better had been addressed promptly. As a result we could see that the quality of the service was continuously improving.

Staff told us they were clear about their roles and responsibilities. Staff had a good understanding of the ethos of the home and the quality assurance systems in place. This helped to ensure that people received a good quality service. They told us the manager was supportive and promoted positive team working.

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?

Good

The service was safe.

When we spoke to people who used the service they told us they felt safe. Staff had undertaken training with regard to safeguarding adults and were able to demonstrate what to do if they suspected abuse was happening.

We found there were sufficient staff on duty to attend to people's needs. The way in which staff were recruited reduced the risk of unsuitable staff working at the home.

Risks to people's safety and welfare had been assessed and information about how to support people to manage risks was recorded in people's plan of care.

There were systems in place to protect people against the risks associated with the management of medicines.

Is the service effective?

Good

The service was effective.

Staff received on-going training. The training programme provided staff with the knowledge and skills to support people.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had received training and demonstrated understanding of the principles of the Act and people were supported to make decisions about their care, in line with legislation and guidance.

The home had developed good links with health care professionals which meant people had their health needs met in a timely manner when their needs changed.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected and staff were kind and attentive.

People were well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

Is the service responsive?

Good

The service was responsive.

People were involved in planning how their care and support was provided. Staff knew people's individual preferences and these were taken account of.

Documentation was completed with up to date accurate information to support people's needs being met when they transferred between services.

Summary of findings

People had an opportunity to participate in group activities and attention was also paid to people's individual interests and hobbies.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

The service was well led.

Staff and people using the service; their relatives and representatives expressed confidence in the manager's abilities to provide good quality care.

The provider actively sought the views of people and collated them in the form of an action plan to improve the service.

The service was responsive to any comments or complaints they received. They made the necessary improvements where shortfalls were identified.

There were effective quality assurance systems in place to monitor the service and drive forward improvements. This included internal audits and also corporate audits which provided positive feedback about the service.

Staff reported a supportive leadership with the emphasis on openness and good team work.

Rosedale Nursing 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 took place on 16 October 2015 and was unannounced. The inspection was carried out by two inspectors and a specialist professional advisor who specialised in providing services to people living with dementia.

Prior to the inspection we reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send to the Commission by law. We planned the inspection using this information. We also contacted the local authority contracting team to ask for their views on the service and to ask if they had any concerns.

During our inspection we carried out observations of staff interacting with people and completed a structured observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us. We spoke with four people who lived at the service and five relatives.

During the inspection visit we reviewed six people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings, satisfaction surveys, and medication storage and administration records. We also spoke with six members of staff, including nurses, senior cares, care assistance, the activities organiser, the chef, the registered manager and the regional manager as wells as one visiting health professional.

We contacted Healthwatch to ask for their views and to ask if they had any concerns about the home. Healthwatch had completed an Enter and View visit on 29 July 2015. From the feedback we received no one had any concerns.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person told us "I am very happy here, I feel secure knowing the staff are around to help me."

The service had policies and procedures with regard to safeguarding adults and whistleblowing (telling someone). When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. They were able to explain the process to follow should they have concerns around actual or potential abuse. Information the Commission had received demonstrated the manager was committed to working in partnership with the local authority safeguarding teams and they had made and responded to safeguarding alerts appropriately.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and Disclosure and Barring Service (DBS) (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

We spoke with the manager about how they determined staffing levels and deployed staff. They told us each unit had a dedicated staff team which included either a nurse in charge or unit senior care assistant. Staffing levels were determined according to the needs of people living at the service and the manager told us they had the authority to increase staffing levels if required. One member of staff told us; "There is never a problem in increasing staffing when we need to; for example, if someone is very poorly or entering the last days of the lives."

Staff we spoke with said that they felt although they were busy there was enough staff on duty. Their only negative comments related to the use of agency staff. A member of staff said "Agency staff are a problem; some are better than others" and "There's no consistency, we have agency nurses; I'm the only regular nurse; agency staff don't do routine things, so I spend most of the time catching up before I start."

People we spoke with told us they felt there were enough staff on duty. One person said "I think there is enough staff, I never have to wait long for one of them to come." A relative said "Although the staff are busy they always seem to attend to people, you never hear call bells going all the time."

Staff told us they had a daily handover where the leader of the shift passed on relevant information about people's needs and planned event/appointments for the day. Staff were also allocated areas within the home to work and allocated break times in order to ensure there were sufficient staff available. This helped make sure that people's needs were met. During our visit we noted that although staff were busy they had time to spend with people and that call bells were responded to swiftly.

We found that risk assessments, where appropriate, were in place, as identified through the assessment and care planning process, which meant that risks had been identified/minimised to keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to keep people safe. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure people's nutritional and pressure sore risks were minimised..

Accidents and incidents were analysed for trends and patterns; for example if someone started to fall more frequently. In the event of a person falling additional checks were put in place to monitor for any ongoing effects.

There were risk assessments in place relating to the safety of the environment and equipment used in the home such as hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency

Good

Is the service safe?

contingency plans in the event of power failure or adverse weather for example. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

We walked around the building and saw grab and handrails to support people and chairs located so people could move around independently but with places to stop and rest. Communal areas and corridors although homely, were free from trip hazards.

The home was clean. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We spoke with the unit managers responsible for handling medicines on the day of our visit about the safe management of medicines, including creams and nutritional supplements within the home. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. Medication records were clear, complete and accurate and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, care workers had clearly recorded the reason why. Change of font here needs changing)

We saw controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Staff were not permitted to administer medicines until they had completed medication training. The training included a written exam and observation of competency which meant people could be assured they received the medicines they were prescribed safely.

Regular audits were carried out to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted, the senior care workers and manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

Good

Is the service effective?

Our findings

We asked the manager about staff training arrangements. They told us newly appointed staff were allocated a mentor and completed a twelve week induction which included mandatory health and safety training such as moving and handling, first aid and safeguarding adults. Staff were encouraged to complete National Vocational Training (NVQ) and the provider's training team offered access to specialist training such as end of life care, dementia awareness and Mental Capacity Act (2005) training. The manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training and it was relevant to their role.

Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. This meant that staff were well supported and any training or performance issues identified.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met

We saw in people's care plans that MCA assessments had been had been undertaken of people's capacity to make particular decisions and it had been deemed that people did have capacity. These were decision specific for example "consent to care and share information, consent to use of equipment to promote safety. We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

We noted that where a person lacked capacity and this amounted to a deprivation of the person's liberty the registered manager was sending DoLS applications to the local authority to authorise in line with legislation. This meant legal safeguards to protect the rights of people who may lack mental capacity to make some decisions around their care and welfare were being protected.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

We saw that consent to care and treatment records were signed by people where they were able;

When we spoke with staff they demonstrated a good understanding of the issues with particular regard to day to day care practice ensuring people's liberty was not unduly restricted.

Those people who needed it were given discrete assistance with eating their meal and we saw people using adapted cutlery and plate guards in order that they could be independent as possible.

We spoke to the chef who told us all food was fresh and locally sourced. They baked every day to ensure fresh cakes and high calorie smoothies were available to supplement people's diet where they were at risk of weight loss. They told us they had a good relationship with people and they knew people's preferences. Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition

Good

Is the service effective?

Universal Screening Tool (MUST). MUST is a screening tool to identify if adults were malnourished or at risk of malnutrition. Where people were identified as being at risk staff completed daily 'food and fluid balance' charts. The food charts were used to record the amount of food a person was taking each day. Fluid charts recorded the fluid intake goals and there was consistent completion of the totals recorded. People's weights were monitored in accordance with the frequency determined by the MUST score. This information was used to update risk assessments and make referrals to relevant health care professionals, such as doctors, dieticians and speech and language therapists, for advice and guidance if appropriate.

People's records showed details of appointments with and visits by healthcare and social professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), social workers, dietician, speech and language team (SALT), community psychiatric nurses, chiropody and podiatry. The care plans we looked at reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

The home was an adapted manor house with a purpose built extension. As such some parts of the home were less accessible than others. The manager explained consideration was given to this during the preadmission assessment to ensure people's mobility meant they were able to access their bedrooms. We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden.

When we looked around the service and saw distinct contrasts between the areas where nursing care was provided and the areas where people living with dementia lived. We could see that consideration had been given to research associated with supportive environments for people living with dementia. For example we saw in the communal areas the walls were plain which provided a contrast to the coloured furniture. There were pictures on the walls from the 50's and 60's which seemed relevant to the age of people. Rummage boxes were available for reminiscence which all had a different theme. For example seasons, nature, textiles and childhood memories. There were scrapbooks for people to look at featuring events from different decades and the royal family. There was a board telling people what day, date and season it was and what the weather was like outside. The manager explained the provider was due to implement an accreditation scheme based on the work of Professor Dawn Brooker called LIFE (Living In Fulfilling Environments.) The registered manager said she felt the accreditation process would further enhance staff skills and enhance the lives of people living with dementia at the service.

Good

Is the service caring?

Our findings

The service was caring. People we spoke with were complimentary about the care they received. One person said “The staff are so patient.” Another person said “The staff are really good; they come to me when I need them. I prefer to stay in my room and listen to the radio.” A relative told us “I can’t praise the staff enough they are so kind and caring, I never have to worry.”

We spent time in the lounge areas of the home. Staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. There was a calm, positive atmosphere throughout our visit and we saw that people’s requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names. Staff knocked on people’s doors and waiting before entering, ensuring people’s privacy was respected.

We observed that people were asked what they wanted to do and staff listened. In addition, we observed staff explaining what they were doing, for example in relation to giving people their medication. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people’s care preferences and routines. Overall, people looked comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected.

We heard a person who lived at the service talking to the activities co-ordinator and they said, in relation to the bird feeder which the activities co-ordinator was showing them, “Absolutely beautiful one of the nicest boxes I've seen.”; and we heard the activities co-ordinator respond to the person; “I'm just an extension of your hands, you enjoy feeding the birds”. We also saw a member of staff jiving with a person and the staff member told us “X loves jiving”. We also saw the staff comforting people appropriately and gently stroking their arms.

Some people who had complex needs were unable to tell us about their experiences in the home, so we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found staff interactions were positive and benefited people’s wellbeing. Discussions with staff showed a genuine interest and very caring attitude towards the people they supported.

Our observations indicated that people were able to spend their day as they wished. We saw some people involved in communal activities and others preferring to spend time in their rooms. People we spoke with told us that they were asked about their preferences. We saw people’s bedrooms were personalised with their own furniture and possessions or family photographs.

Staff told us they had received training with regard to providing end of life care. Staff told us they received excellent support from district nurses. One member of staff said “We always make sure there are extra staff on duty to attend to people at the end of their life. It’s a privilege to support someone during their final days” We saw an advanced care plan/end of life care plan for one person which included information about the relevant people who were involved in decisions about this person’s end of life choices and details about anticipation of any emergency health problems. This meant that healthcare information was available to inform staff of the person’s wishes at this important time, to ensure that their final wishes could be met.

We were told people had access to an external advocacy service if required and the manager told us they promoted an open door policy for people who live at the service and their relatives. During the day we saw visitors coming and going; they were offered a warm welcome by staff. We spoke to two visitors who said they were very happy with the care their relatives received.

Good

Is the service responsive?

Our findings

One person told us “The staff are lovely, very kind and thoughtful.” Another person told us the staff were very helpful; “They will get me whatever I ask for. I am looked after very well.”

The manager explained that they completed pre admission assessments of people's needs. They said they involved other people in the process such as relatives and health and social care professionals, to ensure as much information was gathered as possible in order to determine whether they would be able to meet those needs. They went on to tell us that prior to admission wherever possible the person would have an opportunity to visit the home before they were admitted either for an overnight stay or a meal. This provided an opportunity for the person to decide if they wanted to live there and for everyone to meet each other.

Following an initial assessment, care plans were developed detailing the care needs and support required to ensure personalised care was provided for everyone. The care plans guided the work of care team members and were used as a basis for quality, continuity of care and risk management.

We reviewed six people’s care plans which included information relating to personal care, mobility, nutrition, daily and social preferences and health conditions. We saw care plans were detailed with corresponding risk assessments in place. They were all up-to-date and had been reviewed monthly and on a more regular basis, in line with any changing needs, and were reflective of the care being given. For instance we saw that one person had lost weight and had been referred to the dietician and now required their food and fluid intake to be monitored. We saw the corresponding records for this. This meant that the person's changing needs had been being monitored. Our discussions with staff indicated that staff knew people well and this would reduce the risk of providing inappropriate care.

Examination of care plans showed they were person-centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what’s important to the person. This was helpful to ensure that care and support was delivered in the way the person wanted. From our discussions with staff it was evident they knew the individual care and support needs of people. Staff told us they had a handover meeting at every shift change where any changes to people’s needs were made known so they were able to provide appropriate care.

We saw evidence that the service used The Cornell Scale for Depression in Dementia (CSDD). This was designed for the assessment of depression in older people living with dementia. A person living with both dementia and depression may find it even harder to remember things and may be more confused or withdrawn. Depression may also worsen the person’s distress manifesting itself in either aggression, problems sleeping or refusal to eat. In the later stages of dementia, depression tends to show itself in the form of depressive 'signs', such as tearfulness and weight loss. By carrying out the Cornell Scale assessment this showed that the service was making sure they were aware of signs of depression and could put a plan in place which may include more activities or regular one to one sessions and we evidence of this in some people’s care plans.

Each person’s care plan contained a social profile (me and my life, enjoy doing chart), where the information had been collected with the person and their family and gave details about the person’s preferences, interests, people who were significant to them, spirituality and previous lifestyle. An example for one person regarding what they enjoyed doing stated “family, gardening, walking, does not like bright nail polish, watches jungle book, enjoys PAT dogs”. An example for another person stated “enjoys music” Recording this information is essential and necessary for when a person can no longer tell staff themselves about their preferences and it enables staff to better respond to the person’s needs and enhance their well-being and enjoyment of life.

The service employed two activities organisers who were available every day of the week. They provide one to one and group activities. We spoke with one of the activities organisers. They talked about their role in extremely positive terms especially their commitment to ensuring activities were personal and relevant to people and how they enhanced people’s sense of well-being. They told us they visited everyone every morning to deliver papers and spend a short amount of time with people. We observed them providing manicures to people and noted that their interaction with individuals was very personalised. For example discussion with one person about their previous employment as a game keeper and another about their

Good

Is the service responsive?

love of 1950s music. They told us of 'projects' people had participated in such as Daffodil Sunday, which included people who lived at the service, their family and friends planting bulbs in the garden; collating a book of favourite recipes; celebration of saints and religious festivals and 'Hollywood verses Bollywood.' We were also told each unit was due to have an IPad with 'breezy' installed which is a programme designed to be easy to use and marketed for old people.

Information about how to make a complaint was available. People we spoke with knew how they could make a complaint if they were unhappy and said that they had confidence that any complaints would be responded to. We reviewed the complaints records; the records indicated the service's complaints procedure had been followed and the complainants had been satisfied with the outcome.

The provider completed an annual survey of people who used the service and their relatives to gather feedback on all aspects of the service provided. Survey questionnaires were confidential and analysed by the provider's quality team. Results were published and with appropriate action plans put in place. The previous survey dated July 2015; 29 out of 57 surveys were returned. Some of the positive comments received included; " Care is very individualised, the home is very well managed, staff are very supportive to relatives." And "Overall, care is excellent the food is good and varied, patients are given dignity and personal care they all deserve and need." Negative comments related to poor laundry service and the lack of refurbishment of the environment. The provider responded with an action plan to address the issues and met with individuals to discuss their concerns.

Good

Is the service well-led?

Our findings

People who lived at the home and their relatives told us they knew who the manager was and saw them regularly around the home; they confirmed they were approachable and responded to concerns and queries.

The staff we spoke with were all complimentary about the manager. Staff told us the manager was very approachable and supportive and felt they had already made a difference and was recognising and addressing low morale. They said they were fair and addressed issues directly with staff but also acknowledged when staff had worked well and provided good care and support. One member of staff said "I enjoy my work it is a lovely atmosphere, we work well together."

Staff meetings had been held at regular intervals, which had given staff the opportunity to

share their views and to receive information about the service. Staff told us that they felt

able to voice their opinions, share their views and felt there was a two way communication

process with managers and we saw this reflected in the meeting minutes we looked at. They said the manager offered an open door and was fair and honest with them.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us that the manager had a regular presence in the service. They told us the manager spent time in the home talking with and working alongside staff.

During our inspection we spoke with the manager about people who used the service. They were able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service. They told us they were proactive in developing good working relationships with partner agencies in health and social care. The feedback we received from these agencies supported these statements.

The manager was knowledgeable and experienced; from evidence gathered through this inspection we could see they placed much emphasis on people receiving a high quality of care. They invested in the staff team to deliver this. The manager spoke enthusiastically about the developing care and support to people living with dementia and implementing the provider's new accreditation quality standard LIFE.

The manager explained there were a range of quality assurance systems in place to help monitor the quality of the service the home offered. This included formal auditing, meeting with the provider and talking to people and their relatives. Audits included regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire fighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop.

Monthly audits and monitoring undertaken by regional managers helped managers and staff to learn from events such as accidents and incidents, complaints, concerns and whistleblowing. The results of audits helped reduce the risks to people and helped the service to continuously improve.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.