Care Quality Commission

London and Manchester Healthcare Ltd

London and Manchester Healthcare Limited

Inspection report

Gainsborough House Nursing Home
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Warrington
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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

This inspection took place on the 12 December 2017 and was unannounced. There were 70 people using the service on the day of our inspection.

London and Manchester Healthcare Limited (known locally as Gainsborough House) is a residential nursing home near the centre of Warrington and is registered to provide accommodation with care for up to 72 people. Rooms are over three floors, single occupancy and all have en-suite facilities. Assisted bathrooms are also available on each level of the home. There are a range of public areas including lounges and dining rooms on each floor. There are communal secure gardens with good access from the building.

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

There was lots of positive feedback about the home and caring nature of staff from people who used the service and their relatives.

People and their families described the care as safe. Staff had been trained to recognise signs of abuse and knew the actions they needed to take if abuse was suspected. People were protected from avoidable harm as risk assessments had been carried out, were regularly reviewed and staff understood the actions needed to minimise identified risks. People were involved in decisions about how their risks were managed and had their freedoms and choices respected.

There were enough staff to meet people's needs and they had been recruited safely. The recruitment process included obtaining employment references and carrying out a criminal record check. Staff were well trained to enable them to carry out their roles effectively.

Staff felt valued and supported by management and by each other and made sure that people's needs and preferences were at the forefront of what they did. Staff received regular on-going training and supervision and had opportunities for professional development. Nurses received training that kept their clinical skills up to date.

People had been involved in decisions about how they would like their care needs met and these were regularly reviewed. Care and support plans provided clear information about people's care needs and staff understood the actions needed to support people and had been kept updated with any changes. People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in place supported this practice.

People and their families described staff as caring, kind and patient and we observed relaxed, friendly

interactions between people and the staff. Staff demonstrated a good understanding of people's individual communication needs and supported people in ways that enabled them to be involved in decisions and express their wishes. People had their independence, privacy and dignity respected.

People were offered choices of meals and snacks throughout the day and information about likes, dislikes, allergies and special diets had been shared with the catering team.

People had opportunities to maintain hobbies and interests and keep in touch with family and friends. Numerous activities took place both within the home and in the local community.

The service was extremely well managed by an accomplished, experienced and highly motivated registered manager. The registered manager and staff were proud of where they worked and committed to delivering a high standard of care. Staff spoke positively about their roles and the teamwork and described how they had embraced the organisation's values.

The culture of the home was open and transparent and people who used the service, their families and the staff team felt able to raise any issues with the management team. Communication was effective and ensured people were kept up to date and felt included.

There was an excellent quality assurance system in place that was effective in gathering information that captured the experiences of people using the service and this information was used to improve outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff that had been trained to recognise signs of abuse and knew the actions they needed to take if abuse was suspected.

Risks to people were assessed and actions put into place to minimise avoidable harm whilst respecting people's rights of freedom and choice.

People were supported by enough staff to meet their needs and checks had been carried out to ensure the staff were safe to work with vulnerable people.

People had their medicines ordered, stored, administered and recorded safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training that enabled them to carry out their roles effectively.

The principles of the Mental Capacity Act were followed ensuring people had their rights and choices respected.

Staff understood people's individual eating and drinking preferences and needs and made sure that people's nutrition and hydration were maintained.

People had access to healthcare whenever it was needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, patient and friendly.

People had their individual communication needs understood

which meant they were able to express their needs and wishes.

People had their independence, dignity and privacy respected.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and regularly reviewed and they were understood by the care team.

People had opportunities to pursue interests, activities and hobbies and to create and maintain links with the local community.

A complaints process was in place that people were aware of and felt able us use if needed.

Is the service well-led?

Good

The service was well led.

The registered manager and the provider put people at the heart of everything and were proactive in seeking people's views and experience of their care and support. They continually looked at ways to improve the service and enhance people's experience.

Communication was inclusive and frequent, enabling staff to engage with the organisation's values and clearly understand their roles and responsibilities.

There was a constant drive to deliver high standards of care. Management and staff were pro-active and learnt from mistakes and made changes to systems and practices in a timely way to prevent re-occurrence.

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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 checked 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 12 December 2017 and was unannounced. The inspection was undertaken by three adult social care inspectors, a specialist nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included statutory notifications and a Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the safeguarding alerts raised regarding people living at the home and other information we held on our database about the service. We also contacted the local authority commissioning and safeguarding teams, the local clinical commissioning group and Healthwatch who all said they had no concerns.

During the inspection we spoke with five people living at the home, eight relatives and a GP who visits the home every week. We spoke with the registered provider's Director of Quality and Compliance and the Operations Director. We also talked to the registered manager, three registered nurses, seven care staff and the wellbeing co-ordinator who was responsible for organising activities and providing some of the staff training.

We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot talk with us.

We checked records related to staff recruitment, training and support, health and safety and the management of the service including quality assurance audits. We also looked at the care and medicine records for seven people and three staff files.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. Comments included: "The home is ok, really ok, I feel safe here"; "I'm very happy to be here, I wouldn't like to live anywhere else and I feel absolutely safe"; "It's quite good living here and it's'very safe".

All of the staff we spoke with felt that people were kept safe at the home and knew what action to take to reduce the risk of abuse and avoidable harm. We saw that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse; staff knew how to escalate concerns about people's safety to the provider and other external agencies as directed by the safeguarding policy. Records we looked at and information we hold about the service showed that where safeguarding alerts had been raised these had been reported to and investigated with the relevant authorities.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistleblowing and that there was a whistle-blowing policy in place. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC, if they do not feel confident that the management within their organisation will deal with their concern properly. All of the staff we spoke with told us that they felt comfortable raising concerns with the registered manager and other members of the management team.

Assessments were carried out looking at any risks to people's safety and how these could be reduced. When a risk had been identified actions had been put in place to minimise the risk whilst respecting the person's freedoms and choices. The risk assessments were linked to the care plans to help prevent or minimise the risk of harm to people using the service. These included assessments regarding people whose behaviour towards other people living in the home required a response from staff. The risks to people were recorded in care plans and identified the staff support required to reduce the risks.

Some people were at risk of skin damage. Actions to minimise the risk of harm included using specialist equipment such as air mattresses and cushions. Records showed us that equipment was checked regularly to ensure it was working correctly. Some people needed help changing their position regularly in order to relieve pressure on their skin. Records showed us this happened in line with their individual risk assessments.

Accidents and incidents were recorded and provided details of what had happened and the actions staff had taken at the time. Each record had been reviewed by a senior manager who detailed any further actions needed to minimise risk of reoccurrence. Communication systems were in place that ensured staff were aware of accidents and incidents and any consequent change to managing risks to people.

Suitable pre-employment checks were carried out to ensure staff were safe working at the service. Records viewed confirmed that staff were required to provide two satisfactory references, photo identification and a

Disclosure and Barring Service (DBS) check prior to starting work at the service. A DBS is a criminal record check employers undertake to make safer recruitment decisions.

Staff provided people with the time and support they required to meet their needs safely and the staff and relatives we spoke with said they thought the staffing levels were sufficient to meet people's needs. Throughout our inspection we observed staff were available to help people in a timely way and had time to talk and spend time with people. The registered manager told us the staffing levels were monitored and increased if people required more support. We saw that the staffing ratio was recently reviewed and more staff had been provided for one of the units because they had identified that a number of people were prone to disturbed sleep and tended to wander around the unit at night.

People were confident that staff were managing their medicines correctly. People said they received their medicines on time. One person, who was a retired nurse, said "I'm happy to leave the medicines to the nurses here". A relative told us that her husband received his medicines on time and that staff recognised this was important because of his condition. People also told us that pain medicines could be requested at any time.

Medicines were administered by trained nurses who had undertaken medicine training. Medicine administration records were suitably maintained and showed that people were supported to take the right dose at the right time. We observed good practice when staff supported people to take their medicines. People were not being rushed to take their medicines and support was provided in accordance with their care plans.

People's medicines were stored correctly and where necessary were kept in the fridge. Staff recorded fridge and room temperatures daily to ensure that the medicines were kept at the right temperature.

We found that the premises were kept clean and hygienic. Staff understood their responsibilities regarding infection control and followed guidelines to ensure that people were protected. For example, staff wore gloves to provide hygienic care and encouraged people to wash and dry their hands to minimise the risk of infection.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

Records showed us that equipment including hoists, lifts and the heating system were regularly serviced and maintained. Fire equipment had been regularly checked and both day and night staff took part in fire drills.

Good

Is the service effective?

Our findings

People were supported by staff that had completed an induction and received on-going training that enabled them to carry out their roles effectively. Induction included some staff completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. When staff were recruited, the first two weeks they had time allocated for completing mandatory training courses and familiarising themselves with the service's policies and procedures. Following this they shadowed more experienced staff to gain understanding of what was expected of them and to enhance their knowledge about people's individual care needs. Staff's competency was assessed over a probationary period, and if completed successfully, staff could then start to support people without direct supervision from senior staff.

Records showed that one to one supervision and appraisal meetings and group sessions were carried out to provide staff with further opportunities to identify their on-going developmental and training needs. We looked at a number of staff records and saw that supervisions were comprehensively documented and had focus on learning, development and staff welfare. Staff annual appraisals were also comprehensive and well documented; staff were sent an appraisal preparation document so they could say what was important to them in their role and what they would like to discuss at the meeting.

We saw that the provider kept a record of on-going staff training which detailed the dates of when staff had completed various training and the implementation of training into practice was monitored during observations, supervisions and appraisals. Staff attendance at training was 95% overall.

Staff we spoke with confirmed that they received regular supervision and felt supported in their work. The manager held regular team meetings which were offered at different times to provide flexibility around working patterns to optimise attendance. We saw that minutes from these meetings were recorded and made available to staff who were unable to attend.

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 found that the service was working within the principles of the Act. Mental capacity assessments had been completed for people and DoLS applications had been submitted to the local authority. We saw that best interest decisions had been taken for people and had included input from staff, families and health and social care professionals. Staff had completed MCA training and had a good understanding of the legislation and how to put it into practice

when supporting people. DoLS were documented well and a summary of dates for renewal was kept to maintain the currency of authorisations.

People were provided with adequate nutrition and hydration. People we spoke with were complimentary about the food that was available and prepared for them at the home. They told us that snacks and drinks were always available. One person said "The food's very good and there's plenty". Another said "It's pretty good on the whole, plenty of choice". One person who was a vegetarian said that they had a wide choice of meals; "The kitchen staff cook something to suit me, they don't mind".

Information had been gathered about people's like and dislikes, allergies and any special diets and this information had been shared with the catering team. Menus were produced each day and people were able to make choices for each meal from a range of hot and cold options. People were involved in menu planning and had opportunities to feedback comments about food quality and menu options. People were able to choose where they took their meals and we saw that some had modified crockery to support them to remain independent at meal times. When people needed help with eating and drinking we observed care staff supporting the person at their pace and ensuring people's dignity and wishes were respected.

Records we looked at included nutritional assessments and care plans that detailed people's specific needs and risks in relation to their diet. People's weights were monitored and advice sought from the relevant professionals, such as speech and language therapists (for swallowing assessments) and/or dieticians where necessary.

People had access to healthcare and records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, specialist health teams and dieticians. We spoke with a GP who visited the home at least weekly. He said he had no concerns about the home and trusted the nurses to provide good care.

We saw that the environment was dementia friendly, with clear signage, orientation aids and areas to promote sensory and occupational engagement. We saw that people had reminiscence boxes outside their rooms so that they could recognise their room through personal and meaningful memorabilia but also to equip staff with details of each person's interests in order to engage in meaningful conversation and engagement. Bedrooms were personalised with plentiful toiletries and personal effects and there was plenty of visual as well as tactile stimulation around the home.

There were designated areas available for people to use and spend time socialising or with their visiting families. Each floor had an activity room, a TV lounge, a quiet lounge and a library. Spacious and well furnished communal spaces allowed people to move around freely with mobility aids. People had access to the outdoor facilities and could spend time in the garden. We observed staff supporting people to access different rooms so they could take part in the activities offered.

Good

Is the service caring?

Our findings

People felt well cared for and valued by the staff that supported them. Comments included: "The staff are all pretty good and very helpful"; "They're wonderful"; "I have no problems with the staff attending when required, they are very good". One relative said the staff team were "very good, excellent in fact". Another said "This home was recommended to me; it's a very good home". A third said "The staff are lovely, you'll see them sitting with residents, talking or just holding their hand".

The home provided a welcoming and homely atmosphere for people. Visiting was unrestricted and family and friends were welcomed and involved in the life of the home. We observed people having a relaxed, friendly relationship with staff, sharing moments of fun and laughter.

Staff knew what was important to people and paid attention to details which enhanced people's wellbeing. We found that staff were aware of people's histories, preferences and important events to them. We observed staff having conversations with people that involved personal information about them, for example how many children they had and their profession. People's relationships with their friends and relatives were valued and the importance of these relationships was understood by staff. The care and compassion received by people was extended to families who also felt supported by the staff.

We observed staff showing kindness and patience with people. Staff supported people in an unhurried way helping at a pace that was comfortable for the person. People told us that staff never seemed rushed and were "like friends". People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything. We observed that staff had time to listen to people and patiently listened to people's life stories. Before starting a conversation, staff positioned themselves in a front of a person so they could see them properly and ensured they had the person's full attention before they started talking to them. This meant that people were encouraged to participate in conversations as much as possible. We noticed that staff applied different communication methods, making sure people understood what was said, using short, simple sentences where appropriate. We saw that one staff member got their message across by gestures when a person could not understand what they were saying.

People said staff gave them choices, treated them with respect and protected their privacy and dignity. People were supported to make choices, where possible, in all aspects of their lives such as the food they ate, the clothes they wore and the activities that they engaged in. One person said "I have a choice when to go to bed and when to get up. I can stay up late if I want to". Another said that staff asked if they were ready to get up and with regards to going to bed they said "I can go any time I want to''. One of the relatives said that the staff asked permission of his wife before carrying out any care; "The staff don't force her to do anything".

We observed staff knocking on bathroom and bedroom doors before going in, which ensured that people had privacy. Staff told us they provided a private environment for people before they started supporting them with personal care and that they encouraged people to maintain their independence as much as

possible.

Records held information on people's religious beliefs. An activity co-ordinator told us they looked to accommodate every person's religious beliefs.

People told us they were able to take part in elections and were registered for postal votes. A relative told us that his wife's post was always delivered to her unopened.

Good

Is the service responsive?

Our findings

People told us that staff were responsive to their needs.

Needs assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. People were reassessed every six months. The plans contained clear and very detailed information about people's individual needs and the actions staff needed to take to support them. These included care plans in relation to people's physical and mental health and social needs. Records also included suitably maintained repositioning charts and information on dietary and fluid intake. The care plans were updated monthly and when people's needs changed. Daily entries were made to monitor people's conditions which meant that information was regularly reviewed and actions taken to address any concerns identified, for example where people required additional support with moving and handling.

A care worker told us "We have time to read the care plans. We have a handover every day and any changes they (nurses) will inform us".

People who used the service and their relatives were aware of their care plans and felt involved in them. One person told us they had signed their agreement to the care plan, knew they could ask for it to be changed if required and had been involved in making changes to it.

People and relatives we spoke with told us that their cultural and personal preferences were respected and we found that people were given choices about who provided their care (male or female) and whether they had any special dietary requirements in association with their religious or cultural beliefs.

We observed that staff responded to people's care needs quickly where necessary and followed healthcare professionals' guidelines to ensure people's wellbeing.

The provider had a clear understanding and appreciation for the importance of end of life care planning. Records we looked at showed that people's choices and preferences about how they wished to be cared for at this stage of their lives had been considered and planned for, in accordance with best practice guidelines. We saw that some people had been involved in making decisions about whether or not they wished to receive lifesaving interventions at the end of their lives, where they wanted to spend their final days and what arrangements were to be made after death. Staff we spoke with confirmed that they received all of the relevant information they required to ensure they supported people in accordance with their final wishes and how important it was to promote a peaceful and dignified death for people.

The home employed a wellbeing coordinator who planned activities for people and two activity coordinators who facilitated them. They were clearly enthusiastic and passionate about ensuring that people had access to a variety of social and leisure opportunities. We found that activities were facilitated with people on both an individual and group basis.

People told us they had a wide range of activities to choose from. One person told us "I go to as many as I can". Another told us "I go to the art classes and have a couple of paintings displayed on the corridor wall. I enjoy the bingo, quizzes, the Elvis impersonator and when they bring animals in".

We saw that staff reminded people about the activities taking place on the day so they would remember to attend them. Activity plans showed that a broad range of activities were planned and people had a say about the activities they wanted to be facilitated. Activities included making cards, exercise to music, a computer club, bingo, Tai chi and a current affairs discussion group. People could access the garden which contained seating areas and areas of interest such as bug boxes, bird houses and a hedgehog house.

On the day of inspection we saw people taking part in an art class and a laughing yoga session. There were also activities for those who were bedbound. We observed people being given individual attention such as having their hands massaged and the wellbeing coordinator was helping one person who used the service to put together a playlist of music they enjoyed.

Other activities included such things as an 'intergenerational programme', which involved local children coming into the home to meet the residents and take part in craft sessions. There were activities involving the local community such as visits from church ministers and the church choir, visits from Warrington Wolves, an antiques roadshow held in the home and a Christmas market. Staff also invited entertainers to perform in the home.

Engaging and participating within the local community was a key part of the home. Records showed and people confirmed they went out in the community regularly. This ensured that people were provided with opportunities to socialise and build relationships. We saw photos of people enjoying going out shopping or to the pub or garden centre.

People also told us they were able to and were encouraged to keep in contact with families and friends. Electronic devices were available and staff helped people to use them to stay in touch with people who were important to them. This helped to protect people from the risk of social isolation.

The service had a complaints procedure in place and people understood how to raise their concerns. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. People told us they felt able to speak up and share their concerns with the staff team. They were confident that the concerns raised would be appropriately investigated and actions taken to make any changes necessary.

There were systems in place to monitor complaints received. Records were suitably maintained to ensure that actions were taken in good time, for example to inform the complainant about the outcome of their concern. We saw that all complaints made were investigated to the complainant's satisfaction which meant that improvements were made as necessary.

We also viewed the compliments received by the service. People's relatives thanked staff for the support they provided to their family members.

Good

Is the service well-led?

Our findings

There was a clear management structure in place which ensured good leadership at the service. The registered manager was responsible for managing the service and had support from the operations director and director of quality and compliance.

There was an open and transparent culture. People, staff and families were kept informed about how the service was developing and the provider ensured that any learning from feedback they received was shared across the organisation.

People and their relatives told us the management team were approachable and available when they needed to talk to them. Comments included: "I'm impressed, this home is the best"; "The manager's very approachable and there's a nice community spirit in the home"; "The phrase, 'her door's always open' really applies". People who used the service said the manager had introduced herself to them when they first came to the home and that she regularly asked them if they were happy with the service.

The staff team shared a clear vision aiming to deliver high quality care for people and strongly expressed their values around the person centred care they provided for people. Staff were passionate about working there and were very complimentary about the management. A member of staff said "I love working here, the manager's brilliant and all the senior staff are very approachable. There's a nice atmosphere; I can't say anything bad about the place". Another staff member said "I've worked at six other homes and this is the best - the team work is excellent, handovers are really good, there's good communication and fun activities for residents". A third member of staff said: "This is the best manager I've ever worked with".

The management team provided a 24 hour on-call service if staff needed advice on urgent matters outside of normal office working hours. There was a lead nurse on each floor to provide direct supervision and support for the staff team as necessary.

We found that the staff team were aware of their responsibilities and knew what was expected of them. Staff meetings were regularly held and well documented, with an excellent structure that gave consistency and a framework for checking all relevant topics were covered. Records showed that open communication was encouraged at staff meetings which involved staff in developing the service and showed the manager was open to the suggestions made to improve the service.

Systems were in place for staff to share information which ensured continuity of care provided for people. There were daily, weekly and monthly meetings carried out to share information about care being delivered to people. Nurses provided a handover to the next shift to inform them of people's individual needs and the actions they had to carry out to meet those needs. This ensured that information was not missed and people had the support they required.

The provider ensured that service development was based around the feedback they received from people using the service, families and staff. People's views and experiences were gathered and acted on to improve

the service. Where people had provided feedback on the quality and safety of the service, this was cascaded appropriately to ensure that the relevant departments received the feedback that was most pertinent to them.

Records showed that relatives were invited to attend meetings to keep them involved in the services being delivered to people.

There were effective systems in place to monitor the quality of the services being provided. The director of quality and compliance had introduced a clear governance framework with an audit regime covering all the fundamental standards. The management were responsible for carrying out regular quality assurance audits and we saw evidence that the information gathered as part of these processes had been analysed and evaluated.

For example, audits were carried out of how staff obtained people's consent, which focussed on ensuring that people were helped to make their own choices, and included checks that staff carried pictorial cards assisting people with dementia in making choices and keeping them informed. The audit also looked at mental capacity assessments, that Deprivation of Liberty Safeguards had been appropriately applied for and that best interests decisions had involved the person, their family and relevant health and social care professionals.

Audits of issues around safeguarding looked at training, staff's understanding and quality of referrals.

Other audits carried out included: staff training, supervision and appraisals; people's dependency and staffing levels; infection control; accidents and incidents; medication audits looking at storage, administration, management of controlled drugs, stock control and disposal.

Clinical audits included areas such as wounds, weight loss, hospital admissions and infections.

Falls review meetings were also held where analysis took place to identify trends and actions needed to reduce risk.

These audits were conducted by the manager and then re-audited by the head of quality and compliance. On examination the audits were of high quality and comprehensive.

There was a formal documented annual review of complaints in the home, to identify trends and look for learning opportunities. There were also regular audits of complaints and staff knowledge of how to deal with them. The audits checked availability and visibility of information to assist people in making complaints should they so wish. Posters in the home displayed "You said we did" information, which included actions taken on comments from people who used the service, relatives and staff. The provider clearly saw complaints and feedback as a method of continuous improvement.

The head of quality and compliance carried out a variety of visits, including manager support visits and service overview visits, which were well documented and demonstrated an appetite for quality and continuous improvement. She had provided "Person centred workshops" for staff and these had led to staff becoming more aware of considering the perspectives of people who use the service and allowed them to develop as reflective practitioners. This showed a transformational approach to management and a forward thinking leadership team.

The manager carried out daily walk round checks to identify any issues requiring action. Weekly clinical risk

meetings were held and well documented; these considered matters such as new admissions and people's nursing needs and medical conditions. These meetings were minuted and any identified actions were allocated to an individual or team to complete. Care plans were audited regularly; the quality of the audits was high with extensive narrative rather than check boxes.

The provider was working on making information more accessible and was in the process of introducing easy read documentation. They had access to a translation service for those whose first language was not English.

The provider had commissioned an independent survey in 2016, completed by 19 residents and 26 relatives. The overall score was high and well above the national average. The provider used the survey to inform their development and improvement. They examined ways in which satisfaction could be improved and implemented changes to achieve this. This is good practice and demonstrated an appetite for continuous improvement.

People's personal records were stored securely in a locked cupboard when not in use but they were accessible to staff, when needed. There were policies and procedures in place for dealing with confidential data. Staff had been trained in the Data Protection Act and confidentiality and knew who they could, and could not
share confidential information with. This ensured that people's confidential information was protected in line with data security standards.

The service worked in partnership with other agencies to ensure person centred care for people. Information was shared on a need to know basis with local authorities, clinical commissioners and multidisciplinary teams to ensure that the support provided for people was joined up, for example when a person was admitted to a hospital.

The registered manager knew the different forms of statutory notifications they had to submit to CQC as required by law and according to our records these were sent to CQC in good time.