HC-One Limited

Falstone Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 25 May 2016 and was unannounced. A second day of inspection took place on 26 May 2016 and was announced. We also contacted relatives during from 6 to 7 June 2016.

Falstone Court is a two storey home that provides nursing or personal care for up to 40 people, most of whom are living with dementia. At the time of the inspection there were 39 people living in the service.

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 had a good understanding of safeguarding and were confident in their role of safeguarding people. Any safeguarding concerns were investigated with the outcomes fed back and practices changed if necessary in order to prevent reoccurrences. Staff also knew about the whistleblowing policy and told us they would use it if necessary.

People had risk assessments in place and associated care plans were clearly linked and updated in line with risk assessment reviews. There were also general risk assessments regarding the premises and environment.

Records were kept for all accidents and incidents including details of investigations, outcomes and action taken. The registered manager analysed accidents and incidents to identify any trends and put additional measures in place to reduce the likelihood of any reoccurrences.

Medicines where managed safely, effectively and in a way which reflected people's individual needs. All records were up to date and fully completed, with medicine audits being carried out regularly.

Staffing requirements were assessed in line with peoples' needs. The registered manager also considered the skill mix and gender of staff. From staffing rotas we saw staffing levels were consistent required. Staff were recruited in a safe and consistent manner with all necessary checks carried out.

Staff received regular training on core subjects such as safeguarding, Mental Capacity Act 2005 (MCA), deprivation of liberty safeguards (DoLS), moving and handling, infection control and management of medicines. They also received training on specific subjects relating to people's needs such as dementia awareness. Staff felt supported in their roles. They received regular supervisions, direct observations and annual appraisals.

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Best interest assessments were evident within care files and DoLS authorisations were in place for most people who used the service.

We observed during mealtimes people were enjoying their meals, some independently and others with support from staff. There were choices available for people and support provided by staff was gentle and at an appropriate pace to each individual.

Care plans were personalised, detailed and contained people's personal preferences, likes and dislikes. Care plans were up to date and reflective of each person's individual needs.

There was a wide range of activities available both within the home and in the community for people to become involved in and enjoy. The home had a full time activity co-ordinator who worked with people and family members to design activities programmes tailored to people using the service both as a group and individually. Relatives spoke very highly about the activity co-ordinator and the range of activities that took place in the home.

Relatives told us they knew how to complain and would be confident in raising any concerns. Staff told us they felt supported in their role and could talk to the registered manager about anything.

The provider had a robust quality assurance and audit schedule in place which was carried out in practice. This ensured the quality of the service provided was assessed and monitored from every aspect and appropriate action was taken to improve and develop the service where possible.

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.

Relatives told us their family members were safe and comfortable living at the service.

Staff were confident in their role to safeguard people and keep them safe.

People had risk assessments in place to monitor and reduce risks in relation to their individual needs.

Medicines were managed safely.

There were enough staff to meet people's needs. The registered manager monitored staffing levels in line with people's needs and the skill mix of staff.

Is the service effective?

Good

The service was effective.

Relatives were confident staff had the right skills and experience to meet the needs of their family members.

Staff received regular training and were supported in their roles.

People's specific dietary requirements and nutritional needs were met.

People had access to healthcare professionals as they needed them.

Is the service caring?

Good

The service was caring.

Relatives spoke very highly of the service and staff. They also told us staff kept them informed of things happening in the service and specifically with their family members.

People were treated with dignity and respect. Staff addressed

people gently, by their preferred name and people responded positively.

People had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

Relatives told us the service was responsive, that staff knew their family members and identified if something was wrong or somebody was upset.

People had a range of care plans which included details of their likes and dislikes.

There was a range of activities that took place both inside and outside of the service. Relatives spoke very highly of the activity co-ordinator and the organisation of activities in the service.

Regular resident and relative meetings took place.

Is the service well-led?

Good

The service was well-led.

Staff and relatives told us the registered manager had a positive impact on the service and was very approachable.

The registered provider had a robust quality assurance system in place that promoted best practice and was used to drive improvement in the service.

Staff attended a number of different meetings including daily briefings and regular staff meetings. Staff were able to raise any concerns as well as share ideas for further improvement of the service.

Falstone Court

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 comprehensive inspection took place on 25 May 2016 and was unannounced. A second day of inspection took place on 26 May 2016 and was announced. We also contacted relatives on 6 and 7 June 2016.

The inspection team consisted of one adult social care inspector.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR) and this was returned before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

Falstone Court is situated on the same site as Falstone Manor. They are both under the same registered provider and they have one interlinking corridor on the first floor. They share the catering and laundry services and staff. We contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

The people who lived at this home had complex needs and this limited their communication, so we spoke with relatives and asked for their views. We also conducted a Short Observation Framework for Inspection (SOFI) during the lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spent time in the communal areas.

We also spoke with six members of staff, including the registered manager, a nursing assistant, a care assistant, the activity co-ordinator and the chef who was also the head of catering. We looked at four

people's care records and four people's medicine records. We reviewed five staff files, including records of the recruitment process. We reviewed supervision and training records as well as records relating to the management of the service. We also carried out observations of care and support delivery throughout the service.

Good

Is the service safe?

Our findings

Relatives told us they felt their family members were safe. One relative said, "The staff are lovely and the service is great. It's safe as well because there's a security door. I can go away knowing [family member] is safe and getting well looked after." Another relative we spoke with told us, "We know my [family member's] named nurse. I'm aware of all the risks. The care plan's just been put in and I'm always kept informed. I've got no doubt in my mind they're safe."

The registered manager and staff demonstrated a good understanding of safeguarding. Staff were able to identify several types of abuse and described potential signs to look out for. For example, marks on a person's body, a person being withdrawn or not presenting as they used to be. Staff were aware of the reporting process and felt confident in reporting any concerns to protect people. One staff member said, "I would report it straight away to whoever's in charge. If I wasn't happy (with the response) I'd ring the operations director."

There was a safeguarding file available that included details of safeguarding concerns, alerts and the subsequent action taken. For example, disciplinary action taken with staff members. Safeguarding records reflected those notified to the Care Quality Commission (CQC). Records showed safeguarding concerns were investigated and outcomes communicated to the person involved, if appropriate, and all other relevant parties.

The registered provider had a whistle blowing policy in place which was displayed on noticeboards around the home. Staff told us they were aware of the policy and knew how to use it. The registered manager actively encouraged staff to use the whistle blowing policy and ensured staff were aware of and understood it.

People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed. All identified risks had appropriate care plans in place which detailed the measures required to help minimise those risks. For example, where someone had been assessed as being at risk of poor nutrition and underweight, a referral had been made to the dietetic services to assess the person's diet and suggest ways to improve their weight. The person's weights and MUST scores were monitored on a weekly basis.

The provider had generic risk assessments in place for the premises and environment which included first aid, legionella, moving and handling, windows and infection control. All general risk assessments were reviewed annually to ensure they were up to date and relevant. They were stored centrally in the registered manager's office so they were accessible to staff.

Fire evacuation procedures were on display in communal areas. Each person had a personal emergency evacuation plan (PEEP) in place. These included details about support each person required in an emergency. For example, how many staff were needed, any equipment required and if there were any communication needs.

The registered manager had a fire box in the nurse's office which was designed for staff to grab in an emergency. The box contained a copy of the latest fire risk assessment, PEEPs for everyone who used the service, details of the fire zones and overview plans of the home. It also contained a first aid kit, identity wrist bands and the service's business continuity plan. This meant the home was equipped and prepared to deal with an emergency evacuation while minimising risks to people.

Accidents and incidents were recorded in a log. Appropriate records were kept which included details of events that had happened, people involved, any injuries sustained and any potential causes. All accidents and incidents were investigated and appropriate action was taken. The registered manager kept a computerised record of all accidents and escalated them to different provider teams depending on the severity of the incident and risk. For example, duty of candour related accidents and incidents would be alerted to the registered provider's standards and compliance team.

Records confirmed medicines were managed safely. All medicine administration records (MARs) viewed were completed accurately. Records included staff signatures to confirm medicines had been administered at the prescribed dosage and frequency. Staff competencies were regularly assessed by the registered manager or deputy manager to ensure staff administering medicines had the relevant skills and knowledge to do so safely. Regular medicines audits were carried out by the registered manager to identify any medicines errors.

Staff files we viewed showed the registered provider's recruitment process was followed so staff were recruited with the right skills and experience. Prior to confirming appointments all necessary checks were carried out for each new member of staff including references and disclosure and barring service checks (DBS). DBS checks are carried out to confirm whether prospective new care workers have a criminal record or are barred from working with vulnerable people.

Relatives told us there were enough staff in the home to support their family members. One relative said, "The carers work really hard. They do give very good care. When I pass the day room there's always a member of staff sitting in with them (people). I feel there's always someone there." Another relative said, "I feel quite happy that if I walked in here I'd see staff around, sat with people" Staff also told us there were enough staff on duty to support people. One staff member said, "Oh yes definitely there are enough staff. It doesn't matter what shift you're on, we all gel together well. There's some really good staff here."

The registered provider had recently introduced a new role to the staffing structure to support the shortage of nurses. The registered manager explained the nursing assistant's role to us and what responsibilities they had. The registered manager told us they worked out staff rotas based on the needs of each person and the levels of support they required with different tasks. We reviewed staffing rotas for a four week period and found staffing levels to be consistent and in line with assessed levels. Throughout the inspection we observed people being supported by staff in a timely manner and at a pace comfortable to each person. People were not left unassisted for long periods of time and staff were visible around the home.

Good

Is the service effective?

Our findings

Relatives told us they felt their family members were supported and cared for by staff who were skilled and experienced to do so. One relative said, "It's a lovely, lovely home. I'm a nurse so I know what type of care [family member] gets. They are being valued, cared for and looked after." Another relative told us, "They're all brilliant with [family member]. The care, the treatment they get, the food, we couldn't ask for better." A third relative told us, "The staff are lovely and so friendly, so professional."

Staff had up to date training including safe handling of medicines, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), fire safety, moving and handling and safeguarding. Additional awareness training was available to staff members that reflected people's specific needs, for example, dementia awareness.

The service had an electronic system called 'Touch' that staff accessed to review their training records and see when refresher courses and new courses required completing. One staff member we spoke with told us, "All your training is on the touch system. You can ask the manager if there's any training you want to do too."

Staff told us they felt supported in their roles and they received regular supervision and annual appraisals. Supervisions are regular meetings between a staff member and their manager to discuss how their work is progressing and to discuss training needs. Records we viewed showed staff received regular supervisions. Discussions covered a range of areas including any specific issues or concerns, people living in the service, training and development. Agreed actions were recorded and were followed up in the next supervision sessions.

The provider had a policy and procedure in place for each staff member to receive an annual appraisal. Appraisal discussions covered their role, training received, objectives, any performance issues and future learning and development. Staff told us and records showed that they received annual appraisals and all were up to date for all staff.

During the inspection we observed a meal time experience in the first floor dining room. The atmosphere was calm and people were served their food in a polite, respectful manner without waiting for long periods of time. Due to the complex needs of people, they were unable to choose a meal when asked verbally. We observed care workers showing people both options plated up and asking them which one they wanted. Staff explained what each option was. We saw people pointing to the meal they wanted. This meant people had a choice where they had their meals. People were given gentle encouragement to eat their meals independently where possible. People who were unable to eat their meals independently were supported by staff members with patience, at a pace comfortable to each individual. People had a choice of two meals every mealtime. The chef told us they always had alternatives should people not prefer either meal on the menu. Alternatives included omelettes, jacket potatoes and sandwiches.

We spoke with the chef and asked how they organised the two main choices each meal time. The chef explained they received a dietary notification sheet when people first arrived at the service and they revised

these over time to add further information about people's likes and dislikes. The chef told us further information came from feedback from staff members on what people seemed to enjoy during mealtimes as well as information from relatives during resident of the day chats. The service operated a 'resident of the day' scheme which included heads of service areas sat with people and their relatives and reviewed their care needs and personal preferences. We observed people receiving their choice of meal which meant there was enough of each choice to satisfy people's preferences.

The chef told us, "We get the menu from head office and we tinker with it (to suit people's preferences)." The chef went on to tell us how they tried to encourage people to eat to support them to maintain a healthy weight. They said, "We go around to see the resident on the day and talk about what foods they like." They went on to tell us one relative had discussed portion sizes with them and how large portions put their family member off eating meals. They told us, "[Person] really likes salads so we make them up two small salads and give them one at a time." The chef explained that had had a positive impact as the person consumed more food over the course of the day than previously.

The registered manager discussed concerns of people's weight loss with the chef who then explored alternative foods and supplements they could offer to the person. The chef told us they met with people and their relatives to gather ideas for alternative meals based on food the person previously enjoyed. For example, one relative had mentioned their family member previously liked pate and crusty bread. The chef told us they went and bought those to try with the person. They explained it was early days and they would continue to monitor the person but they were eating more and seemed to being enjoying those foods.

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.

The registered manager explained how best interest decisions were made and demonstrated knowledge and understanding of MCA and DoLS. People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations. Detailed care plans were created to ensure the least restrictive options were considered for people. For those who required a DoLS authorisation there was a clear audit trail showing when DoLS applications had been submitted to the local authority, when outcomes had been received and authorisations for those granted. Expiry dates were recorded to trigger a reminder for the registered manager to make a new application. We saw DoLS applications, authorisations and notifications to the Care Quality Commission were stored appropriately.

Staff understood the principles of MCA assessments and when they should be completed. Staff also had an understanding of DoLS including what they were, when they were used and understood that, due to the complex needs of people living in Falstone Court, most of them had a DoLS in place. At the time of the inspection there were 36 people subject to a DoLS authorisation. Two people had very recently arrived at the home and were awaiting assessment from a the responsible local authorities.

We saw people had access to a wide range of health professionals including GPs, dieticians, speech and language therapists, district nurses and tissue viability nurses. Records of any professional visits to the home or appointments attended by people were kept, as well as contact notes of discussions staff had with health professionals or treatments people had received.

Good

Is the service caring?

Our findings

Relatives told us the service and staff were caring. One relative we spoke with said, "Staff couldn't be more supportive and helpful." Another relative told us, "The staff are very caring. [Family member] treats them as a family. They all come and chat with you (when you visit)." A third relative said, "The nurses in charge are great and keep us informed. If anything happens they always ring me and let me know. I definitely trust them 100%. [Family member] is quite happy and content." A fourth relative told us, "The staff in here are great. They do care in here. They are all lovely. It's like an extended family."

The atmosphere was warm, calm and fairly busy with people in different parts of the home. Relatives visited their family members and sat with them in communal areas as well as their own rooms. Relatives told us there was a nice atmosphere in the home. One relative we spoke with said, "It's homely it's a good atmosphere. Even the domestics are always happy and singing and asking how we are." Another relative told us, "It's a pleasant place to come." We observed staff chatting to people in communal areas and people responding positively with smiles and body language. For example, one person was wandering in the corridor and staff approached them to see if they wanted to go into the lounge, they smiled and held their hand out then followed the staff member to the lounge for a cup of tea. One relative told us, "They're (staff) good and affectionate towards people like cuddling them if they're down in the dumps."

During our inspection we observed staff supporting people with daily tasks, such as mobilising around the home, taking part in activities and eating their meals. People were supported to make individual choices and decisions where possible. For example, they were shown prepared meals and actual snacks on offer so they could choose by sight which they wanted.

Throughout the inspection we observed staff treated people with dignity and respect. Staff spoke with people in a warm, respectful manner. When speaking with people who were seated, we observed staff lowering themselves down to the person's level, calling them by name and softly speaking to them. Staff explained the support they were offering to people and reasons why, where necessary, and gained permission before providing it. For example, asking if someone was ready for some lunch and offering to support them to walk to the dining room. We observed staff knocking on people's doors before entering. Relatives told us they saw this also. One relative told us, "I've seen a lot of staff go into my [family member's] room but I've never not seen them knock on the door first. They always knock."

Staff addressed people by their preferred name when speaking with them. One relative told us, "They call [family member] nana because that's what all the family call them." One staff member reiterated this and told us, "We call [person] nana because they respond most positively to this name as their family call them it."

Information was displayed and promoted around the home regarding 'Total Voice Sunderland' advocacy services. At the time of the inspection no one required an advocate. The registered manager told us and records showed someone had recently accessed an advocacy service for their DoLS authorisation.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs, wishes and preferences. One relative we spoke with told us, "They treat everybody as individuals and as much as they can, cater for their individual needs. I couldn't envisage [family member] being anywhere else." Another relative said staff were, "Brilliant, excellent, very hard working. We know all of them now. They don't just look after [family member] if you come in, (they look after everyone)." They went on to say, "Oh yes definitely, they know [family member's] needs. We've been in and someone was upset, they know straightaway what could be upsetting them. They're a good crew." A third relative told us it was, "Brilliant how quickly they (staff) knew [family member's] name and all about them. [Family member] has settled fine."

People had a range of care plans in place to meet their needs including personal care, eating and drinking, medicines, skin integrity, continence and mobility. Care plans were personalised and included peoples' choices, preferences, likes and dislikes. For example, one person's personal care plan stated '[Person] has no preference to bath or shower but they would like either two to three times per week, in the evening.' Care plans contained relevant detail and clear directions to inform staff how to meet the specific needs of each individual. For example, one person's nutrition and hydration care plan instructed staff to monitor the person eating their meals as they had swallowing difficulties and to prompt and encourage them to eat their meals.

Care plans were reviewed on a regular basis, including when people's needs changed. All care plans we viewed were up to date and reflected the needs of each individual person. Records showed people and their relatives were involved in planning and reviewing their care and support.

Relatives told us they were involved in care planning for their family members and were kept informed when people's needs changed. One relative we spoke with said, "If doctors visit or [family member] has a planned test at the hospital they always ring me and let me know and let me know the results. They keep you very well informed." They went on to tell us, "They're really good with plans of care. I go a couple of times a year (for care plan reviews). They ask is there anything you want to add, do you think anything has changed." Another relative told us, "We go in (to the home) and do the reviews and the paperwork."

The home had a full time activity co-ordinator who worked with people and their relatives to design appropriate activity programmes. There was a range of activities available for people to take part in including baking, bingo, keep fit, films, pampering, arts and crafts and a sensory room. People went out into the community to visit garden centres, go for walks along the sea front for an ice cream and go out for lunch. People also had one to one activities which they chose themselves. For example, staff reading to them, going out for a walk or spending time in the sensory room with music and dressing up. During the inspection we observed people making cakes in the small kitchen on the ground floor.

Relatives told us there were lots of activities in the home which they felt had a positive impact on people. One relative we spoke with said, "There's something going on all the time, every day." Another relative told us, "[Activity coordinator] is very good, every day they're doing something different. It's fun when you come

in, the staff are all fun. Sometimes staff are in fancy dress." They went on to tell us, "We come in and the girls are in the lounge doing (people's) nails." A third relative said, "There's a new girl took over (activities) now. They're excellent. When my [relative] visited, [family member] was having a dance and a sing along." A fourth relative, when talking about activities, told us, "They (staff) are absolutely fantastic. They have encouraged [family member] sometimes. They remember they're there and they include them (in activities)."

The home arranged a number of fund raising events such as raffles and fetes to raise money for activities within the home and external events. The registered manager told us they arranged an annual fundraising event during the Sunderland Air Show selling refreshments and food to people visiting the show. This was organised jointly with another service. The registered manager told us this was an ideal fund raiser due to the location of the home being on the seafront. There was a 'residents and relatives welfare committee' in place that was chaired by a relative. The committee made all decisions around how funds raised would be spent during their monthly meetings. This meant people and relatives were involved in planning activities for the service. We spoke with the relative who was the chair of the committee who told us, "They're has to be a minimum of four members to make a decision." They told us they found the meetings positive as it gave relatives and residents some control and say on the service and how to improve it for people.

Regular resident and relative meetings were also held in the home. Discussions included updates on the home's refurbishment plan, recruitment of new staff, kindness in care awards and bedroom redecoration plans. Other discussions included the 'Brighten Our Home' programme which was a competition for staff to work with residents to brighten an area of the home, making it brighter and more decorative, on a budget. We observed areas of the home that had been decorated with wall art such as a forest display with handmade bird houses attached to the wall. The registered manager told us people had made the leaves for the trees and created the bird houses with staff support.

Relatives told us they knew how to make a complaint and felt confident any issues would be dealt with quickly. One relative we spoke with said, "There's nothing you could complain about with the staff and the care in here. But if I've asked for things to be done in [family member's] room it gets done straight away." For example, putting some pictures up. They went on to say if any small issues are raised with staff or the manager, "Within the day it's done, it's sorted." Another relative said, "I do feel like I can approach the staff and talk to them, that's one of the most important things. I know if I did have a problem or a complaint they would listen to me and the issue would be resolved. But I haven't needed to (make a complaint)." A third relative told us, "I've never had any qualms or complaints. When it's someone that you love, believe me, I would complain. If I wasn't getting the response I wanted, I would go higher."

The registered manager had a complaints file which contained a record of all complaints received. Records showed the registered manager fully investigated complaints received, liaised with relevant professionals where required and fed back outcomes to complainants. Any required changes were identified and actioned. At the time of our inspection there were no changes required to the service from recent complaints received.

We saw thank you cards and compliments received from people's relatives, praising the service their family members received whilst living at the home. The registered manager recorded them on the electronic system and stored them in a file in the office for staff to view.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post since 14 September 2015. They were proactive in meeting their responsibilities in relation to submitting relevant notifications to CQC. Staff told us the registered manager operated an open door policy and was approachable. During the inspection we observed staff entering the registered manager's office to speak with them about people and the service and people living there. Staff told us the registered manager was approachable. One staff member we spoke with said, "It's good to be able to speak to your boss like that (in an informal, relaxed manner)."

Staff told us they felt the service was well-led. They told us they felt confident and comfortable going to the registered manager with any issues or concerns. One staff member we spoke with told us, "[Registered manager] fits in brilliant. Anything I want or need [registered manager] is always here to guide and give advice if something sits in my mind and I'm in doubt. I work closely with GPs as well so they're supportive." Another member of staff said, "She's really, really good. She knows her stuff. I think that gives you that extra confidence because she can recite lots of information." A third member of staff told us, "Yes I feel supported, [registered manager] is great and is there when you need them. I look forward to coming to work every day."

Relatives also spoke positively about the registered manager. One relative we spoke with said, "Now [registered manager] has come in and is permanent it's much better because there's a permanent manager." They went on to tell us, "She has an open door policy. She's one of the most approachable people you can come across." Another relative we spoke with said, "I've met her, she's lovely, she's here for the long stay. I haven't had any concerns but if I see her she stops and says hi and has a chat." A third relative said, "She seems absolutely fine. She's a lovely lady."

Throughout the inspection there was a management presence in the home with the registered manager being readily available for staff, people who use the service, relatives and other professionals to speak with. During out of hours, the registered manager told us there were on-call arrangements in place which included the registered manager, the deputy manager and management staff from a neighbouring service. The registered manager explained they had a rota system in place to cover both the home and the provider's neighbouring service. Contact names and numbers were available in the office for staff to access as and when required.

The registered manager told us they completed two daily walk arounds in the home to monitor and record findings for a number of areas including the care provided to people, infection control, nurses stations, staff rooms and the general appearance and feel of the home. They also gathered feedback from people, relatives and any visiting professionals. The registered manager completed one walk around on the morning and noted any required actions. They allocated actions to relevant staff members and checked actions had been completed during the afternoon walk around.

The provider had a robust quality assurance system in place that promoted best practice and identified improvement opportunities within the home that were then acted upon. The home's quality assurance system tool kit was named 'Cornerstone'. It provided a structured approach to quality audits and when they

needed to be completed. Audits regularly carried out related to areas such as medicines, care plans, falls, health and safety, infection control and the dining experience. The audits were effective in identifying any issues and areas that required action or improvements. For example, staff to read and sign the new policy of safer handling of people. All lighting in the home to be checked to be ensure all areas of the home were well lit to reduce the risk of people suffering falls due to poor visibility.

Daily briefing meetings, also known as 'Flash' meetings, took place in the home to discuss different aspects of the service and to suggest ways to drive improvement. Flash meetings were attended by the registered manager and the heads of departments such as activities, domestic, maintenance and administration. Discussions included people receiving the service, the resident of the day, catering, activities, housekeeping, care support and any clinical issues such as anyone with infections or pressures sores. Flash meetings took place before the start of a shift to share important information with staff to prepare them for their shift.

Falls team meetings took place on a monthly basis and discussed people and occurrences when they had suffered falls and how the risk of future falls could be reduced such as specialist equipment, bedrails, increased staff support and assistive technologies. Other discussions included analysing the number of occurrences, if they had increased from the previous month and if there were any trends with particular situations, areas or people. Any agreed actions were recorded and addressed at the next meeting. Actions included contacting a person's GP to request a review of their low blood pressure and current medicines.

As well as completing all other regular audits, the home completed a system called 'resident of the day'. On that day senior care staff checked the person's care file, had a monthly update meeting with the person and their relative if required and checked their medicines to ensure they were correct, up to date and being administered appropriately. A member of the kitchen staff met with the person and their relatives to discuss their choices and preferences in relation to meals, snacks and drinks. Domestic staff completed a deep clean of the person's room, unless they declined. The activity co-ordinator met with the person and their relatives to review their activities programme to ensure it was meeting the person's specific needs and preferences. The maintenance person completed all maintenance checks in the person's room and arranged for any repairs to be completed. This meant the person and the relative were involved in planning every aspect of their care to ensure it was personalised to them, up to date and in line with their changing needs, preferences and wishes.

The assistant operations director for the service completed a monthly audit of the home which assessed the environment, staff files, care records, medicine administration and management audits. The registered manager completed a self-assessment form each month and reported to senior management whether the home was compliant with quality themes. These included the environment, staff files, care records and medicine management. Any actions identified were re-visited the following month and recorded if they had been completed. The registered manager told us, "There is a structured audit but they also conduct additional checks during the process. They might cover a specific theme like dignity and dining."

Staff meetings were held regularly and staff told us they were able to discuss various topics. Discussions included feedback on safeguarding, complaints received and dining experiences, compliments received by the service and training. Minutes viewed included any agreed actions for staff, for example, to undertake training in special diets and open heart and minds dementia care.

The service had a staff rewards scheme called 'Kindness in Care'. People, relatives, colleagues and professional visitors were asked to nominate staff who had shown passion and dedication to providing the kindest care and made a difference on peoples' lives. Nomination forms included details of how staff members had shown the kindest care. On a bi monthly basis one staff member was chosen from

nominations received and they received a reward which was displayed in the home. This awards scheme was implemented to recognise and celebrate the kindest care delivered by staff. One staff member we spoke with who had received the award told us they were proud to receive the award and recognition for their work.