Care Quality Commission

Methodist Homes

Greenways

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?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 10 and 14 May 2018 and was unannounced.

Greenways is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation, for up to 44 older people, who are living with dementia and who require support with their personal care or nursing care needs. On the day of our inspection there were 38 people living at the home. The home is purpose built. Corridors and doorways provide space for people with mobility needs who use wheelchairs, as well as other equipment, to move around the home. A passenger lift is provided so people could access the first and second floor. All bedrooms are single and have an en suite toilet. The accommodation is divided into five units over three floors; each with its own lounge and dining room with a small kitchen. There is a main lounge area and accessible gardens with tables and chairs for people to use.

At the last inspection on 3 and 7 November 2016 we found the service was in breach of three regulations. We found the service did not provide sufficient staff to meet people's needs. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection we found improvements had been to the staffing levels which had increased and were in sufficient numbers to meet people's needs. This regulation was now met.

At the last inspection of 3 and 7 November 2016 we found the provider had not ensured the home was adequately cleaned so unpleasant odours were eliminated. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection we found the home was clean and hygienic and there were no offensive odours. This regulation was now met.

At the last inspection of 3 and 7 November 2016 we found the provider did not have adequate systems to monitor and improve the quality of the services it provided. This included a previous requirement regarding the safe management of medicines not being fully implemented as well as the provider failing to send an action plan as required. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection we found improvements had been made to the quality assurance in the home. This requirement was now met.

We made a recommendation in the last report regarding the provider being able to demonstrate people had a preference regarding the gender of staff who provided personal care, and, whether they wished to have a key to their bedroom. The provider sent us an action plan of how they were to address this. At this inspection we found these preferences were asked of people and recorded in the care records.

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

2008 and associated Regulations about how the service is run.

Staff had a good awareness of their responsibilities to protect people in their care and for reporting any concerns. People said they received a good standard of care.

Risks to people were assessed and care plans devised to mitigate these.

Staff recruitment procedures ensured only staff who were suitable to work in a care setting were employed.

Medicines were safely managed.

The premises were purpose built, safe and well maintained. Equipment was available for people who were living with dementia to interact with independently, which helped improve the quality of their life. People had personalised their rooms.

There were systems to review people's care and when incidents or accidents had occurred.

People's health and social care needs were assessed. There was evidence staff were trained and had current guidance such as in palliative care, pressure area care and in promoting people's rights regarding personal and sexual relationships. Staff had access to a range of training courses including nationally recognised qualifications in care. Staff were also supported with supervision and their performance was monitored by regular appraisals.

People were provided with varied and nutritious meals. There was a choice of food at each meal and people said they liked the food.

Staff supported people to access health care services such as their GP as well as when needing more specialist assessment and treatment from a dietician or the community nursing team.

Staff supported people to make their own decisions and to have as much control about their lives as possible. Where people did not have capacity to consent to their care and treatment this was assessed. Where these people had their liberty restricted an application for a Deprivation of Liberty Safeguards (DoLS) had been made to the local authority.

People were observed to receive care from kind and caring staff. People were consulted about their care and how they liked to be supported. Staff demonstrated an understanding of the rights of people irrespective of their age or disability.

People received personalised care that was responsive to their needs. Care plans reflected people's needs and preferences. A range of activities were provided based on the needs and preferences of people.

The provider had a complaints procedure and records were made of any complaint or concern raised. These records showed complaints were looked into and a response made to the complainant.

Whilst there were no people in receipt of palliative care staff were trained in this and there were plans to extend this to more staff. Advanced care plans had been devised with people regarding how they would like to be treated at the end of their life.

The service was well led although we identified some isolated areas where action need to be taken which

were addressed during the course of the inspection. People, relatives and staff were able to contribute to decision making in the home and described the management of the service as approachable and responsive. There were a number of audits and quality assurance checks regarding the safety and quality of the services, including seeking the views of people who lived at the home.

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.

Risks to people were assessed and guidance was in place to mitigate these.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Sufficient numbers of staff were provided to meet people's needs. Checks were made that newly appointed staff were suitable to work in care.

Medicines were safely managed.

The home was found to be clean, hygienic and free from any offensive odours.

People's care was reviewed and incidents were monitored and action taken to make improvements.

Is the service effective?

Good

The service was Effective.

Staff had access to current guidance and training regarding care procedures. Staff were supported by a range of training and supervision.

People were supported to eat and there was choice of varied and nutritious meals.

Healthcare needs were monitored and people were supported to access health care services.

The service is purpose built and is suited to meeting the needs of people.

People were consulted about their care and the provider followed the guidance of the Mental Capacity Act 2005 (MCA) where people did not have capacity to consent to their care and

treatment.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind and caring. Staff promoted people's rights to choice, privacy and independence.

People were consulted and involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's views and concerns were listened to and acted on. The service had a complaints procedure and complaints were acted on and complainants responded to. We identified one complaint was not fully recorded which was rectified during the inspection.

Staff responded promptly when people used their call point to ask for assistance although we found on one occasion this was not the case.

People received personalised care which was responsive to their needs. Activities were provided and people had opportunities to make suggestions about this.

Whilst there were no people in receipt of end of life care, staff training and care records showed the service had policies for palliative care.

Is the service well-led?

Good

The service was Well Led.

There was an inclusive culture where staff, people and relatives were involved and consulted about care and how the home operated.

There was registered manager and team of senior staff to coordinate care. The home was supported and monitored by the provider's regional management team.

The safety and quality of the service was effectively checked and audited.

The provider worked well with other agencies including health and social care services.

Care Quality Commission

Greenways

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 14 May April 2018 and was unannounced. The inspection was carried out by one inspector 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 service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This 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.

During the inspection we spoke with 11 people and two visiting relatives of people who lived at the home. We spoke with five care staff, the chef, the registered manager, the provider's area support manager and the provider's regional manager.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for four people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of medicines administered to people and complaints. We looked at staff training records and staff supervision records.

Good

Is the service safe?

Our findings

At the last inspection on 3 and 7 November 2016 we found the provider was in breach of Regulation 18 as adequate numbers of staff were not deployed to meet people's needs. We made a requirement notice for this to be addressed. The provider submitted an action plan to confirm that action was being taken to improve staffing levels. At this inspection we found improvements had been made to increase staffing levels. At the previous inspection we found there were six staff on duty and two senior staff from 8am to 8pm. Staff had also commented that they felt enough staff weren't provided and we observed staff were not always present to supervise people in communal areas. At this inspection there were between seven and nine care staff on duty plus two senior staff. We observed there were enough staff to safely look after people and staff told us the staffing levels had improved and they considered there were enough staff to look after people. Staff said any vacancies or staff absences were covered by the home's own staff or agency staff. People and their relatives said they considered there were enough staff. We judged the requirement made at the last inspection regarding the numbers of staff needed to meet people's needs was now met.

At the last inspection on 3 and 7 November 2016 we found the provider was in breach of Regulation 15 as the home was not cleaned sufficiently as odours caused by urinary incontinence were noticeable in some bedrooms and communal areas. We made a requirement notice for this to be addressed. The provider submitted an action plan to confirm the action being taken to tackle malodours. At this inspection we found improvements had been made. The premises were found to be clean and there were no odours caused by urinary incontinence. People commented that the home was clean with comments such as, "This is a clean and tidy home." Hand sanitisers were available for staff and visitors to use for the prevention of infection. Staff were observed to wear protective clothing such as aprons and gloves to prevent the possible spread of infection. The service employed cleaning staff who we observed in the home. We judged this regulation was now met.

People told us they felt safe at the home. We observed staff supported people in a safe way, such as checking people were feeling well and if they needed anything. Staff were also observed to assist people safely when people needed help with their mobility or by using equipment to move from one place to another.

Staff were trained in the safeguarding of people and knew what to do if they needed to raise any concerns regarding the safety of people. Staff said people were looked after well and received a good standard of care. Training in safeguarding procedures was provided for staff and staff were aware of their responsibilities to ensure people's right to a good and safe standard of care. Staff demonstrated a commitment to the safety and welfare of people and said they would report any concerns to their liner manager. Staff knew the importance of ensuring accurate records were kept of any incident. Staff also knew they could contact the local authority safeguarding team if they needed to.

Risks to people were assessed, recorded and reviewed on a regular basis. Assessments regarding mobility and dexterity were well recorded. Risk assessments gave staff clear guidance on how to support people when they were supported to move. Where people experienced a fall or had a 'near miss' this was recorded

and the person's needs reviewed. For example, one person's care records showed a referral was made to the specialist NHS falls team and specialist equipment provided to ensure staff would be alerted if the person got up in the night. The risks of people developing a pressure sore to their skin was assessed using a recognised assessment tool. Corresponding care plans detailed the action to prevent or alleviate pressure sores were recorded and showed how often the person needed repositioning and if specialist equipment was needed such as an air mattress which was provided. Records showed the staff liaised with the community nursing team regarding pressure area care and there were records of community nurses having an input into care plans regarding pressure area care. Care plans also included details where staff might experience behaviour related to mental health needs which could be challenging and what staff should do. Staff knew people well and described techniques they used to distract and engage people at times of the day when they knew they may become agitated.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical appliances, hoists, passenger lift and risks of Legionella. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked. First floor windows had restrictors so people could not fall or jump out. Health and safety checks were carried out and recorded each month regarding the environment and any identified risks. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety and the alarms and emergency lighting were tested as required. There were contingency plans in place in the event of a fire or need to evacuate the premises. A valid was certificate of liability insurance was displayed.

We looked at the service's procedures for the handling, storage and administration of medicines. Staff completed a record of their signature on a medicines administration record (MAR) when they administered medicines to people. Stocks of medicines also indicated medicines were administered as prescribed. Medicines were securely stored and temperatures maintained of the medicines storage room and the fridge storing medicines to ensure these were stored correctly. Staff who administered medicines received training in this and also had a competency assessment to ensure they followed the correct procedures.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting.

In the 12 months preceding the inspection the provider had raised 17 alerts to the safeguarding team at the local authority for their consideration. These ranged from medicines errors to issues regarding the moving and handling of people. The provider had liaised with the safeguarding team about these and completed investigations where needed. Following these being considered appropriate action was taken where needed and changes made to ensure lessons were learned.

Good

Is the service effective?

Our findings

People told us they were satisfied with the standard of care they received from the staff. The provider updated its policies and procedures and staff training to ensure current guidance and legislation was used to support the effective care of people. Staff had access to a comprehensive programme of training courses. These courses ranged from health and safety management, information management, plus care and clinical care procedures. Current guidance on procedures such as pressure area care and prevention from a specialist national training and campaign organisation were displayed for staff to see.

People's needs were assessed before they were admitted to the service and following admission. These were comprehensive and showed physical care needs as well as mental health and recreational needs were covered. Staff knew the importance of seeing the person holistically and the need to deal with emotional and psychological needs as well as physical care needs. Staff had a good awareness of people's rights to be independent and to receive a good standard of care irrespective of their ability or age. Staff were trained in equality and diversity.

Newly appointed staff had an induction which they said involved a period of shadowing more experienced staff and enrolment on the Care Certificate. Records of staff induction were maintained and showed staff had registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff said the induction was organised well and included a period where they 'shadowed' more experienced staff before being assessed to work more independently. A competency assessment was carried out on newly appointed staff before they worked independently. These were recorded and showed newly appointed staff were observed working with people as part of the assessment.

The service employed 30 care staff. Thirteen of the care staff had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2, 3 or 4. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff said the training was of a good standard and that they were able to discuss their training needs and how these would be met. This included staff being able to suggest relevant training courses for them to attend. The provider and management team monitored staff training on a spreadsheet to ensure each staff member had received updates in those courses considered mandatory to their role. These included fire safety, health and safety, first aid, infection control, food hygiene, safeguarding, dementia, nutrition and hydration, end of life care and moving and handling. Staff also completed more specialist training in specific subjects or courses which were in more detail such as end in end of life care.

Staff said they received regular supervision and felt supported in their work, although one staff member said there was a period when these lapsed but were now provided regularly. Records showed supervision took place and involved staff and their line manager discussing their work. There was also a system for assessing staff performance on a regular basis.

Each person we spoke to said the food was good and that there was a choice of food. For example, one person said, "I like this home and the food is nice, I have put on weight. A relative commented that their relative who lived at the home was well nourished due to the good quality of the food. There was a menu plan which showed there was a choice of between two to four dishes at each meal. The chef explained how each person was asked in advance what they would like to eat which was recorded and passed to the kitchen. The menu plan showed varied and nutritious meals. We observed the lunch on both days and saw people were supported to eat and that the food looked attractive. People had access to drinks in their rooms and in communal areas.

Nutritional assessments were completed on those at risk of losing weight or dehydration. Where applicable people had a nutrition support plan with details of any dietary needs. Where relevant the input of the speech and language therapist (SALT) was included in nutrition care plans. The kitchen staff had a record of any dietary requirements such as a diabetic diet, soft or fork mashable foods or where people had a fluid thickener to help them swallow. There was no coded system to alert staff delivering these foods to people such as colour coded trays or a note; the chef said the care staff had knowledge of these people's dietary needs so would know who should have each meal. In view of the fact that agency staff were used the provider may wish to consider this. Records of people's weight was maintained as well as a record of people's food and fluid intake so staff could monitor this effectively.

People's health care needs were monitored and referrals made to medical services where needed. There was an assessment of each person's health care needs in the care records which was evaluated each month. Records also showed contact was made with people's GP when needed as well as other health care services such as physiotherapy services, the continence nurse, services for people at risk of falls, and the community nursing team.

The home is purpose built and designed for use by older people and people with mobility needs. Corridors and doors were wide so wheelchairs and other equipment which people used to mobilise could be easily manoeuvred. Floor levels were even which also helped people with mobility needs. There were communal bathrooms with bathing facilities for those with mobility needs. There was a passenger lift to all floors. Communal areas consisted of lounges and dining rooms with kitchenettes which people were observed using. There was a large lounge which people used and could accommodate a number of people for specific events. All bedrooms are single and had an ensuite toilet. People had personalised their rooms with their own belongings. Each bedroom had a display outside the door with a picture and name of the residents and other personal items to identify the room's occupant. The gardens were well maintained and included places for people to sit. People were observed to be able to move around the home safely and without restriction.

There were numerous displays and equipment to support people who were living with dementia such as notice boards with the date, time and weather. There were notice boards showing activities and the meals offered. Equipment was also available for people to use and interact with such as moveable wooden equipment on walls throughout the home as well as more personal items such as specialist baby dolls which we observed were of benefit to people living with dementia.

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.

Where people had capacity to consent to their care and treatment their care records showed they were consulted about their care and had signed a record to acknowledge they were in agreement with their care plan. Where people did not have capacity to consent to their care and treatment there was an assessment of this and the provider had applied to the local authority for a DoLS authorisation as the person's liberty was restricted for their own safety. The provider informed us that two people at the home were subject to a DoLS and further applications for a DoLS had not yet been determined by the local authority. Where people had a Power of Attorney, such as a relative, which enabled them to make decisions and to consent to care and treatment on behalf of them there were copies of these in care records. Care plans also included details of 'best interests' decisions meetings regarding any restrictive care where people were subject to a DoLS.

Staff had received training the MCA and knew the principles of the legislation and the need to obtain people's consent and when an application for a DoLS authorisation was needed. Staff were observed to ask people how they wanted to be supported and asked their agreement before helping them.

Good

Is the service caring?

Our findings

The staff and provider treated people with kindness and respect. The staff's own value base and that of the provider emphasised the rights of people to be treated with respect and to be involved in decisions about their care. There was notice called, 'Value Statement' in the entrance hall which set out the home's values of treating people with dignity and respect. We asked staff about their value base in providing care for people and staff knew the importance of treating people with dignity and respect, of valuing privacy and of promoting independence. Staff said treating people with dignity and respect was integral to their work and was reflected in the culture of the home. Staff told us they treated people the same irrespective of their disability, sex or age. Staff expressed a positive attitude and approach to looking after people who were living with dementia and gave examples of how they alleviated people's distress by involving them in recognised strategies such as diverting them to activities they enjoyed. Staff said they treated people in the way they would like to be treated themselves or how they would treat one of their relatives. The provider informed us that the values of compassion, kindness and respect were assessed at the staff recruitment stage and promoted via the induction and training. Staff had completed the provider's training entitled, 'Living the Values,' which promotes the values of respect and independent for people.

We observed staff spoke to people in a friendly and caring way. Staff interacted well with people asking them how they were, how they wanted to be helped and offered them choices. Staff intervened when people were either distressed or needed some emotional support. We observed that people and staff had a good rapport and that staff knew people well. For example, one person and a staff member joked and laughed together and knew each other well. The staff member spoke to the person with respect and was kind in the approach. This person said the staff were, "Very good." Relatives also said the staff treated people well. For example, one relative commented, "I think this home is well run and mum is happy here."

People's care plans were individualised and showed how people liked to be supported with personal care and those areas of care they could do themselves so they could maintain their independence. Details about daily lifestyle preferences were recorded and people said they were able to choose how they spent their day. Communication needs had been assessed and there was evidence to show people's rights to leading a lifestyle of their choice was promoted as well as their religious needs.

People said they were consulted about their care and that staff took notice of what they said. Care plans showed evidence of people being involved and consulted about their care and that relatives were also involved in care reviews. We observed staff knocked and waited before entering people's rooms.

The provider confirmed people were able to have a key to their bedroom door if they wished. The provider told us people were able to choose the gender of the care staff who would be providing personal care to them; a record of this preference was made on people's care records.

Requires Improvement

Is the service responsive?

Our findings

The provider audited the times staff took to respond when people asked for assistance by using the call points in their bedrooms. The call point system logged all calls and the response times of staff. These were checked on a weekly basis by the home's management and action taken if any calls were not responded to within three minutes. People told us they were generally satisfied with the time it took staff to respond but one person said this was not the case on the morning of the inspection. We looked at the call point log which showed staff had not responded until 16 minutes after one person requested help. Prior to this call being activated, staff had responded within the timescales but staff had not always recorded in the person's care log in their bedroom that they had responded nor what the issue was the person needed assistance with. We activated the call point system to test the call point response time and staff arrived after 52 seconds. The management team of the service agreed that the response times for this one person on the morning of the inspection needed to be looked into which they confirmed would take place.

Whilst the provider had looked into and responded to any complaints we found the registered manager had looked into one issue raised by one person and concluded that no further action was needed but had not recorded this is the provider's own complaints log. Notes had been kept of the registered manger's investigation and these were added to the complaints log during the inspection.

People received personalised care which was responsive to their needs. People and their relatives were satisfied with the care. For example, one "Everything that is good in this home is good and staff do a good job." A relative said, "I would be happy to recommend this home to anyone."

Care records demonstrated people's needs were assessed before they were admitted to the service. The care plans were individualised, person centred and holistic. There was a personal profile which included the person's life history, preferred routines and choices as well as religion if applicable. Details about personal care were recorded and gave staff clear guidance on what the person can do themselves and what and how staff needed to do to support the person. People's communication needs were assessed so staff knew how to support people in the way people needed and preferred. Discussions with staff and observations showed staff upheld people's rights to be treated equally.

The care plans were reviewed with people and their relatives and staff confirmed they discussed people's ongoing care needs at regular staff shift handover meetings so they were updated on any changes. Staff confirmed the care plans gave them the right information on how to support people. People's care needs were reviewed and updated on a regular basis.

There was an activity programme which was displayed for people to see which showed a variety of activities for people. People also had a copy of the activities programme. The provider informed us that these were based on consulation with people. Each person's social and recreational needs were assessed. Group and individual activities were provided which reflected person centred care. For example, we saw a record of one

person attending music therapy on a regular basis. Group activities included singing and art and crafts. People said they liked the activities. Relatives were observed visiting the home and said there were no restrictions on visiting times.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Care records included details about people's communication needs. There were examples of signage in the home to assist those people who were living with dementia.

The provider listened to and responded to any complaints. There was a complaints procedure which was supplied to each person. Relatives and people said they felt comfortable raising any concerns or complaints if they had them; they said they would speak to a member of staff or the manager. In the 12 months preceding the inspection the provider had received 16 complaints. We reviewed how the provider had dealt with these. Each complaint was recorded and along with details of how it was looked into and a response to the complainant. These included written responses and records of meetings with complainants as well as action the home was taking to rectify any shortcomings.

The provider had a Duty of Candour policy which is required by Regulation 20 of the Health and Social Care Act 2008 and outlines what providers must do when things go wrong and an apology when applicable.

At the time of the inspection there were no people in receipt of end of life care. People's care plans included details of their wishes for their future care and how they would like to be treated at the end of their life. Staff were trained in end of life care and the provider's training matrix stated 86% of staff were trained in this. A senior member of the care staff team said staff were also able to complete a nationally recognised qualification in end of life care called, The Six Steps Programme.

Good

Is the service well-led?

Our findings

People and their relatives commented on the friendliness and openness of the staff as well as the home being well run. For example, a relative commented, "I would be happy to recommend this home to anyone." People made similar positive remarks such as, "The home is very well run. I am happy here," and, "I am very happy in the home and everyone is friendly."

Staff reported improvements had been made in the management of the service after a period of change of registered managers. Staff described the new registered manager as, "doing a great job." Another staff member said of the new registered manager, "She's been brilliant. She checks with us – how we have been. She's approachable, helpful and willing to help. She has a good knowledge of care."

The service was overseen and supported by the organisation's regional management team. The home's own management team consisted of a deputy manager and a team of senior care staff who had a lead responsibility for making decisions about care within their allotted staff team.

The culture of the service promoted the involvement of people, relatives and staff. As well as feeling supported and valued, staff said they had opportunities to raise any issues either on an individual basis or at the staff meetings. Staff said they felt listened to and any issues or concerns were acted on. As well as staff meetings and staff shift handover meetings there were 11am meetings each day where staff could discuss issues and developments regarding the care of people. This enhanced communication within the staff team.

The provider took steps to include people and relatives in decision making via relatives' and residents' meetings. These were recorded and showed people and relatives were able to raise issues and the action the provider was taking about them. People's views were sought by a 6 months survey carried out by an external agency. These were summarised into different performance areas such as whether people were satisfied with the standard of care and the food. The survey document allowed the service to see a comparison with previous survey results so any trends of improvement or deterioration could be identified. For example, the survey showed 93% of people were satisfied with the overall standard of care in 2016/17 which had increased to 100% in 2017 /2018. Where issues were raised by the survey there was an action plan to address this such as 87% of people feeling staff had time to talk to them. The provider informed us that Methodist Homes Association have been shortlisted for two national awards in care and that Greenways had increased its own internal rating due to positive comments about the home.

A number of audits and checks were used to check on the safety and quality of the service. These included an analysis of accidents and incidents as well as any medicines errors. Regular checks were made regarding equipment such as hoists, slings, support plans, staff supervision and training. There was a also monthly audit schedule regarding checks on items such as any people's money held for safekeeping and the emergency procedures. An external infection control audit was carried out and the provider's regional management team also carried out regular audit checks. The system of checks and audits of quality and safety included incidents, complaints, falls, weight loss and skin integrity which were reported to the area

manager for evaluation, support and guidance.

The provider had acted in response to the last inspection report and taken action regarding any requirements or recommendations. The provider outlined in their provider information return how the service would be maintaining and improving the quality of its services.

The provider worked well with other agencies and appropriate referrals were made when issues regarding possible safeguarding concerns were raised to the local authority safeguarding team. Care records showed the staff worked well with community health services such as community nursing teams and other health care professionals regarding areas such as pressure area care and nutritional needs of people.