Grace and Compassion Benedictines

Holy Cross Care Home

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

About the service
Holy Cross Care Home is a residential care home providing personal and nursing care to 56 people at the time of the inspection. The service can support up to 60 people. The home is a spacious, purpose-built property, situated within the grounds of Holy Cross Priory. Nursing care and residential care are provided on two floors.

People's experience of using this service and what we found
People were happy with the care they received and told us they were treated with kindness. One person said about staff, "They have lovely senses of humour. They are very attentive. They are efficient and really care about you. There's a real warmth."

People told us they felt safe, were well supported and there were sufficient staff to care for them. People were supported by staff who were skilled in meeting their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported support this practice.

People received kind and compassionate care. People's independence was promoted by staff. People were treated with respect and dignity and supported to make decisions about their care.

People were supported to engage in activities that interested them. One person said, "I get informed of things going on. There's a very good notice board and staff are always quick to point out when activities are about to start."

The registered manager was well regarded and had a clear vision for the service which was understood by the staff and embedded within their practice. There were effective quality assurance systems in place that were used to drive service improvements. People, their relatives and staff were asked for their feedback about the home and meetings were held regularly.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 20 April 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Holy Cross Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two inspectors on day one. One inspector returned for day two of the inspection.

Service and service type
Holy Cross Care Home 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 service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, the new manager, two

registered nurses, three care workers, an activity coordinator and the head chef. 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 could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We contacted five professionals who regularly visit the service for their feedback the home.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at the service. One person said, "Oh yes, there's always someone on duty. I've always felt safe here. Whenever I've rung my bell someone's come. As quickly as they can."
- Staff told us they received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. Staff had a clear understanding of the different types of abuse, how to recognise these and what to do should they witness any poor practice.
- Incidents had been escalated appropriately where safeguarding concerns were highlighted. The manager had made appropriate notifications to the CQC and the local authority to report incidents of concern.

Assessing risk, safety monitoring and management

- Risks to people were identified, and comprehensive assessments were in place in areas such as falls. Some people had risks associated with their mobility and needed support to move around, and there was detailed guidance for staff in how to support people in the way they preferred.
- Risks to people's mobility was assessed. Mobility risk assessments and falls care plans were clear on people's level of mobility, what equipment they needed and how many staff were required to support them. For example, one person's fall risk assessment was linked to their osteoporosis care plan and guided staff on how to support the person safely to mitigate any pain. The person's care had been discussed in a nurse's handover where an occupational therapist referral was discussed along with what appropriate equipment should be provided.
- Risks to people's environment had been completed, including any potential risks with their own living spaces.

Staffing and recruitment

- There were enough staff to ensure people remained safe. People and their relatives told us there were enough staff to meet people's needs. One person said, "Yes there are. There's definitely always someone you can go to."
- We observed people being supported quickly when they asked for help, while call bells were responded to quickly. Call bells are electronic devices used by people in their rooms to alert staff that they require support. Staffing levels were good during the lunch time period to ensure people sat and ate at the same time.
- Staff told us there were sufficient numbers of staff for them to support people safely and spend time with people. One staff member said, "We are very well staffed." Another staff member told us, "We are very lucky. We get cover. There're never any shortfalls, extra staff is never a problem, so we have time for people. That's what I like about it."

● Recruitment checks were robust and ensured people were supported by staff who were safe to work before they started work at the service. This included obtaining suitable references and undertaking Disclosure and Barring Service (DBS) criminal record checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable individuals from working with people who use care and support services.

Using medicines safely

● People needed support with medicines. There were safe systems in place to ensure medicines were administered safely. Staff had received training in administration of medicines and had regular checks to ensure they remained competent.

● The administration and recording of medicines were safe. We observed staff giving people their medicines. Staff were patient and ensured people had taken their medicines before leaving. Staff used personal protective equipment when administering medicines.

● Medicines were stored and disposed of safely. Medication Administration Records (MAR) showed people received their medicines as prescribed and these records were completed accurately. Where people had 'as and when needed' (PRN) medicines, staff were supported by guidance on when to administer these. One person required their medicines to be administered at specific times and records showed staff were doing this.

Preventing and controlling infection

● All areas of the service were seen to be clean, tidy and smelt fresh. Records showed staff maintained a consistent and thorough cleaning schedule of all areas of the service. One person said, "Oh it's beautiful, there's none of the smells you get elsewhere. Everyone who visits remarks on this." One relative said, ""It's very clean and never unhygienic."

● Each person had an infection control risk assessment to support them when at risk from health-related infections. For example, when people have had antibiotic treatment or pressure area support.

● We observed staff using personal protective equipment (PPE) when carrying out personal care and administering medicines. Staff received training in infection control and food hygiene. Kitchen audits were completed that identified any potential risks with cross contamination of food and infection control.

Learning lessons when things go wrong

● Incidents and accidents were consistently recorded, and staff understood their responsibilities to report any concerns. The registered manager had oversight of all incidents and accidents to ensure appropriate actions were taken, including the review of risk assessments and care plans.

● The provider had reviewed the incidents of concern and when things had gone wrong and made appropriate changes to the service. For example, the registered manager had reviewed practices and made significant changes following a safeguarding enquiry about pressure area support and raising safeguarding issues. Training and supervision for registered nurses had increased while a weekly risk meeting had been introduced to which the registered manager now attends on a weekly basis.

● Wound care policies and procedures were completely revised, with additional training and competency assessments implemented for registered nurses. One wound specialist who had worked closely with the service said, "They have done really well. They have really engaged and sustained the improvements. All hats off to them. The recruitment of the clinical lead has really enhanced performance. They have dramatically improved." The registered manager said, "We all have heightened awareness of it now. It's included in all our supervisions. I did supervisions with all RGNs that targeted safeguarding. I've improved my response time and completing them much more."

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into the service. The provider had ensured that protected characteristics, such as people's religion, race, disability and sexual orientation were explored and recorded appropriately. This information was reflected and recorded in their care plans before care was provided.
- People's needs were assessed using evidence-based guidance to achieve good outcomes. For example, people who were at risk of malnutrition had risk assessments in place. The provider had consulted national guidance and implemented the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. The MUST tool enables provides to monitor people's risk of malnutrition. For one person, records showed that staff's use of the MUST tool had prompted staff to work closely with colleagues in the mental health team to ensure they were appropriately supported.

Staff support: induction, training, skills and experience

- People told us staff were well trained to support their needs. When asked if staff had the skills to support them, one person said, "Yes they do. I don't see how you can do better. They are very attentive. They are efficient and really care about you."
- When new staff commenced employment, they underwent an induction and shadowed more experienced staff until they felt confident to carry out tasks unsupervised. New staff were supported by a registered nurse for 12 weeks during their induction period. One staff member said, "Yes we had an initial orientation such as where everything is and fire safety plus an induction which was really thorough."
- Training had been identified according to the needs of the people living at the service. These included safeguarding, mental capacity act, medication, dementia, managing falls and prevention, person centred care and positive behaviour support. One staff member said, "The training is fantastic."
- Staff told us they felt well supported in their roles and were provided with regular supervision sessions. One staff member said, "Yes, every three months and I have an appraisal. I can discuss my training needs. I'm asked if I am happy and of anything needs changing and can agree changes with my supervisor."

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to have enough to eat and told us they liked the food they received. People were given choices of what they wished to eat and were provided alternatives if they requested this. One person said, "The food is very good. It's quite a good range of choices."
- We observed the lunchtime meal in the dining room. Tables were attractively laid with tablecloths, napkins, cutlery and condiments and special cutlery for people it. Staff reminded people what dishes they

had ordered the previous day, as it was presented to them. The food looked hot and nutritious.
● When some people had difficulty eating independently, staff assisted them patiently. Adapted cutlery and plate supports were provided to assist those people who struggled with fine motor skills and hand-to-mouth feeding.
● People's specific dietary needs were known and met effectively by staff. For example, some people had their food mashed or pureed to allow them to swallow it safely. The chef said, "For example, I sieve one person's food a number of times to ensure it was sufficiently pureed." Kitchen staff followed guidance provided by speech and language therapists (SALT) to ensure people ate safely.
● Other dietary needs were well managed by staff. For example, people living with diabetes were provided sugar free alternatives, while one person with coeliac disease was provided with a gluten free diet. Staff had measures in place to prevent cross-contamination of their food with other ingredients.

Adapting service, design, decoration to meet people's needs
● People's needs were met by the design and decoration of the home. The environment was conducive to people's needs, especially those living with dementia. Large print signs assisted people in finding their way around the home. People's rooms had memory boxes outside with photos of loved ones and personal pictures to safely orientate them to their own space.
● The home was accessible for people and had a number of communal areas for people to socialise and have private time with relatives and friends. Corridors were wide for people to move safely, while people had access to equipment that supported them to mobilise. Toilets had automatic motion detector lights so that people did not have to locate switches or pull cords when accessing them.
● People's rooms were comfortable and personalised. Each room had an en-suite bathroom to ensure and promote their privacy. Records showed the management team met frequently with maintenance staff to discuss ways to improve and maintain safety with the environment of the home.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People and their relatives told us staff provided them with effective support with their healthcare needs. One relative said, "The other night they called a night doctor. The night nurse was jolly good."
● People had access to health and social care professionals. Records confirmed people had access to a GP, opticians, and dentists and could attend appointments when required. Referrals were made to specialist services such as falls and speech and language therapists, as needed. One health professional said, "I have found the staff are open to advice and support when meeting their resident's physical, spiritual and personal care and nursing needs. I am always asked to document my visit outcomes and commend the staff on their vigilance in that respect."
● People's oral health care was assessed, and they could see a dentist, if this was needed. Oral health care plans captured the level of assistance the person required and the results of any recent dentist appointments. Records showed these care plans were reviewed monthly.
● When people's health deteriorated, observations such as people's pulse rate and blood pressure were taken by nurses to monitor their health. These observations would inform nurses of what actions should be taken. For example, one person living with dementia and anxiety showed signs of deterioration and hallucination. Regular observations were undertaken by nurses over a period of time to monitor their recovery.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People said they were consulted about their care and records showed people had agreed to their care and support. People's capacity to consent to their care and treatment had been considered and was documented appropriately.
- Where people lacked capacity to make specific decisions, appropriate assessments had been made. Decisions made in people's best interests were recorded to show how the decision had been made in accordance with the legislation. The manager had made appropriate applications for people where DoLS could apply.
- Staff understood their responsibilities regarding the MCA and demonstrated a good knowledge on seeking consent and people's capacity to make decisions.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were consistently positive about the caring attitude of staff. They told us staff were kind, approachable and welcoming. One person said, "They are always cheerful, and I've never heard anyone be rude. I love them all and I mean that. They'll always be very kind to me." One family member said, "He has a lot of fun with the carers and nuns. They are so caring. The nuns are very warm."
- People told us staff provided them with emotional support when they needed. One person said, "Yes, they are caring. They are good at calming us if we are worried."
- We observed a number of caring interactions. One carer was addressing a person and used a rhyme with their name. The person laughed at this and joined in with the carer.
- People's diverse needs were captured when they moved to the service and staff supported them to meet these needs. For example, spiritual care plans recorded people's chosen faiths and how they practised them. They recorded their spiritual history and what denomination they followed. People of all Christian faiths were supported, and services were arranged at the service for people to practice their faith. One staff member said, "Everyone had different values and beliefs. I treat people as I would like to be treated and look at the whole person."
- People told us staff treated them with the utmost respect. One person said, "Yes we are in a convent so one of the first things they are taught is to be respectful." Another person said, "The carers have such a nice attitude. They always have time to do what you want. It's more hands on here, I admire that." We observed a handover meeting where staff respectfully referred to people by their titles.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect, and their privacy was protected. People told us staff ensured their dignity was maintained when providing care.
- People's independence was encouraged and supported by staff. People and their relatives told us staff consistently encouraged them to maintain their mobility and promote their independence. One person said, "They always encourage me. They know what I can do and can't do." One relative said, "He's in a bigger room and happy. He's become much more independent. The nurses put my mind at rest. They encourage him to mobilise." Another relative said, "When he came here he couldn't sit or stand. They've made him mobile."

Supporting people to express their views and be involved in making decisions about their care

- People and their family members told us they could express their views and be involved in their care.
- People were involved in reviews of their own care every six weeks. Residents were formally invited to be

involved in a two-day review of their care with the clinical lead. People knew their lead staff member well and felt comfortable telling the about changes they wanted. Care plans were updated, and this information was handed out to staff at handovers.

● People and their relatives told us their opinions were sought, and ideas and suggestions acted upon. For example, people were actively involved in the recruitment of new staff. Participation was open to everyone at the service and people could ask interviewees their own questions and provide feedback on their suitability. During the inspection we observed three people preparing to attend an interview to fill a clinical position.

● Where people were unable to advocate for themselves or had no representative that could do this on their behalf, staff supported people to access an advocate or advocacy service.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People and their relatives told us staff provide personalised care and were responsive to their needs. One person said, "I have Parkinson's and sometimes it's very difficult to move around. They ask me what my needs are. If I need to have assistance washing and dressing, they'll help me. I like to be independent." One staff member said. "Our ethos is to work in a person-centred way. To look after people as they want. It's their home."
- Care plans reflected changes to people's circumstances, how these affected the person and what staff could do to support them. For example, care plans guided people on how to support people living with dementia who may display some behaviours that challenge. One professional said, "I have worked with the staff to help them learn ways to meet the care needs of individuals with challenging behaviours."
- Care plan reviews were used effectively to ensure staff provided responsive care. For example, one person's review identified they were worried about their weight. Reviews of their supported identified an increase in their anxieties and behaviours which prompted referrals to specialist mental health support. A multi-disciplinary meeting was undertaken, and actions put in place. By the next review, it was noted the person's emotional wellbeing had improved.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were being met. The provider had considered and implemented the guidance within the Accessible Information Standards (AIS). The provider had identified people's different communication needs, in line with these standards, and had assessed how information should be recorded or shared with the person in an accessible way that met their communication needs.
- People were given information about their care, and about their home, in ways they understood. For example, activities sheets, care plan reviews, service user guide and resident meeting minutes were provided in large print for those with visual difficulties.
- People had communication care plans in place to support staff to understand their wishes and engage with them more responsively. Information about people's anxieties were reflected in these plans to ensure staff could communicate effectively.
- Staff supported people with other communication needs. Pain boards and picture cards were used to support people communicate their wishes. Hearing loops were available for people when they undertook activities.

● Staff supported people with technology to meet their religious needs. For example, staff uploaded prayers onto their electronic tablets while another person was supported to increase the text size on their device due to their visual impairment.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to follow interests and participate in a range of activities that were relevant to them. For example, one person who was a former physical education teacher loved taking part in the music for movement events. They said, "The two ladies who organise them are very enthusiastic. I like the activities where you do some physical exercise like arm chair yoga." One relative said, "The activities are very good. There's lots too choose from. The activity coordinators are much involved in activities, they really do make it interesting." Another person said, "There are a lot of activities. They are very well chosen, there are singers, pianists there's something for everyone."

● People and their family members told us staff were proactive in ensuring people avoided social isolation, especially those living with dementia, and were encouraged to remain active and engaged. Staff ensured one person at risk of social isolation received a weekly activity timetable and was reminded of events that interested them such as weekly religious services and quiz evenings.

● Some people had a picture frame at the entrance to their rooms with photos or pictures they felt represented them. This served as both an orientation for people as well as a prompt for staff to start conversations with people when visiting their rooms. One person said, "It's like a village. There's a lot of comings and goings. People are always walking by and talk to you."

● People were supported to participate in activities outside of the home. People had access to a bowling green outside of the home, while people were supported to attend events that were relevant to them. For example, three people who loved horse racing were supported to attend local race meetings. Trips had been arranged to attend the county air show and seaside towns while people had been invited by the local girl's school to watch their nativity.

Improving care quality in response to complaints or concerns

● People knew how to make a complaint and told us they would be comfortable to do so if necessary. They were also confident any issues raised would be addressed. One person said about raising a complaint, "Yes, I would. I haven't had to yet though. I have the odd grumble, but they respond quickly."

● The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required. The registered manager told us they had not received any formal complaints and looked to address any issues as they arose.

End of life care and support

● People had care plans in place, where applicable, to record future planning and advanced wishes for their end of life support. These captured any spiritual guidance they wished for, preferences for pain relief, details on funeral arrangements and family members and professionals who were involved in decisions about their care.

● The registered manager had ensured staff were appropriately skilled and prepared to provide end of life support. End of life training had been provided and group visits had been arranged to local funeral services and crematorium. The local hospice had provided training and guidance for staff to support one person with motor neurone disease to support them with up-to-date training on the use of breathing equipment to support them at the end of their lives.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was a registered manager in place. However, prior to the inspection, the registered manager had been appointed as the new director of care by the provider but had not fully taken up the role. A new manager had been recruited and we were told that they would by seeking to register with the CQC. We observed a residents meeting where the new manager spoke about their role and answered questions from people and their relatives about themselves and how they would support them in the future. One person said, "Oh yes, we have just changed managers. They look after us."

● The registered manager had frequent meetings with each area of the service such as maintenance, kitchen staff, heads of department, housekeeping and activities coordinators. Records showed staff's roles and identified area of responsibilities were discussed.

●The provider undertook a range of quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included medicines, health and safety, infection control, care plans and falls. The results of which were analysed to determine trends and introduce preventative measures. For example, an infection control audit had highlighted the risk of staff with nail care and wearing jewellery when providing clinical care.

● The provider had informed the CQC of significant events in a timely way, such as when people had passed away, where there had been suspected abuse and any significant injury. This meant we could check appropriate action had been taken.

●The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received positive feedback in relation to how the service was run, and our own observations supported this. One relative said, "Oh yes, it is well run. (The registered manager) is a real stickler to having things done correctly. Everything is very organised. Everything is immaculate." One person said, "I think she is very efficient and runs a tight ship. I'm grateful to her."

● Staff told us how the registered manager was open and inclusive. One staff member said, "There are always opportunities to do this (raise concerns). The registered manager has an open-door policy. She

listens to us and takes things up." Another staff member said, "We are very much encouraged to raise concerns on an individual staff level like personal issues and client care. the management are incredibly supportive."

● The culture of the home was positive and enabled people to live how they wanted to. There was a relaxed and friendly atmosphere within the home.

● Staff worked in a person-centred way to support people to achieve good outcomes. For example, the registered manager and owner hosted annual events for people, their friends and families to attend to building a sense of community and maintain relationships for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were actively involved in developing the service. For example, people had suggested a pub in the home and this was created by the provider. People had also chosen the name of this new area of the home. People could attend staff meetings and bring points of discussion.

● There were systems and processes followed to consult with people, relatives and staff. For example, people had raised an issue with the effectiveness of the air conditioning. Records showed this was addressed by the registered manager and maintenance staff.

● Regular residents' meetings and quality surveys ensured peoples voices were heard and listened to. One person told us, "Yes we have meetings every month. They act on any suggestions." Another person said, "We've had several surveys throughout the year. If anything is mooted, we are asked what we think." Another person said, "We have a care plan meeting with the top nurse and we raise any concerns. They are very good at responding."

● Professionals told us the managers and staff were welcoming and worked in partnership with them. One professional said, "I have always had a good professional working relationship with the care home manager and the staff at the care home. I am made to feel welcome regardless if I have made an appointment or not."

Continuous learning and improving care

● The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift.

● The registered manager demonstrated a willingness to learn from mistakes and improve existing practices. For example, risk assessments had been comprehensively updated following an NHS alert on the increase of COSHH incidents nationwide. There was a clear identification of existing control measures in place and any actions required to improve safe practices.

● Professionals told us the registered manager and staff worked in partnership to learn and improve care. One professional said, "(The registered manager) had been very proactive during the enquiry, we could see great improvements with the training for staff, this included additional training for staff members such as registered nurses and admin staff. Holy Cross are now working more closely with other professionals such as the tissue viability team who are supporting them with training."

Working in partnership with others

●The service liaised with organisations within the local community. For example, the local authority to share information and learning around local issues and best practice in
care delivery.

● The registered manager had established good partnership working with healthcare professionals such as GP's, Speech and Language Therapists and tissue viability nurses to meet people's needs.

● The service worked closely with local churches and schools while charitable organisations visited the service.