Jasmine Care Holdings Limited

Manor Place Nursing Home

Inspection report

116 Church Lane East
Aldershot
Hampshire
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Tel: 01252319738

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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 10 and 11 April 2018 and was unannounced. Manor Place Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 60 people in a three storey building, providing care on four designated units for people who require nursing and/ or dementia care. Communal areas were located on the ground floor, and the service was situated around an enclosed courtyard area and secure garden. At the time of the inspection there were 52 people living there.

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

People had been safeguarded from the risk of abuse; staff understood both their role and duty to protect people and had access to relevant guidance. A range of risks to people had been assessed and care plans were in place to manage them. The required utility and equipment safety checks had been completed to ensure their safe use. People were safe as they were cared for by sufficient numbers of staff whose suitability for their role had been assessed. Processes were in place to ensure people received only the medicines they required, from trained staff. The service was clean and staff had undergone relevant training to enable them to understand how to protect people from the risk of infection. Processes were in place to ensure learning took place following incidents and improvements had been made to people's care to reduce the risk of repetition.

People's needs had been assessed prior to them being offered a service. The provision of people's care reflected good practice guidance. Staff had received a suitable induction to their role, on-going training and supervision.

People's nutritional and fluid intake needs had been identified and met. Processes were in place to ensure staff worked both across the organisation and with external professionals to ensure people's health and social care needs were met. People were supported to access a range of healthcare professionals.

The service was in the process of being refurnished to ensure it met people's needs. The garden was attractive, secure and accessible for people.

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

People told us they liked the staff, whom they felt had promoted both their independence and their privacy and dignity, visitors were welcomed. Staff treated people kindly and ensured they were comfortable. Overall people were asked for their views about their care and offered choices about their care. The registered manager had taken action to ensure all staff consistently promoted the choices available to people at lunch.

Staff understood people's needs and work was underway to ensure written care plans were fully centred on the individual. Staff had undertaken training in meeting the needs of those living with dementia, although some staff were more confident than others in their interactions with people. People's needs for social and spiritual stimulation had been met. People's complaints had been listened to, responded to and used to improve the service. People had been well supported at the end of their lives.

People were cared for within a positive culture where staff felt valued. Staff felt improvements had taken place to the quality of people's care under the leadership of the registered manager. There was a clear management structure and oversight and support provided both from the provider and regional manager. The registered manager was visible and accessible to people within the service. Processes were in place such as audits, trackers, surveys and meetings to monitor the quality of the service and to drive improvements for people. Staff worked in partnership with other agencies.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from the risk of abuse through the processes and staff training, which were in place to protect them.

Risks to people had been assessed, their safety monitored and risks managed for them.

There were sufficient, suitable staff to keep people safe.

Processes were in place to ensure people received their medicines safely.

Processes were in place to ensure the service was clean and that people were protected from the risk of acquiring an infection.

Learning had taken place and improvements were made following incidents.

Is the service effective?

Good

The service was effective.

People's needs had been assessed and their care was delivered in accordance with best practice guidance.

Staff had undertaken relevant training and supervision to ensure they were suitably skilled to support people.

People had received sufficient amounts of food and drink to meet their needs.

Staff worked together within the service and with external organisations to ensure people received effective care and treatment.

People were supported by staff to access healthcare services.

The service was in the process of being re-furbished for people and their needs had been taken into account during this process.

Legal requirements had been met when people lacked the capacity to consent to their care.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and ensured they were comfortable.

People were asked for their views about their care and overall they had been offered choices. The registered manager was taking action to ensure staff consistently offered people the choice of lunch options provided.

People's privacy, dignity and independence had been respected.

Is the service responsive?

Good

The service was responsive.

People received their care from staff that understood them as individuals. Work was underway to ensure this knowledge was fully reflected in people's care plans.

People's needs for social and spiritual stimulation had been met.

People's complaints had been listened to, responded to and used to improve the service.

People had been well supported at the end of their lives.

Is the service well-led?

Good

The service was well-led.

People were cared for within a positive culture.

There was a clear and well-established management structure and responsibilities and legal requirements were understood.

People who used the service were engaged and involved, through meetings and quality assurance surveys.

Processes were in place to monitor the quality of the service provided and to drive improvements for people.

Staff worked in partnership with other agencies.

Manor Place Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 April 2018 and was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection, we requested and received written feedback on the service from a specialist nurse, a social worker, a social services team manager and the fire brigade. During the inspection, we spoke with 17 people and two relatives. We spoke with night and day staff, including three nurses, the clinical lead, seven care staff, two kitchen staff, one laundry assistant, the deputy manager, the regional manager and the registered manager.

We reviewed records which included four people's care plans, four staff recruitment and supervision files and records relating to the management of the service.

The service was last inspected in March 2017 when it was rated as requires improvement overall.

Good

Is the service safe?

Our findings

People told us the service was safe. Their feedback included, "I get my medicines." "I feel safe. The staff look after me." "The building is secure. The fire alarm goes off once a week when they are testing it." "I have a hoist. I've got confidence in them" and "I have my own slings – we all do because it's not hygienic to use each other's." A relative told us, "There are enough staff day and night."

Staff told us they had undertaken safeguarding training, which records confirmed and relevant policies were available. Staff were able to demonstrate their knowledge and responsibility to protect people. They told us that if a bruise or mark was observed on a person's skin then a body map was completed to ensure there was a record of the injury. We saw examples of completed body maps in people's care plans and that relevant actions had been taken where required to safeguard people.

The registered manager had attended relevant safeguarding training for managers and understood their role. Records demonstrated that when safeguarding incidents had occurred, the registered manager had reported them, co-operated fully and ensured any learning points were identified, shared with staff and applied to minimise the risk of re-occurrence for people.

Staff spoken with were able to tell us about the individual risks to people and how these had been managed for the person's safety. A range of risks to people had been assessed and care plans put in place to manage them, these included for example: risks to personal safety, mobility, falls, skin breakdown, personal care, nutrition, choking, medicines and wounds. Where people required assistance when they moved for example, it had been documented how many staff were required to support them and any equipment they needed. We observed staff used safe moving and handling techniques with people. Staff maintained 'falls registers' for people to enable them to identify any trends and to demonstrate the actions taken to protect people. Risks to people from skin breakdown had been assessed and relevant actions taken to maintain their skin integrity, such as seeking medical advice, applying moisturising creams, ensuring people had pressure relieving equipment and regularly re-positioning those people at risk who could not do this for themselves.

Where people were cared for in their beds, staff ensured that they had their call bells within reach. As not everyone understood the purpose of the call bell, records demonstrated that staff had made regular checks upon those in their bedrooms, to check upon their welfare and comfort.

Staff had ensured that the required safety checks had been completed in relation to fire, electrical, gas, water and equipment safety for people. The fire service confirmed to us that there were no issues with fire safety.

Staff assessed the individual needs of people and this information informed the dependency scale, which was used to ensure there were sufficient staff, to meet people's needs. There were normally 11 care staff on duty in the morning until 14:00 when this reduced to nine. There were also three nurses on the day shift, in addition to the clinical lead, who also worked with people when needed. At night, there were two nurses or a

nurse and a senior care staff member if the provider had been unable to deploy a second nurse, and five care staff. The service did not use agency staff but had their own bank staff available whom they called upon to cover sickness and annual leave. Nurses told us they had been asked to cover a lot of additional shifts lately, however, a new nurse had been recruited for the nights to increase nursing capacity for people and ease pressure on the nurses.

Staff told us and records confirmed they had undergone recruitment checks as part of their recruitment and these were documented. These included a full employment history, record of interview, the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had checked that nurses were registered with their professional body and had no restrictions upon their practice. People were cared for by staff whose suitability for their role had been assessed for their safety.

Nurses told us they had undertaken medicines training and had their competence to administer people's medicines assessed, which records confirmed. Relevant polices and processes were in place to ensure the safe ordering and management of medicines. People who took 'PRN' medicines (which are those taken 'as prescribed') had protocols in place to ensure their safe use. Staff maintained a record of any 'homely remedies' people were given for minor ailments. Secure processes were in place to monitor, record and store 'controlled medicines' which require additional levels of security. People's fluid thickeners were safely stored in accordance with national guidance to ensure people were not at risk of choking on them accidentally.

The registered manager told us people's medicines had been reviewed by the community pharmacist to ensure they were only prescribed medicines they actually required and were not over medicated. A tracker was also maintained of those people prescribed anti-psychotic medicines which can be used to control people's behaviours; this ensured they were only used when required and not excessively.

The service was visibly clean, household staff were observed cleaning the building across the course of the inspection. The service and equipment had been cleaned in accordance with the provider's cleaning schedules. People were observed to have their own personal slings, which a person confirmed, in accordance with national guidance to minimise the risk of them acquiring an infection and these were regularly laundered. Staff were observed to transfer people's soiled laundry in red bags as per national guidance and the laundry staff explained that this was then washed separately, this minimised the risk of cross-contamination. There were plentiful supplies of personal protective equipment, which staff wore when they provided people's care. Staff had undertaken infection control training, to ensure they understood their responsibilities.

Visitors were provided with hand gel at the entrance of the service and dispensers were located around the service to enable people, staff and visitors to clean their hands. The bathrooms were well stocked with supplies of soap and handtowels to ensure people could wash their hands. Guidance on the importance of hand washing was displayed and staff's hand hygiene had been audited. Staff had supplies of wet wipes for people to wipe their hands prior to lunch. Processes were in place to encourage good hand hygiene, to prevent the risk of infection.

Records showed that where people had experienced an untoward incident, such as a fall for example, an incident form had been completed and reviewed in order to identify if any further measures were required to protect the person from the risk of repetition. People's relatives had been informed of incidents and staff

had been updated about changes to people's care. We heard staff being given feedback on meetings that had taken place to ensure they were aware of relevant information. A staff member confirmed, "At the meetings we talk about what we need to care for people if there are problems with the caring we look at better ways together to care for people in the future." Processes were in place to ensure learning took place and improvements were made to people's care if something went wrong.

Good

Is the service effective?

Our findings

People told us the service was effective. Their comments included, "The staff work well together. "They have a dentist come in. They take me to the optician." "I had my feet done today by the chiropodist" and "They tell me to drink that and that. I like the food."

People's needs were assessed prior to them being offered a service and staff were then briefed, so they could care for people and meet their needs effectively Where people lived with health conditions, they had a specific care plan, which identified their care needs and required actions to effectively manage their condition. The community matron informed us, "Their pressure sore management is vastly improved, matches the complex patients they tend to have - they keep me in the picture all the time." Lead nurses had been appointed for infection control, diabetes, pressure injury and palliative care to promote good practice.

Staff kept themselves up to date through attending in-house and external training, and updates from agencies such as the Care Quality Commission (CQC) and the National Institute for Clinical Excellence (NICE) and from learning shared at the provider's registered manager's meetings. Staff could access training and receive updates from the provider's membership of a local trade association.

Staff told us they had completed an induction to their role, which records confirmed, and shadowed more experienced staff before being rostered to care for people. Staff also said they had been required to undertake the Care Certificate if they were new to care; this is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised.

Staff told us and records confirmed that they completed a range of training; they told us management checked what they had learnt after training, which records confirmed. Staff also attended mini training workshops over coffee breaks to refresh their knowledge. One told us, "I can always ask my colleagues and the nurses if I do not understand, they never mind you asking, and I feel comfortable doing that." Staff felt well supported within their role.

Staff and management had been supported to undertake professional qualifications in social care. Nurses said they had been supported with their professional re-validation process to ensure they maintained their registration and were fit to practice for people, which records confirmed.

Staff told us they felt supported and received both one to one and group supervisions, which records confirmed. This enabled staff to discuss any concerns they had, their personal development and the training that they had completed. Supervision was a two way process and staff could record their comments on the supervision form. Staff also received an annual appraisal, to review their progress and look at what training would be beneficial to further their development.

People had nutrition care plans, which identified their dietary needs such as whether the person required a soft or pureed diet. If people required a pureed meal then each element had been pureed separately to ensure it looked appetising. People had been regularly weighed and those at risk of malnutrition identified,

the GP informed and any relevant action taken such as referring the person to the speech and language therapist or dietician for guidance. Kitchen staff showed us records of who required their meals fortified with extra calories to increase their weight. People were also offered 'shots of cream' to increase their calorie intake, where required, a relative confirmed their loved one's diet had been fortified to increase their weight. Staff told us the kitchen was open 24 hours a day so that if a person wanted a drink or snack outside mealtimes or at night, this could be provided.

People's food and fluid intake had been monitored where people required this to ensure they received sufficient for their needs. We saw that staff offered people drinks across the course of the inspection and ensured these were placed within reach. There were sufficient staff to provide support to those who required assistance with eating or drinking.

The staff shift handover was attended by nursing and care staff in addition to management. This provided staff with the opportunity to discuss how best to support people. We heard staff discuss how they were going to support a person with their behaviours which challenged staff whilst they made a referral for input from the local mental health team. There was evidence staff worked with a variety of external organisations to ensure people's needs were met. Staff worked with the community matron and diabetes specialist nurse to ensure people received effective care.

The service had a GP who visited weekly, they could also be called between clinics should people need to be seen earlier. Anyone who came to the service who had lived locally had been encouraged and enabled to stay with their own GP in the area. In addition, a chiropodist visited the service regularly to provide peoples' foot care where required. Home visits were arranged with both the optician and dentist, which a person confirmed. Peoples' records demonstrate they had seen a range of health and social care professionals dependent on their personal needs.

A programme of decoration and refurbishment was underway. Communal areas had been re-decorated to make the service lighter and brighter and lighting levels in some areas were being increased to ensure they met people's needs. Furniture such as dining chairs had been replaced. We noted hand rails had been painted in a contrasting colour to the walls to make them more visible to people when they orientated themselves. Flooring had also been replaced, to ensure it was safe and suitable for people. Signage was in place to enable people to orientate themselves. The garden was attractive, secure and accessible for people. Records demonstrated people had been consulted about their wishes for the spring planting of the garden, which looked attractive.

We observed that whilst the dining areas for Victoria and Churchill wings were not as popular as on Nightingale wing, people were observed to utilise them. Two people in the Victoria dining room told us they regularly ate there. There were sufficient rooms to enable people to eat in a dining room if they wished, but a number of people on Victoria and Churchill wings either ate in their bedrooms or had their lunch on side tables next to their seat.

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.

Staff told us they had undertaken training in MCA and DoLS, which records confirmed. Staff understood the application of the MCA in relation to their role and there was a list for staff of people subject to DoLS, to ensure they were aware. Where an application had been made under the DoLS, this had been underpinned by a MCA assessment of the person's capacity to consent to the care they required, to demonstrate why the application was required. The provider maintained a log of those people who had a Lasting Power of Attorney (LPOA) in place and whether this was for health and welfare or finances or both. This ensured they knew who had appointed a representative to act upon their behalf. Legal requirements had been met when people lacked the capacity to consent to their care.

Good

Is the service caring?

Our findings

People told us they liked the staff. They felt staff promoted their independence, that their privacy and dignity was upheld and visitors were welcomed. Their comments included, "They do look after me. I feel they are my granddaughters. They are all good and kind. They don't talk down to me." "I'm very, very happy. I don't think I can be happier. The girls are so kind and gentle and caring and so are the men. They're very patient and sweet natured. I'm so grateful for being treated like a human being. It's mainly the attitude and the ethic of 'we will try to make them as happy as we can'." "The staff are good with me." "I spend my time how I want." "I take my own nightdress off. I do it myself. I can say what I do and don't want to do." "They (the staff) ask me my opinion on things and I would say." "I don't have anybody coming in the door without knocking not like the other place I lived in." A relative told us "I turned up at 9.45 one night – no-one bats an eyelid about when I come, and I'm always made to feel welcome."

Staff showed that they were focused upon peoples' welfare. We observed staff ensured that people were comfortable and warm. Staff were heard to orientate people and told them that it was lunchtime. Staff told people what was on their plate. Some staff were observed to use touch where appropriate and to enjoy a giggle with people. People enjoyed their interactions with staff.

The registered manager told us they monitored if staff were caring to people during their daily walkabout and conversations with people. They also sought feedback through surveys. The last survey showed that out of those who responded, nine people rated the quality of care as very good, seven as good and one as fair. Processes were in place to monitor how caring staff were.

People's care plans provided staff with guidance about how to communicate with people in a manner they could understand and which took into account their needs related to their age or disability. Care plans stated if people needed regular reminders, if they needed the information provided in short, simple sentences or if staff needed to speak more slowly to the person to enable them to understand the information.

The staff we spoke with had a good understanding of what was important to people and were knowledgeable about their preferences, hobbies and interests. There were two 'residents of the day' when people's care plans were reviewed and staff were asked to comment about each of these people at the staff shift handover and say what they knew about them. Staff demonstrated they knew these people's likes and dislikes, their medical history and the support and care with which they needed to be provided. This sharing of information helped reinforce staff's knowledge about each person and to see them as individuals.

Staff told us they offered people choices about their care, such as what to wear, one staff member commented, "I would offer the person choices and I would make sure that they did not feel rushed." A person confirmed, "They give me time to do things myself." Staff told us people could get up and have breakfast when they wished. We observed some people chose to get up whilst others remained in bed. Overall, we saw people were offered choices about their care by staff, for example, we heard staff consult people about decisions and ask them if they would like a drink or the window open. The registered manager

told us people or their relatives were involved in their pre-admission assessment and care planning to seek their views and involve them in planning how they wanted their care provided.

People told us they had been able to decorate their bedrooms as they wished. We saw that some people had brought personal possessions to display, such as picture and ornaments. People had made choices about their personal space.

However, we noted not all staff consistently offered people a choice of the two hot meals available at lunchtime. Not all staff showed or told all people who might not have been aware that there was a choice and assumed people would have the steak and kidney pie. Although no one objected to the meal provided, the second option was available on the hot trolley ready for people. We spoke to the registered manager who told us the chef who was absent during the inspection normally prompted staff to offer both choices and that staff were nervous due to the inspection. They advised us they would address this issue with staff and review how they can demonstrate that people have all been offered a choice of the two lunches provided.

We also noted that although people had been provided with a copy of the menu in their bedroom, there was no visual information displayed in the dining rooms to aid people in making their choice, especially for those who might struggle to understand the options available. We spoke to the regional manager who advised that during the recent redecoration the picture menu boards had been removed and not yet re-hung. They took prompt action to arrange for these to be replaced for people.

Staff underwent equality and diversity training and covered privacy and dignity during their completion of the Care Certificate. The Care Certificate is a set of standards that social care staff work towards in their daily working life. It is the minimum standard that should be covered as part of induction training of new staff. Staff told us how they promoted people's privacy and dignity whilst providing their care. One told us, "I protect someone's dignity by the way I approach them. I would knock on the door and speak to them and ask if they wish me to assist them with for example personal care. I would make sure that the door was closed before I started that the person was happy that the curtains were closed if appropriate and I would try to make the person feel comfortable." A relative confirmed to us, "They do respect their dignity here. They always knock on his bedroom door when they come in." We witnessed staff knock on people's bedroom doors before they entered.

Staff understood the importance of promoting people's independence, one staff member commented, "Independence is encouraged, we encourage residents to walk and explain why it is good to them; if they find walking difficult we support them and we give them time, we never rushed [them]. It is important people continue to do what they can themselves." We observed that overall staff did promote people's independence, for example, by encouraging them to walk where they were able.

People and their relatives both told us that visitors were welcome to visit as they wished. A person confirmed, "Visitors can come and go." People also told us they went out with their families as they wished.

Good

Is the service responsive?

Our findings

People told us they had care plans; they had things to do and knew how to raise any issues which they felt would be listened to. People's comments included, "There is enough to do." "I can go straight to anyone if I was unhappy about something." "If I needed to complain I wouldn't have any qualms as [registered manager] is very open to it." "Staff always try to find answers for you."

There was a comprehensive handover sheet which provided staff with relevant information about people. Staff spoken with demonstrated a good knowledge of the people they cared for and people confirmed they felt staff had a good knowledge of them.

Not all written care plans consistently contained sufficient information about the person and their background to make them fully 'person centred.' This is where the care plan is designed around the person as an individual rather than their needs and conditions. People's daily notes did not always give a full picture of the person's day or mood. We spoke to the regional manager, who was already aware of this issue. They had arranged two face-to-face person centred care planning training sessions for staff to enable them to write more personalised care plans. They were also looking into replacing the paper-based care planning system and had obtained quotes for a computer-based system to aid staff, many of whom did not speak English as their first language, with fuller recording. Staff had a good knowledge of peoples' needs and action had been taken to ensure care plans were more person centred for people.

Staff had undertaken training in both dementia and challenging behaviour to enable them to understand the needs of those living with dementia. Staff documented peoples' behaviours when they challenged them and sought relevant assistance from external professionals. At the shift handover, staff discussed any information that they needed to be aware of relevant to people's behaviours, to ensure they received the care they required. Overall, staff interacted well with people living with dementia. We observed staff gently supported a person when their behaviours presented a potential risk to ensure their safety. Staff worked together to support another person who was refusing to eat, trying a different member of staff as an approach to engage the person. Some staff we observed, however, were slightly more reserved or not as confident tending to focus on the task in hand rather than the quality of their interactions with the person. We fed back our observations to the registered manager, for them to consider whether any further training was required for these staff, to increase their confidence.

The two activities co-ordinators produced a monthly activities schedule for people. Activities took place daily, including weekends. These included reminiscence, exercises, visits from the hairdresser, painting, one to one activities, nail care, external entertainers and movies. The needs of men had been recognised and they had their own 'club.' The registered manager told us and records confirmed people also attended external activities such as a day service, visits to a local garden centre and walks. A person told us, "I went to the park in my wheelchair last week and it was lovely to see the spring flowers and the ducks on the pond. I played snakes and ladders this morning – I won one and the carer won one as well." People who wanted to attended a church service on Sunday and were supported by staff. A person who could not attend church told us. "The priest comes here, and he comes to see me in my room." Staff took the guinea pigs to visit

people, which a relative confirmed. This provided pet therapy and stimulation for people. Records documented what social activities had been offered to people including those who remained in their bedrooms. People's needs for social and spiritual stimulation had been met.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's sensory losses and disabilities had been assessed during their pre-admission assessment and documented in their care plans to ensure staff were aware. The registered manager gave an example of how the needs of a person who was deaf had been met through non-verbal methods of communication.

People and their relatives had been provided with a copy of the complaints policy upon their admission to the service. Information about how to make a complaint was displayed and there was a suggestion box for people to submit their ideas.

Records demonstrated that where concerns had been brought to the provider's attention, relevant investigations had been completed in accordance with the published complaints process. Issues had been addressed with staff where required. Where appropriate, the registered manager had met with people and their families to discuss the issues raised. People's' complaints had been listened to responded to and used to improve the service.

When people had settled into the service, people and their families were encouraged to make provision and choices about their end of life care. A relative confirmed they had been involved in this process for their loved one. We saw on one file for example, the person's advance care directive that had been completed with them and their family. This gave the staff information about the care and support the person would like provided at the end of their life that met their expectations. For example, how they would like to be cared for and who they would like to be with them at the end of their life.

Staff told us they had undertaken palliative care training. Nurses had also received training in the use of a syringe driver, which delivers a steady flow of injected medication continuously under the skin and can be used to relieve people's symptoms towards the end of their life. Staff also involved the local hospice with people's end of life care where appropriate. For example, one person had received aromatherapy input and hospice staff had supported nursing staff with the complex care of another person at the end of their life. The community matron had fed back to us and the service how sensitively staff had managed a particular person's care at the end of their life. This showed people had been well supported and that their needs were met as they neared the end of their lives.

Good

Is the service well-led?

Our findings

People told us the service was well led, their comments included. "We have a lovely manager. She's a lovely person. She listens to you. She's reasonable. She's fair." "The manager is a nice person because she explains everything to me. She knocks on the door and comes and chats with me. She manages well as it must be difficult. I think staff are happy with their jobs." "Staff always try to find answers for you. The manager is absolutely lovely, approachable, gets things sorted. She's got her finger on the button all the time."

The provider's mission statement was prominently displayed. They aimed to provide 'a welcoming and homely atmosphere.' Staff told us they learnt about the provider's purpose during their induction.

Staff told us the service was a good place to work. One staff member commented, "I have seen a big improvement in the way people are cared for and the numbers of staff. This is now a happy place to work." Another commented, "There have been a lot of changes for the better." The community matron informed us, 'Manor Place - are working really hard, they attend everything that I put on and put in place everything I suggest. Since [registered manager] has been in post there has been a huge improvement - the staff all feel very supported and motivated - and she knows exactly what is going on all the time.' Staff were recognised through the introduction of an 'Employee of the month' scheme where people and relatives were asked for their views about which staff had done something extra for people to enhance their experience. People were cared for within a positive culture where staff felt valued.

Staff felt well supported and well-led by management. One said, "We have staff meetings regularly where you can put forward new ideas, I feel that I am listened to and the nurses and the manager are very supportive. I feel happy to go to them if I want to ask anything, they are all very helpful." Another commented, "We talk about any problems to the manager and she does listen. I feel comfortable talking to the manager and I feel supported."

There was a clear management structure with the registered manager, a deputy manager and clinical lead, all of whom had been in post for a period of time. The registered manager completed a monthly report for the provider, covering areas such as safeguarding and issues for people or staff. This demonstrated that actions were being taken to upgrade the call bell system for people. The registered manager told us they were looking at how to ensure the call bells did not ring across the entire building and at how the length of time call bells took to be responded to could be captured and therefore monitored for people.

Since the last inspection, the provider had appointed a regional manager across their services to support the registered manager in their role and increase oversight of the service. The regional manager also arranged meetings between the provider's registered managers to enable them to meet up to support each other and to share good practice and learning across the services for people.

The registered manager was visible and accessible to people within the service. They completed a daily 'walk round' of the service and spoke with people. They also noted what was happening within the service in relation to incidents, complaints, reviews and staffing, for example. The night staff told us the registered

manager sometimes did 'spot checks' on them at night, to ensure they were carrying out their duties as required, which records confirmed.

Staff produced a monthly newsletter for people and their relatives to inform them of what was happening and to provide an insight into life at the service. There were regular resident/relative meetings and staff meetings during which people and staff's views were sought, and they were consulted. Following the last meeting, there were now two activities staff, people had chosen plants for the garden and re-decoration of communal areas had taken place. A recent initiative had been the introduction of a 'quality assurance meeting' attended by a mix of staff, residents and relatives, who had jointly reviewed areas such as food, infection control and activities, in order to collectively identify any areas for improvement in the service for people.

People, their relatives, professionals and staff had been sent a quality assurance survey. Feedback had been very positive overall. Feedback received from a professional as part of the survey demonstrated that there was a positive approach to making improvements in the quality of peoples' care. Following the survey, people had been provided with feedback on the actions taken, which demonstrated their views had been sought and acted upon.

The clinical lead told us staff had spent a lot of time putting in place audits and different ways of finding out how people felt about the care in the service, to make improvements and to make sure actions had been completed. A range of aspects of the service had been audited, these included: infection control, people's care plans and medicines, for example. Where issues were identified, relevant action had been taken. For example, following the infection control audit, new cleaning schedules and room checks had been introduced to ensure cleaning was of the required standard. A range of trackers were maintained, in relation to falls, infections, weights, pressure ulcers, hospital admissions, for example, to enable the registered manager to identify what action had been taken and any trends that required action.

Staff worked in partnership with other agencies. They attended training and learning forums organised by both the local authority and the clinical commissioning group (CCG). Staff had worked with a local hospice team, to enable people to access specialist day care services. The service was participating in the 'Red bag' initiative in conjunction with the local CCG and national guidance. This is where a red bag is used to transfer paperwork, medication and personal belongings when a person is admitted to hospital and stays with the person before being returned home with them. Staff had worked with other providers to improve people's experience of hospital admission.