Sainthill House Ltd

Sainthill House 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

The inspection took place on 14 and 16 September 2016 and was unannounced. The previous inspection of the home was carried out on 23 and 26 October 2015 where we found breaches of regulations. These related to safe care and treatment, safeguarding service users from abuse and improper treatment, and good governance. The service was rated as 'requires improvement' and the provider was required to submit an action plan explaining what they were doing to meet the legal requirement to improve the service.

We carried out this inspection in September 2016 to check whether these improvements had been made. Sainthill House is registered to provide accommodation for 19 people who require accommodation and personal care. The service provides care and support for up to 14 older people who may have physical and/or mental health needs. The service includes Sainthill Cottage, attached to Sainthill House, which provides care and accommodation for up to five younger people who have a learning disability. At the time of the inspection there were five people in the cottage and 14 people in the main house, with three people coming in for day care.

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

The registered manager had kept us informed about progress towards achieving the provider's action plan, and we found significant improvements in all aspects of the service since the last inspection. There had been input from the local authority Quality Assurance and Improvement Team (known as QAIT). QAIT had evaluated the quality of the support provided, highlighting what was going well and making recommendations where improvements were needed. The provider had further developed the quality assurance system, and used the findings to create a comprehensive service improvement plan. At the time of this inspection the majority of the improvements had been made. People were very positive about the service. One person told us, "It's extraordinary…There is a family mentality. The staff have a good relationship with each other and I've got to know them all very well. It's an ideal placement". A member of staff said, "I'm very proud of what we have done at Sainthill".

At the last inspection in October 2015 we found staff did not understand their role in relation to infection control and hygiene, which placed people at risk. At this inspection we found improvements had been made. Staff had received training, PPE (Personal Protective Equipment) were readily available and accessible for staff, cleaning hours had been increased and weekly and monthly housekeeping and infection control audits were carried out.

At the last inspection we saw medicines administration records (MAR) for the application of creams and topical medication were not always being signed by staff. At this inspection we found systems were now in place to ensure people received all of their medicines safely. MAR charts had been completed correctly, care

plans contained clear guidance for staff and mandatory training was in place about topical medication administration. Regular medication audits ensured this improvement was maintained.

At the last inspection in October 2015 we found people's rights were not always protected under the Mental Capacity Act 2005 (MCA). Staff did not have an understanding of the MCA or how the principles applied to their practice. People's capacity to make particular decisions had not always been assessed and documented, or a best interest process followed. In addition, people had not been referred for assessment under the Deprivation of Liberty Safeguards (DoLS). This meant they were potentially being deprived of their liberty to receive care and treatment without being assessed to determine if this was in their best interests and legally authorised under the MCA. At this inspection we found staff understanding of the MCA had improved significantly following training. The service was now working within the principles of the MCA, and applications had been made for people to be cared for under DoLS where appropriate. This meant people's human and legal rights were now protected.

At the last inspection we found people and their relatives were unsure of whether they had been involved in the planning and review of their care. At this inspection people and their relatives confirmed they had been involved in developing and reviewing their care plans with the support of their keyworker.

At the last inspection we found the service had not notified the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities. Since this inspection improvements have been made. As far as we are aware, the provider now met their statutory requirements to inform the relevant authorities of notifiable incidents.

People told us they felt safe. There were sufficient numbers of staff deployed to meet their needs. They were protected from the risk of abuse through the provision of policies, procedures and staff training, and an effective recruitment process. Risk assessments and care plans were effective in enabling staff to minimise risks and support people according to their needs and preferences.

People were supported to maintain good health and had access to healthcare services. People were referred appropriately and guidance followed. One health professional commented, "They flag anything up with us they need. I have no reason to have any concerns. Everybody is happy and the carers are fantastic".

People had sufficient to eat and drink and received a balanced diet, and care plans guided staff to provide the support they needed. People were extremely positive about the quality of the food. Comments included, "The food is very good" and, "The meals are very nice…You can ask for something different that's not on the menu".

Staff promoted people's independence and treated them with dignity and respect. People were supported to make choices about their day to day lives, for example how they wanted their care to be provided and how they wanted to spend their time.

People's relatives said they were made welcome and encouraged to visit the home as often as they wished. They said the service was good at keeping them informed and involving them in decisions about their relatives care.

There was a committed staff team at the home which was well supported by managers and the providers. An induction and training programme was in place to support them to do their jobs effectively. Ongoing professional development was encouraged for all staff members. One member of staff told us, "I've been doing care for 10 years. They are the first manager that's ever listened to me and allowed me to progress

[with qualifications]. They empower you to be the best you can be". In addition the manager had given staff additional responsibilities to further develop their knowledge and skills and build confidence.

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.

There were effective systems for maintaining infection control and hygiene.

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

There were sufficient numbers of staff to keep people safe and meet each person's individual needs.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

Is the service effective?

Good

The service was effective.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People received effective care and support from staff with the experience, skills and knowledge to meet their needs.

People were effectively supported with nutrition and hydration.

People were supported to maintain their health and access healthcare services. Staff sought medical advice appropriately and followed it.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

People were supported to maintain ongoing relationships with

their families and told us they were able to have visitors at any time.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in developing and reviewing their care plans with the support of their keyworker.

People were able to take part in a range of activities according to their interests and make a valued contribution to the community at Sainthill House.

There was an effective complaints process which people were supported to use if necessary.

Is the service well-led?

Good

The service was well led.

As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents.

The provider had effective systems in place to monitor the quality of the service.

People were supported by a motivated and dedicated team of management and staff.

Sainthill House Care 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 14 and 16 September 2016 and was unannounced. It was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other data and enquiries.

We looked at a range of records related to the running of the service. These included staff rotas, supervision and training records, medicine records and quality monitoring audits.

We looked at the care provided to 19 people, observed how they were supported, looked at four care records and spoke with five people to help us understand their experiences. We also spoke with two health and social care professionals and seven staff including care staff, the cook, registered manager, deputy manager and provider. Following the inspection we telephoned two people's relatives, and a health and social care professional who supported people at Sainthill House, to ask for their views about the service.

Good

Is the service safe?

Our findings

People at the service and their relatives, told us they felt safe. Comments included, ", Oh yes, I feel safe. The staff are very careful" and, "It's the place I've felt most relaxed in".

At the last inspection in October 2015 we found that staff did not understand their role in relation to infection control and hygiene, which placed people at risk. At this inspection we found improvements had been made. Staff had received training in infection control and this topic had been discussed in supervision and at staff meetings. Alcohol gel and dispensers for PPE (Personal Protective Equipment) were placed on all floors of the home, were easily accessible and being used by staff. Cleaning hours had been increased, and weekly and monthly housekeeping and infection control audits were carried out. A relative told us that if they saw the toilet needed cleaning after their family member had used it, they told staff who were "… there straight away. They are very good. They clean it up in no time at all".

At the last inspection we saw medicines administration records (MAR) for the application of creams and topical medication were not always being signed by staff. This meant it was not possible to tell whether people had received this medication, or if it was effective in treating their condition. At this inspection we found systems were now in place to ensure people received all of their medicines safely. For example, there was clear guidance in care plans informing staff what topical medications had been prescribed and when and how to apply them. MAR charts had been completed correctly. Topical medication administration awareness was now part of the mandatory training for staff, and minutes showed the topic had been discussed several times at staff meetings. Regular medication audits ensured this improvement was maintained.

There was a comprehensive medication management policy. All staff had received training in administering and receiving medication. People were given their medicine from a locked cupboard in their room, to minimise the risk of medication errors. People managing their own medicines had been assessed as safe to do so, with the involvement of their GP. Medicines which required additional security were kept in a separate locked cupboard. Two members of staff had responsibility for ordering and receiving medication, completing the returns, stock checks and audits. The registered manager gave them dedicated time for this task, which meant they could do it thoroughly with no distractions. A new computerised medication management system was being introduced, which the registered manager told us would further improve the safety and efficiency of the process.

There were sufficient numbers of staff deployed to meet peoples' needs and to keep them safe. Managers or senior staff were on-call in case of emergency 24/7. One person told us, "There's a reasonable amount of staff. Even during the night somebody comes to help. They will come quickly if help is needed". The registered manager told us the staff team had been largely consistent and agency staff had not been used, saying, "The staff are fantastic, they are brilliant at helping out." They told us this was important as people could become anxious if there were new faces at the home.

Risks of abuse to people were minimised because the registered manager ensured all new staff were

thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. They were aware of the service's whistleblowing policy and told us they would feel confident to use it. Staff had safeguarding training, which was updated every year. This allowed them to maintain their knowledge and awareness. The registered manager had worked with the local authority to address safeguarding concerns and taken any action necessary to minimise risk. The service had staff disciplinary procedures in place, and we saw they had been used effectively to manage poor staff practice and keep people safe.

Care plans and risk assessments supported staff to provide safe care. Since the last inspection the registered manager had developed a new care plan system which contained clear risk assessments and guidance for staff on how the risks should be managed. For example, one person had been assessed as being at risk of falling in the shower, but wished to shower independently. The care plan showed that an agreement had been reached with the person which would minimise the risk. Staff would, "check from time to time by knocking on the door and calling their name to check they were OK. Agreed if [the person] does not respond to the call check, staff will enter the room to ensure they are ok."

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. These records were audited by the provider, in order to identify any causes, wider risks and trends. The provider and registered manager could then take any preventative actions that might be necessary to keep people safe.

There were effective arrangements in place to manage the premises and equipment and plans for responding to emergencies or untoward events. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations. People had individual personal protection evacuation plans (PEEP's), which took account of their mobility and communication needs. This meant, in the event of a fire, staff and emergency services staff would be aware of the safest way to move people quickly and evacuate them safely.

Good

Is the service effective?

Our findings

People received effective care and support from staff with the necessary experience, skills and knowledge. For example a member of staff told us about the work they were doing to build a relationship with a person who found it difficult to trust the staff. They told us, "I keep going every day to sit with them for five minutes. If I can see they are getting agitated I'll leave saying, "See you later!" They can sit with me for 10 minutes now".

At the last inspection in October 2015 we found people's rights were not always protected under the Mental Capacity Act 2005 (MCA). The 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. Staff did not have an understanding of the MCA or how the principles applied to their practice. People's capacity to make particular decisions had not always been assessed and documented, or a best interest process followed.

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). At the last inspection in October 2015 several people were eligible for assessment under DoLS but had not been referred.

We checked whether the service was now working within the principles of the MCA, and whether applications had been made for people to be cared for under DoLS where appropriate. We found people's human and legal rights were now protected. Care plans contained mental capacity assessments and best interest decisions. Staff were able to demonstrate a clear understanding of the MCA, and described working with people whose capacity to make particular decisions fluctuated, and their involvement in a complex best interest decision making process. One member of staff showed us an 'aide memoire' they carried in their pocket to remind them of the MCA principles and best interest process. Training had been provided and was ongoing, with several dates booked for staff over the next few weeks. The registered manager arranged one to one training sessions for those staff who did not attend. In the Provider Information Return (PIR), the registered manager stated, "The majority of the staff have undergone level two safeguarding and level two mental capacity and deprivation of liberty safeguards [training] to better understand when our clients are at risk, and to be able to identify and report this risk without delay. Where before, very few of our clients had a deprivation of liberty application in place, now all the clients that are assessed to lack capacity have a DoLS in place. Staff now have a wide understanding of why these safeguards are in place".

A 'key worker' system enabled staff to develop and maintain a good understanding of people's individual support needs and preferences. People knew who their key worker was, and told us they valued their support. Photographs of the key worker were displayed in people's bedrooms as a reminder. One person's care plan stated, "Your keyworker, supported by the Sainthill House manager and staff team, will act as an advocate and support you with your care and assist you to maintain social, recreational, cultural and

religious links through daily activities inside and outside the home". One person described their key worker as "Extraordinarily good". A health and social care professional commented, "The key worker knew the person really well".

Information about any changes to people's needs was shared at the staff handover, which took place three times a day, and at an additional daily staff meeting. Every person was discussed, which meant staff were given a comprehensive update every time they started a shift.

New staff had a comprehensive induction, which gave them the basic skills they needed to care for people safely. This covered a range of essential topics like moving and handling, first aid, and fire safety. During this period they worked alongside more experienced staff to get to know people and about their care and support needs. The manager told us, "If we feel [a new member of staff] needs more support we will provide it". New staff were also undertaking the new national skills for care certificate. This is a more detailed national training programme and qualification for newly recruited staff.

People told us they thought the staff were "well trained". There was an ongoing training programme for all staff which allowed them to keep their knowledge and skills up to date. The manager told us they were using a new training provider with more flexibility over training times and delivery method which made it easier for staff to participate. Mandatory training was updated annually and included moving and handling, infection control, health and safety, fire training, care plan training , safeguarding, MCA and DoLS. The registered manager told us some of the training, like MCA, was repeated to reinforce the learning because, "it needed to be well understood". Additional training was arranged as required to allow staff to understand and meet the specific needs of the people they were supporting, for example epilepsy awareness, specialist training by the Huntingtons Disease Association and a study day on pressure ulcer prevention run by the tissue viability service.

Staff had one to one supervision every eight weeks as well as group supervision. They also had an annual appraisal. Supervision provided an opportunity for them to receive feedback about their performance and discuss any problems and areas where they need to improve. Staff told us the manager was available for support between supervision sessions saying, "If you go with an issue they will document [the discussion]".

Care plans guided staff to provide the support people needed to ensure they had sufficient to eat and drink and received a balanced diet. For example, "[Person's name] needs prompting and redirecting as they get confused at times and forget what they are doing. They need encouragement with fluids as they sometimes forget to drink". Red cutlery and plates had been introduced to help a person living with dementia to "better identify their meals". People were weighed every month and their nutritional status monitored regularly. Food and fluid charts were kept when required. We saw that concerns about weight loss or choking risks had been referred appropriately to external professionals and guidance followed.

The menu for the week was on display in the dining room and the cook discussed people's preferences with them each day. People commented, "The food is very good" and, "The meals are very nice…You can ask for something different that's not on the menu". People could choose whether to eat in the dining room or in their room. People's dietary preferences were documented and respected. For example, one person's care plan stated, "[person's name] would like to prepare their own breakfast if staff bring them warm milk in a small jug for their cereal and a cup of tea without sugar". The cook explained the service was able to cater for people with special dietary needs, like a diabetic or pureed diet, although this was not needed in the main house at present. The people in the cottage had their own arrangements for meals and on the day of the inspection were having a takeaway.

We observed practice during part of the lunch time period. Staff provided calm reassurance and support to people who needed it. People were not rushed, but encouraged to take as long as they needed to finish their meal. Equipment was provided to help people to eat independently, like plate guards.

People were supported to maintain good health and had access to healthcare services. One person told us the registered manager arranged any medical appointments they needed. Community Nurses and other professionals visited people at the home, and their visits were documented in people's care plans. One health professional commented, "They flag anything up with us they need. I have no reason to have any concerns. Everybody is happy and the carers are fantastic".

Since the last inspection, gates had been installed at the entrance to Sainthill House. Several relatives commented on how this had improved people's safety because it minimised the risk of them leaving the grounds and finding themselves on the main road. People could now enjoy the garden independently, which was the case during the inspection. Planning permission was in place for additional improvements to the home which included joining the buildings together to create a sunroom for residents.

Good

Is the service caring?

Our findings

People told us they were supported by kind and caring staff. Comments included, "Staff are extremely kind. They always ask how you want things done" and, "It's extraordinary…There is a family mentality. The staff have a good relationship with each other and I've got to know them all very well. It's an ideal placement". This view was shared by relatives who told us, "The staff are very genuine…and the way they treat the residents is genuine".

Certificates of appreciation were given to several people at the residents and relatives meetings for their contribution to life at Sainthill House. These included, "...for giving support to the kitchen, gardening and extending their caring nature to the staff and residents at Sainthill", and "…for tirelessly caring for our pet".

Staff were committed to promoting people's independence and supporting them to make choices, and people told us their choices and preferences were respected. One person told us, "It's very relaxed. There are no rules and regulations". One person's care plan stated, "[person's name] is an independent person and likes to do as much for themselves as possible". A member of staff described the importance of supporting people to make meaningful choices, particularly when they had lost confidence having previously lived in an institutional setting where choices were made for them.

Staff respected people's privacy and all personal care was provided in private. For example, some people had intercoms installed in their bedrooms to alert staff when they were having a seizure. A best interest process had been followed under the Mental Capacity Act (MCA) to ensure this was the least intrusive and restrictive option, and the intercom was turned off when personal care was being provided to protect their privacy.

People were supported to maintain ongoing relationships with their families and told us they were able to have visitors at any time. Each person had a single room where they were able to see personal or professional visitors in private, although one relative expressed a wish for an additional room where they could meet in private apart from the person's bedroom. One person told us, their family, including children, visited regularly, and were "always received kindly. We go in my bedroom or outside". Staff understood the importance of involving and informing families, and that they sometimes needed support as well. One member of staff told us, "Families need support to understand that people are ageing and changing". Families were encouraged to ring for an update about the welfare of their relative, or if they had any concerns. Staff supported one person living at Sainthill House to visit their relative in a nursing home.

People's end of life wishes were recorded in their care records. This meant staff and professionals would know what the person's wishes were and could ensure they were respected. Training in end of life care was planned for staff. In the PIR the registered manager stated, "As part of staff development we aim to support our staff team with end of life training to give the staff team a better understanding of what to expect if someone passes away and how to support the clients in a dignified and culturally sensitive way. The aim of the end of life training will also be
to give the staff team a better understanding of what an advance will is and [ensure] advance wills and

decisions are taken into account according to the resident's wishes".

Good

Is the service responsive?

Our findings

At the last inspection in October 2015 we found people and their relatives were unsure of whether they had been involved in the planning and review of their care. Since that inspection improvements have been made. Staff meeting minutes showed the registered manager had explained it was the key workers responsibility to actively involve people in their care plans and invite them and their relatives to formally review the care plan. This information had also been shared at a residents and relatives meeting, "Sainthill's aim is that on a monthly basis, we get to spend time with the residents and establish whether that care plan is reflective of the client's needs and wishes. Relatives and residents are encouraged to be more involved in their monthly reviews". People and their relatives confirmed they had been involved in developing and reviewing their care plans. Comments included, "[Staff member's name] is my key worker. We've done my care plan", and, "My key worker is extraordinarily good. We talked through my end of life care plan. They were very sensitive and open about it…they get to know the person you are". We saw that people had signed their care plans to say they had read, understood and agreed with them.

Each person had their needs assessed before they moved to Sainthill House, to determine whether the service could meet them. Information about the person's support needs and history was gathered from the person, their relatives and health and social care professionals. A designated member of staff had responsibility for the admissions process. Their role included showing the person around and introducing them to people. They also supported the person with practical tasks like making a list of their belongings and registering with a GP. Risk assessments and care plans were completed within the first 24 hours, which meant staff promptly had the information to support the person according to their needs and wishes.

Since the last inspection a new care planning system had been introduced. Care plans contained very clear and detailed guidance to help staff understand and respond appropriately to people's needs. For example, the care plan of a person who had difficulty with communication advised staff to, "Watch face and lips carefully. Focus completely, don't try and do something else at the same time. If you haven't understood tell the person calmly. Ask them, "Can you say that again really clearly?" During the inspection we observed staff supporting the person in line with the guidance in the care plan. A member of staff told us, "The care plans are so much better and so easy to follow. Everything you need is right in front of you. They are such a useful tool".

People told us how much they liked their bedrooms. They looked homely and comfortable, and were decorated according to the person's needs, tastes and preferences. A relative told us, "It's as near as you can get to home".

People's care records contained a 'meaningful activity care plan' which stated, "Our aim is for you to enjoy your stay here and feel stimulated and engaged in social events of your choice. We will support you with making friends and feeling supported and going out in the community. We will support your family and friends to visit you". There was a timetable of daily activities which people could join in with if they wished. This included visiting entertainers, quizzes, reflexology, hand massage and gardening. There were also events such as an 'afternoon tea' and a summer fete. In addition people engaged in a wide range of

individual activities according to their interests. For example, one person, who was an artist, enjoyed running a weekly painting club with the people living in the cottage. They told us, "I can help out. It's very rewarding". People also enjoyed helping in the kitchen and working in the garden. The manager told us increased staffing and a new volunteer had increased the amount and range of activities, including more trips out in the minibus and individual trips to the shops. On the day of the inspection some people had gone to the cinema for a 'dementia friendly' screening of an old film classic. People's care plans contained a record of the activities they had done and observations about whether they had enjoyed them. This helped staff to understand what benefitted the person, particularly if they were unable to verbalise this themselves. One person's record stated, "[Person's name] came and listened to the music and appeared really relaxed when listening. It does appear to calm them down and influence how they seem to feel".

The home had a clear written complaints policy and procedure with a copy displayed in people's rooms. People pointed it out to us and told us they would feel able to raise any concerns with the manager if necessary. One person told us, "[Managers name] is very good. They are always pleasant to talk to. If you want to ask them anything they'll get it done". We saw from records that complaints were dealt with effectively. A relative had written to inform the manager their concern had been resolved, saying, "I am very happy with the way my complaint was dealt with". There had been two complaints about lost property. In the PIR the manager stated "Discussion with the staff team about these incidents has increased the staff team awareness about handling property and how to safeguard this property, even if the clients have short term memory loss". This demonstrated that the complaints process was used to drive improvement at the service.

Good

Is the service well-led?

Our findings

At the last inspection in October 2015, we found the service had not notified the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities. Since that inspection improvements have been made. As far as we are aware, the provider now met their statutory requirements to inform the relevant authorities of notifiable incidents. They promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The provider had confidence in the registered manager and told us, "[Manager's name] has done this home proud…They have developed a good structure and culture, and given staff skills and particular responsibilities. It helps them to feel valued…I have a lot of confidence in them". People, relatives, staff and health and social care professionals were also very complimentary about the registered manager. People commented, "The manager is a very kind person. They are very knowledgeable in their profession" and, "[Manager's name] runs it in an extraordinary way…There is openness, They are very patient. Their ethos is very good. It just rubs off". A member of staff told us, "[Managers name] is very supportive. You can go to them with any issue. They will listen and get you to reflect on how the issue could be resolved. They are always positive. I've never known them to be unnecessarily critical".

The provider and manager had been proactive in addressing the concerns raised during the last inspection in October 2015. They had welcomed audits of the service, for example by an external pharmacist and the local authority Quality Assurance and Improvement Team (known as QAIT). QAIT had evaluated the quality of the support provided; highlighting what was going well and making recommendations where improvements were needed. The provider had also arranged for service managers to review the quality of care in each other's' homes every three months, and provide objective and constructive feedback to each other. The recommendations made had been used to develop a comprehensive service improvement plan. At the time of this inspection the majority of the improvements had been made. The manager told us, "I want the best possible service for the clients. We have made a huge amount of progress. I'm getting feedback from the staff and residents that it feels like a 'home from home'. Staff were also proud of the progress that had been made at the service telling us, "I'm very proud of what we have done at Sainthill".

The service had its own quality assurance system to monitor the care and environment at the service. Audits were completed every month looking at areas such as medication, infection control and the environment. Residents, relatives and staff were asked to complete an annual survey, commenting on issues such as the quality of the accommodation and support provided, and the way the home was run. Feedback was also sought at the residents and relatives meeting, held every six to twelve months. A relative told us the meetings were, "Very good. I am able to make suggestions and say if I don't like something". Minutes showed that people and their relatives had been asked for their views about the activities provided, menus and ideas for developing the garden. People, relatives and friends also gave feedback using the 'Carehome.co.uk' website.

The manager told us, "I strongly believe in my staff. With enough support we can develop them. My biggest resource is my staff team and I invest a lot in them". Regular staff meetings were held, and minutes taken, which meant information and discussion could be shared amongst the whole staff team. Staff were encouraged to continue with their professional development, working towards additional qualifications relevant to their roles. One member of staff told us, "I've been doing care for 10 years. They are the first manager that's ever listened to me and allowed me to progress [with qualifications]. They empower you to be the best you can be". The manager had also given staff additional responsibilities to further develop their knowledge and skills and build confidence. For example, there was a 'first aid liaison' who ensured the first aid boxes were replenished and it was clearly indicated where the first aid boxes were; a 'dementia lead'; an 'infection control lead'; an 'admissions lead', and two 'medication leads', one for the cottage and one for the main house. There were also plans for staff to work across both sites which would further expand their knowledge, as the people in each home had very different needs.

A staffing structure, including the registered manager, deputy manager, and team leaders provided clear lines of accountability. This meant all staff were supported and monitored effectively. In the PIR the manager stated, "We have introduced new roles for the staff. The Team Leader role has been introduced in order to increase the leadership on the floor and support for junior staff. We now have five team leaders and one deputy manager with specific roles and responsibilities but also as a support for all junior staff". Staff were positive about the restructure, telling us, "everything just seems to click".

People, the manager and staff told us the provider was very supportive and visited the home for a 'walk around' every week. The manager and provider met weekly for an update and to discuss any concerns. A monthly meeting with the manager of the providers other home provided an opportunity for peer support and sharing ideas about best practice.

The provider and managers participated in various forums for exchanging information and ideas and fostering best practice. For example, the deputy manager was a dementia 'champion' for the Alzheimer's Society working to educate the public about dementia though 'dementia friends'. They had used research undertaken at Stirling University to inform developments at the service for people with dementia, like a 'reminiscence wall' to stimulate discussion and special plates and cutlery to support people with eating.