Care UK Community Partnerships Ltd

Montfort Manor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Montfort Manor is a residential care home providing personal and nursing care to 47 people aged 65 and over at the time of the inspection.

Montfort Manor accommodates up to 68 people across three separate floors, each of which has separate facilities. One of the floors specialises in providing care to people living with dementia and another with nursing needs.

People's experience of using this service and what we found
People did not always receive person-centred activities meaningful to them as information about peoples likes and interests had not always been used to plan activities for them. Despite the service's excellent outdoor facilities, we observed people living with dementia did not have a walk in the garden or go outside all day. We made a recommendation for the provider to review their management of activities for people, in particular for people living with dementia.

People's communication needs were known but there was potential improvement to use more alternative methods of communication such as the use of pictures. We made a recommendation the provider reviews their use of alternative communication methods for people, especially for people living with dementia.

People were protected from abuse and avoidable harm. People and their loved ones we spoke with told us they felt safe and staff were knowledgeable in their duties to keep people safe. Risks to people and from the environment were fully assessed and managed to support people to stay safe. Accidents and incidents were reviewed to understand lessons learnt and prevent reoccurrences.

There were enough safely recruited staff deployed to keep people safe and meet their needs.
People were supported to take all their medicines safely and told us they were happy with the care they received for their medicines. We were assured that the provider was managing infection prevention and control effectively.

People's care needs were fully assessed and included their preferences to ensure their needs were met and clear outcomes planned. Staff were well supported to ensure they had the knowledge, skills and competence to fulfil their roles.

Mealtimes were a positive experience for people, people's choices were promoted, and people were supported to remain safe from risks around eating and drinking. People's healthcare needs were monitored and met. Staff worked with other healthcare professionals when required to achieve this.

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

this practice.

People were treated with respect by staff who were kind, caring and attentive in their interactions with people. People were supported to make choices about their care and day to day living. People's loved ones told us they were kept informed and involved in their care.

People's rights to privacy and confidentiality were respected and people's dignity was maintained. People were supported to maintain their independence where possible and their care plans informed staff what they could do for themselves and when they needed support.

Peoples care records contained person centred information to ensure people's care was relevant and meaningful to them. All people and their loved ones knew how to raise a complaint if they needed to. All people and their relatives we spoke with were very positive about Montford Manor and no-one had any complaints.

People's wishes around their end of life care were recorded and where people were on end of life care, medicines were available to ensure they could remain pain free.

There was no registered manager in post at the time of inspection. However, there were robust interim arrangements with a manager in place who knew the service well. The manager had created a positive, person centred culture in the service. All staff, people and relatives were positive about the manager.

The manager had ensured high quality and safe care for people. Care records were detailed and up to date. Risk management systems were robust. Quality assurance audits and reports were used to check people's safety and quality of care. Staff worked well together, and there were regular staff meetings to ensure good communication.

The provider and manager proactively sought to identify and promote improvements in the service. Quality assurance systems such as audits and surveys were completed alongside other feedback and events, such as incidents to ensure continuous improvement. The manager monitored their progress with any action plans for improvements to ensure these were completed.

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

Rating at last inspection
This service was registered with us on 17/10/2019 and this is the first inspection.

Why we inspected
This was a planned inspection following a new registration.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	**Good**

Montfort Manor

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 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.

Service and service type
Montfort Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. This means the provider is 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff including the operational support manager, deputy manager, two team leaders, a senior carer and two activity staff.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at eight 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 continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and survey results.

Good

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● Systems and policies were in place to protect people from abuse and avoidable harm. People and their loved ones we spoke with told us they felt safe living in Montfort Manor and with the staff who cared for them. One relative said, "(Loved one) is definitely safe, she is always comfortable, they re-position her in bed and are looking after her. We were worried about her going into a care home but it's nothing like you imagine. You get a great feeling when you walk in; staff are friendly and she's always clean."

● Staff were required to read the safeguarding policies and sign to say they understood the content. Staff knew how to recognise signs of abuse and act upon these, including referring any incidents to the local authority. Staff were aware of the whistleblowing procedures and had received safeguarding training. The training was completed by new staff during induction and then repeated every one or two years, depending on the employee's role.

● The manager had kept logs of any safeguarding incidents and had a good knowledge of these. There were posters around the home which displayed how to act upon or escalate concerns about potential abuse. Staff had cards as aide memoires for safeguarding. There was signage for family members and visitors about signs of abuse or neglect.

Assessing risk, safety monitoring and management

● People had pre-admission assessments before they moved into the home. This meant the provider knew they could cater for the person's care needs and the environment was suitable, especially for people with dementia. GP notes and local authority notes were also obtained before care commenced to provide additional information about people's needs.

● People had ongoing risk assessments based on their individual needs. For example, malnutrition, moving and handling, diabetes and other health conditions. Risk assessments were used to provide guidance to staff how to reduce the risks to people. For example, ensuring people using incontinence pads had them changed regularly to prevent irritated skin. Relatives told us staff responded appropriately to risk. One relative told us, "She's definitely safe because she had a couple of falls and they put safety mats down and she has an alarm to stop people coming into her room."

● An electronic system was used to record, assess risk and add mitigating actions to manage the risks. Risk assessments were updated monthly or more often if needed.

● Environmental risk assessments and health and safety assessments were completed for all the mandatory requirements. For example, fire, electrical and gas safety and water temperatures.

Staffing and recruitment

● Staff were recruited safely. Recruitment records contained all the necessary checks and documents to ensure fit and proper persons were employed. This included ID checks, full employment history, checks of

conduct (references), qualifications, a health questionnaire, interview notes and Disclosure and Barring Service (DBS) background checks. DBS checks help employers to make safer recruitment decisions.
● Enough staff were deployed to ensure people's needs were met in a timely way. People told us, "They come when I press the buzzer quite quickly"; "There's enough staff, there's always two on at night. I don't need a call bell, when I was in isolation, I used it and they came", and "There's always a couple of staff coming in to change me and always someone around." Feedback from relatives included, "She's safe as there appears to be people around all the time and looking after her."
● A staff member told us, "I think the number of carers on duty here is about right". We observed people's needs were attended to in a timely way, including during busy periods, for example mealtimes and the morning.
● The manager kept their dependency tool up to date. This scored people's individual needs to identify the correct staffing levels and was colour coded so it could be clearly seen if staffing levels were insufficient.

Using medicines safely
● An electronic Medicines Administration Records (MARs) system was used effectively to ensure people received their medicines as prescribed. This included the use of any 'as required' medicines and 'specific medicines. Safe storage checks were completed such as checking medicines were stored at the right temperatures. Medicines stocks were checked weekly or more regular if required and identified any issues.
● People told us they were happy with the care they received for their medicines. Only trained staff completed medicines administration and their competencies were checked by the deputy manager or nursing staff.
● Other medicines such as topical creams and homely remedies were managed safely. Creams were dated on opening and stored separately from other medicines. Supplements were recognised as medicines and were stored securely. Where required, time specific medicines were given at the right time.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. Visitor's temperatures were checked on entry and a 10-point questionnaire was completed by visitors along with lateral flow testing.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service. Covid-19 testing was carried out prior to admission.

● We were assured that the provider was using PPE effectively and safely. Staff had received training for this. Staff had access to personal protective equipment such as disposable gloves and gowns.

● We were assured that the provider was accessing testing for people using the service and staff. There was frequent testing of staff with weekly PCR testing and lateral flow testing for staff if they had been on leave.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. One person told us, "The home is spotless. They do a deep clean monthly and clean daily." Records of cleaning were maintained. These included 'deep' cleaning (such as carpets) and high cleaning (such as hard to reach locations). Hand hygiene notices and handwashing facilities were in place. Mops, buckets and clothes were used in line with the national cleaning standards.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The premises were clean, hygienic and well ventilated. The provider had built an external private pod attached to an internal lounge for people to visit relatives if required without entering the building.

Learning lessons when things go wrong

● The manager and provider proactively reviewed all incidents, accidents and complaints to identify any lessons to be learnt. This included identifying themes for the provider to learn from. For example, falls were analysed by whether they were witnessed and the time of day. People's hospital attendance was analysed, looking at the reason for visiting and whether they were admitted.

● A 'lessons learnt' system was in use in the home to ensure all accidents and incidents records identified how risks were mitigated to prevent an incident reoccurring and identify lessons learnt. These were shared at clinical review and other quality assurance meetings.

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.

This is the first inspection for this newly registered service. This key question has been rated Good. 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

● People's care needs were fully assessed and included their preferences to ensure their needs were met. People's care plans had clear outcomes planned. For example, one person who suffered with anxiety had clear guidelines for staff what to do to reassure and manage anything that triggered their anxiety. This supported meeting the care plan outcome goal, for the person to feel more settled.

● The provider used well known assessment tools to ensure people's needs were effectively assessed such as their risk of pressure sores or weight loss.

Staff support: induction, training, skills and experience

● Staff had regular training and supervision sessions with managers to ensure they had the right knowledge and skills to carry out their roles. Staff training included safeguarding, moving and handling, the Mental Capacity Act 2005 (MCA), dementia awareness, medicines, health and safety, infection prevention, behaviours that challenge, nutrition, fire safety and equality. There was a combination of e-learning and face-to-face training with annual refresher training, or more frequently when the staff member's personal development plan identified it.

● Staff we spoke with told us they received all the training, support and supervision they needed. Staff induction, training and supervision records reflected the information provided to us. This included the use of any agency staff. We observed staff were confident in their work. For example, how to support someone to transfer from their chair to access the toilet safely.

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

● There were appropriate risk assessments and care plans in place for nutrition and hydration. Choking risk assessments were completed where a risk was identified. People had correctly modified texture diets where there was risks of choking. Referrals to a speech and language therapist (SALT) were made when necessary.

● We observed people's lunchtime experience in the dining rooms. People were offered napkins and aprons to protect their clothes if they wished and staff wore appropriate protective equipment. A lively atmosphere was encouraged. We saw good practice from a friendly, responsive and hard-working group of care staff. Staff were patient with people living with dementia who stood up and walked away several times during the meal. Staff persevered in a kindly manner to encourage people to eat well.

● People were able to eat in the dining rooms, their own bedrooms or at tables in the lounge if they wished. People were offered choices of different meals and drinks. People told us, "The food is very good, lots of choice and I just ask for a drink and they get me one." Another person said, "You can make your own drink it you like, which I do." Comments from relatives included, "Mum seems to enjoy the food, there's a lot of choice. There's always juice and water on the table. Visitors can make their own drinks. They have a nice

café." And, "Mum doesn't eat or drink enough. They rang on Monday to say mum had joined the others in the dining room. They serve her food on a small side plate. Whatever they are doing it is starting to make a difference and she is starting to put weight on."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Care plans provided clear guidance for staff for all people's healthcare needs. Where people had a specific health condition there was additional information provided for staff to ensure they met their needs. For example, how to care for someone who has a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is the use of a flexible feeding tube placed into the stomach to give someone the nutrients and fluids they need where they are unable to have this orally.

● People were supported to access the healthcare they needed. People's health and wellbeing was monitored to promote early prevention and positive outcomes. For example, where people were at risk of developing pressure sores, their skin condition was consistently monitored, and if required referrals were made to the district nurse.

● Staff worked with other health care professionals to ensure people's needs were met. For example, district nurses, GPs and speech and language therapists. We observed a chiropodist visit someone in the home.

● Peoples oral health was comprehensively assessed with a clear care plan.

Adapting service, design, decoration to meet people's needs

● The building had been designed to meet people's need with good access to communal areas, spaces for socialising and outside spaces.

● The environmental needs of people living with dementia had been considered. For example, there was use of contrasting toilet seats. This helps people to be able to access the toilet independently. There was signage on doors which helped people to find where they wanted to go, and bedroom doors could be recognised by the use of personalised memory boxes.

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.

● Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions. Where people could not make their own decision, the best interest decision making process was used and appropriate documentation completed.

● DoLS applications for authorisation of restriction of people's liberty were completed by the manager and renewals were submitted to local authorities as needed.

● Staff had received training in MCA and DoLS, they understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty.

● Where people had a Lasting Power of Attorney (LPA) in place this was recorded in people's care records. An LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

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.

This is the first inspection for this newly registered service. This key question has been rated Good. 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 treated with respect. People told us, "They are very good, they ask you if you want things. It's very friendly." And, "They are lovely and professional, but very kind." Relatives told us staff were, "Staff are friendly, caring, kind and professional."
- We observed staff were kind and attentive in their interactions with people. One person was sat in a quiet area and appeared unwell. Staff attended to them, crouched down to be at the same level as them, spoke to them gently, asked if they were ok and spent time with them. When the person was ready, they supported them to stand and ensured the person did not feel rushed, reassuring them to take their time.

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

- People were supported to make decisions about their care. For example, people told us they could have a bath or shower whenever they wanted, and they could go to bed when they wanted to. One person told us, "There was a residents meeting. I didn't go because everything is fine. It's all fine, I wouldn't change anything."
- People's loved ones told us they were kept informed and involved in their care. For example, "I was invited to a video meeting but couldn't go; they sent me the notes." And, "We now have monthly Zoom meetings. The manager is very approachable."
- We observed people were consistently given choices in their day to day living activities and care. For example, on entering the dining room, people were asked where they would like to sit, and people were asked where they would like to meet with their loved ones who had come to visit.

Respecting and promoting people's privacy, dignity and independence

- People's rights to privacy and confidentiality were respected. Documents were stored securely, and computers were password-protected to prevent unauthorised access to personal information.
- People's dignity was maintained. Staff knocked on people's bedroom doors before entering and ensured doors were closed when people received personal care. Staff ensured bathroom doors were closed when people used bathrooms independently.
- People were addressed by their preferred names. They were well-groomed and appropriately dressed.
- People were supported to maintain their independence where possible. For example, by using adapted cutlery and drink containers to enable people to eat independently; or by using walking aids to walk independently. People's care plans highlighted what they could do for themselves and when they needed support.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement: This meant people's needs were not always met.

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

● One person told us, "There is always some activity in the morning and the afternoon. I don't go often." A relative said, "The activities are not really suitable, but she enjoys watching, she enjoys the singers." People did not always receive person-centred activities meaningful to them. Whilst information about peoples likes and interests was available this had not always been used to plan activities for them. The themes on the activity planner did not always reflect the wishes or preferences of the people living there. We spoke with the activities co-ordinators and asked where they got their ideas for activities, they told us, "It was trial and error to see what they might like".

● Despite three activities co-ordinators being employed for the home, these were not always well deployed. For example, during our inspection, the morning activity was news round and the afternoon was "Arts and Crafts Black history month". Both activity staff were involved in these sessions on one floor and therefore there were no alternative activities on the other two floors.

● There was a lack of consistent meaningful activities and stimulation, particularly on the floor that looked after people living with dementia. For example, we visited one person in their bedroom, their TV was switched off, we asked if they liked television and they said they weren't that interested. When we asked about music, they said, "Oh I love music, I love classical music", but there was no radio or music player in their room. We tried to use the television to play music but there was no signal and the television could not be used. We visited other people's bedrooms and found there were no remotes to switch on the televisions or they didn't work as there was no signal.

● The home had excellent outdoor facilities with a large enclosed garden with seating areas. Yet we only observed one person have a walk in the garden and no one from the floor that cared for people living with dementia went outside all day.

We recommend the provider organises an independent and person-centred evaluation of the management of activities for people in the service, in particular for people living with dementia.

● There were many areas throughout the home for people to socialise. There were excellent facilities in the home for people, such as a cinema, bar and hair salon. People were encouraged and supported to keep in touch with their family and loved ones. We observed people had visitors and chose whether they met them in communal areas, private lounges or in their bedrooms.

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.
● There are five steps to the AIS, to identify, record, flag, share, and meet people's communication needs. The service had taken steps to meet the AIS requirements. For example, people's communication needs were identified in their care plans. One person who had suffered a stroke and was unable to talk since, had clear guidance for staff how they communicate with their body language. There was also a social story in place for staff to use with the person to share their life story. A social story uses pictures to help share information.
● Information was displayed around the home to keep people informed, for example about events and activities. However, this was largely in written form and could benefit from the use of pictures to support people's varying communication needs. Food menus were only available in a written format. We spoke to the manager about this and was told their policy was to physically show people their choice of meals. However, we observed there were occasions when people were asked their choice verbally and were not shown their different options.

We recommend the provider conducts a review of AIS and the use of alternative communication methods for people, especially for people living with dementia.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's preferences, likes and dislikes were assessed and recorded. People's past life histories and social life were listed in their care records. Care documentation was clear about people's choices. For example, one person liked jigsaws as they promoted a calm environment. They liked particular singers and had a favourite doll.
● Peoples care records contained person centred information to ensure people's care was relevant and meaningful to them. For example, people's sleep care plans detailed how they liked their bedroom to be, whether they liked low light or complete darkness and their door shut or ajar.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place and information around the home to inform people how to raise any concerns or complaints they had. Complaints were reviewed monthly as part of the providers quality assurance meetings.
● All people and their relatives we spoke with were very positive about Montford Manor, no-one had any complaints and were satisfied with all aspects of their care and support. All people and relatives we spoke with knew they could complain to the manager or other senior staff if they needed to.

End of life care and support
● People's wishes around their end of life care were recorded. There was one person receiving end of life care at the time of our inspection. Their care plan was clear they were only receiving 'comfort' care and did not want to go into hospital or receive any treatment. Anticipatory medicines were available to ensure the person could remain pain free.
● Staff knew when people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. These had been checked and a copy kept on file.

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.

This is the first inspection for this newly registered service. This key question has been rated Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- Relatives told us they found a positive atmosphere in the home. Comments included, "The home is quite relaxed and happy, it's all good"; "It's a quite cheerful atmosphere", It's a happy atmosphere."
- The manager had created a positive culture in the service. This had resulted in a motivated staff team and quality care for people with positive outcomes.
- All staff, people and relatives were positive about the manager. Staff felt supported by the manager and described the manager and provider as 'approachable and good listeners.' The manager felt supported by the provider and described a range of resources they had access to which supports the governance of the home, for example quality and clinical teams.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no registered manager in post at the time of inspection. The provider had recruited a new manager. In the interim the operational support manager who knew the service well was managing the home with the support of the deputy manager. The deployment of this manager had stabilised the day-to-day operation of the service, ensured continuity and sustainability of governance processes as there had been some upheaval with care staff leaving following the previous registered manager leaving.
- There were robust and effective governance systems in place to ensure high quality and safe care. Care records were consistently comprehensive, accurate and up to date. Risk management systems were robust. An extensive range of quality assurance audits and reports were used by the provider and manager to measure safety, people's welfare and the success of care. For example, key performance indicators were maintained and reviewed monthly. These covered people's care needs, risk management and feedback, checked appropriate action was taken and identified any trends.
- The provider accessed various networks and information from other agencies to keep up to date with the latest information and ensure the service and manager was up to date.
- The manager clearly understood their role and responsibilities and had met the regulatory requirements. Providers are required to notify CQC about events and incidents such as abuse, serious injuries and deaths which they had done.

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

- The manager understood their responsibilities in respect of the duty of candour. They had informed

people, their families and where appropriate external agencies of any incidents or accidents. The manager had recently checked staff understanding of this requirement under a 'policy of the month' review.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was a positive workplace culture at the service. Staff worked well together, and there was a shared spirit of providing a good quality service to people. There were regular staff meetings and daily meetings with department heads to ensure good communication.

● People and their loved ones we spoke with knew the manager and were engaged with the home. Comments included, "The manager is lovely; I can talk to them." And, "I know the manager they are really friendly; they chat to my dad when he visits." One relative told us how they attended a Zoom meeting and said, "I was impressed with how it was run and the topics. They seem to want to listen to families."

● The manager promoted peoples' and staff equality and diversity. Equality and diversity considerations were included in people's needs assessments.

Continuous learning and improving care

● The provider and manager proactively sought to identify and promote improvements in the service. Quality assurance systems such as audits and surveys were consistently completed. Audits were used alongside other feedback and events such as incidents to ensure continuous improvement.

● Surveys were completed with people, their loved ones and staff to gain feedback on their experience of care and the service provided. For example, a relative survey had been conducted over 5 months. The results were collated, analysed and compared against the services previous survey results and against the other providers services average. These showed high levels of satisfaction.

● Action plans were used to track any improvements required and to record the date of completion or any outstanding actions. There were a variety of action plans pertaining to relevant aspects of the service's governance. These showed that the manager and provider had identified and made required improvements. For example, they had identified the need to ensure a risk assessment was in place for every person who was unable to use their call bell effectively. This had been actioned to ensure all staff knew how to identify when people need support if they are unable to use their call bell.