The Trustees of Queen Alexandra Cottage Homes

Queen Alexandra Cottage Homes

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**

Overall summary

Queen Alexandra Cottage Homes provides nursing and personal care for up to 28 people. There were 25 people living at the home at the time of the inspection who had a range of complex health care needs which included people who have stroke, diabetes and Parkinson's disease. Some people required help and support from two members of staff in relation to their mobility and personal care needs.

Queen Alexandra Cottage Homes is a nursing home run by a charity. Accommodation was provided over two floors with two passengers lifts that provide level access to all parts of the home. The home was part of a complex which includes sheltered housing flats and bungalows.

There is a registered manager at the home. A registered manager is a person who has registered with the Care

Summary of findings

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.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 23 and 24 November 2015.

The registered manager had identified a number of changes were required to ensure people received the care and support they required. Some areas had been addressed for example staff had received training and updates to ensure they had the appropriate knowledge and skills to look after people. Other areas, particularly in relation to record keeping were still being addressed.

People and their visitors spoke very highly of the caring and kind nature of the staff and said that there was a lot of respect for their dignity. Staff knew people well and treated them as individuals; they were able to tell us about their choices, personal histories and interests however people's care plans were not personalised and did not always reflect the care and support people received.

Staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS) and people were supported to make their own decisions. People were involved in decisions about their day to day care and support and were able to decide what care and support they required. Staff cared for people with kindness and patience. They were supported to take part in a range of activities maintain their own friendships and relationships.

There were enough staff who had the appropriate knowledge and skills and had been safely recruited to look after people at the home.

People were protected against risks including the risk of abuse, malnutrition and pressure area damage because staff had identified where these risks may be and measures put in place to reduce their likelihood. However, people told us they were not restricted and able to take individual risks which enabled them to remain independent.

People were given choice about what they wanted to eat and drink and received food that they enjoyed. They had access to a varied menu and if they did not like what was on offer alternatives were available.

People were supported to have access to healthcare services and maintain good health. People and their visitors said that they would have no hesitation in raising concerns or complaints and that staff were very approachable and would help to resolve any issues.

Summary of findings

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

Queen Alexandra Cottage Homes was safe.

Staff knew how to recognise and report safeguarding concerns.

People received their medicines safely, when they needed them.

Environmental and individual risks were identified and managed to help ensure people remained safe.

There were enough staff who had been safely recruited to look after people who lived at the home.

Is the service effective?

Good

Queen Alexandra Cottage Homes was effective.

All staff had received effective training to ensure they had the knowledge and skills to meet the needs of people living at the service.

Staff had regular supervision and appraisals.

Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choice about what they wanted to eat and drink and received food that they enjoyed.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Good

Queen Alexandra Cottage Homes was caring.

Staff knew people well and displayed kindness and compassion when providing care.

Staff treated people with respect and their dignity was maintained.

People were involved in day to day decisions and supported to maintain their independence.

Is the service responsive?

Requires improvement

Queen Alexandra Cottage Homes was not consistently responsive.

People received care and support that was responsive to their needs because staff knew them well. However, people's records did not always reflect the care and support they needed.

There was a complaints policy in place and we saw complaints that had been raised were dealt with appropriately in a timely way.

Summary of findings

Is the service well-led?

Good

Queen Alexandra Cottage Homes was well-led.

The registered manager had identified a number of changes were required to ensure people received the care and support they required and action was being taken to address these.

People, staff and visitors told us the registered manager was open and approachable. They said the home was a lovely place to live.

Queen Alexandra Cottage Homes

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 was an unannounced inspection on 23 and 24 November 2015. It was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR) we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records, staff files including staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits, policies and procedures along with information in regards to the upkeep of the premises.

We looked at five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

During the inspection, we spoke with eight people who lived at the home, three visiting relatives, and nine staff members including the registered manager and provider. Following the inspection we contacted five healthcare professionals who visited the home to give us their feedback about the care and support people received.

We met with people who lived at the home we observed the care delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their visitors told us they felt safe living at the home, and their visitors agreed. One person said, "I'm safe as anything," and another person told us, "I feel safe here." A visitor told us, "Mum's absolutely safe here." People told us there were enough staff, one person said, "I think the number of staff is satisfactory, they come quickly enough when I call for them."

Staff were able to tell us how they kept people safe from the risk of abuse. They understood signs of potential abuse. If they had concerns they would report this, if appropriate, to the registered manager or whoever was in charge of the shift. They told us if their concerns related to the registered manager then they would report this to external services. There were safeguarding policies in place and these contained telephone numbers for the local safeguarding team.

Records showed the registered manager had referred concerns to the local safeguarding team when required. All staff who worked at the home received safeguarding adults at risk training and regular updates to ensure they were aware of current best practice.

There were enough staff to look after people safely because there were appropriate staffing levels in place. There was a dependency tool in people's care plan but this was not used to decide staffing levels. The registered manager told us staffing levels were very much based on people's needs and would be adjusted to ensure enough staff were working each shift. People's needs were continually discussed throughout the day and the registered manager and staff were aware if people's needs had increased. We were given an example when one person had been unwell and required more support. To ensure this person was cared for appropriately they received one to one support from a staff member. This also ensured other people received their care as there were enough staff to support them. Agency staff were used occasionally, the registered manager told us, "Sometimes with holidays and sickness we may have 11 staff on duty instead of 12 but there is a limit we wouldn't go below, staff do cover some absences if they can't that's when we use agency." One person said, "They can get a bit short-staffed if they (staff) are on holiday, then they get the casuals in." We saw call bells were answered promptly, one person told us if the used their call bell, "They (staff) come quickly." A visitor told us, "There's great continuity of nursing staff."

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. Staff files showed there was appropriate recruitment and appointment information. This included an employment history, references, and disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults. Nursing and Midwifery Council PIN checks for registered nurses had been recorded and demonstrated they had the appropriate qualifications for their job.

Medicines were stored, administered, and disposed of safely. We observed medicines being given safely and correctly as prescribed. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. Prior to administering PRN medicines the nurse asked people if they required the medicine. There were no PRN protocols in place, these are to provide guidance for staff about why the person may require the medicine and when it should be given. The registered manager had identified this as a concern and all staff were aware of how to administer PRN medicines safely. The registered manager had arranged a meeting with a local pharmacist and this took place during our inspection. The registered manager received the guidance she required and PRN protocols were being put in place with immediate effect. Staff knew people well and understood why and when their medicines were needed.

There were a range of risk assessments in place these included pressure areas, mobility, falls and risks that were specific to individuals for example choking. There was information within associated care plans which informed staff how to support people safely. For example one person who was at risk of developing pressure sores guidance was in place about changing the person's position regularly and informed staff a pressure relieving air mattress was in place. When people's needs changed, for example when they were less able to move independently or when they needed to be supported to move using a hoist, we saw their risks had been reviewed and appropriate actions taken. We asked staff if people were supported to take risks

Good

Is the service safe?

safely. We were given the example of one person whose ability to stand was decreasing. Staff told us, “We didn’t use a hoist as soon as they became unsteady we worked with them but eventually it wasn’t safe to do that anymore.” People said that they were free to do as they liked, but acknowledged that the staff would undertake risk assessments, one person said, “There are no restrictions as such here.” Another person told us how as their health had improved, it had been agreed that they could use the lift unaccompanied. This person said this was a “significant development” for them in terms of freedom of movement.

The home was clean and tidy throughout. Regular health and safety checks were in place and these included fire safety checks including fire drills. We saw all staff had received fire safety training. There was regular servicing for gas, electrical installations**,** the passenger lift, hoists and bath hoists. Environmental risk assessments were in place and had been reviewed regularly.

Good

Is the service effective?

Our findings

People and their visitors expressed confidence in the skills and abilities of the care staff, and felt that they were well trained. One person said, "The staff are very well trained, I think they're very well picked." A visitor told us, "They seem very well qualified here, training is ongoing we have a lot of confidence in them." People said that the food was good at the home. Several people mentioned that there was a new head chef and that the food had improved since his arrival. Comments included, "The food's lovely, I never leave anything," and "The food's excellent here."

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) its principles and what may constitute a deprivation of liberty. 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. There were mental capacity assessments in people's care plans which informed staff whether the person had capacity. When specific decisions were made which may restrict people's liberty specific mental capacity assessments were undertaken to determine if a DoLS application was required. We saw an assessment had taken place for one person who required a lap belt in their wheelchair. The assessment demonstrated this person had capacity and had chosen to use the belt as this made them feel safe and secure. There were currently no DoLS authorisations in place however applications had been made and were awaiting assessment.

People were looked after by staff who were well supported and had the appropriate knowledge and skills. The registered manager had recognised improvements were needed in relation to staff training and had engaged the services of an external training provider. The registered manager told us, "There's been a really big push on training this year," this was confirmed by staff. Training included infection control, moving and handling, MCA and DoLS and person centred care. We saw further updates had been booked and further training in relation to dementia and end of life care. Nurse's clinical training included palliative care and wound care. Staff told us they enjoyed the training they received and it was presented in a way they understood. One staff member said, "It's nice being a small group, you can ask questions and it makes sense."

In addition to formal training we observed that care staff were supported by the nurses to understand about the care they were providing. During handover we heard a nurse reminding staff to encourage a person to drink more because they had a urinary tract infection. Staff were told, "It's important to encourage fluids it will help to flush the infection through." Another person had developed a chest infection and the nurse was asking staff how the person had presented the previous day. She asked if the person had been eating and swallowing their food without difficulty. She explained that swallowing difficulties may result in food entering the person's lungs and cause an infection. From our observations it was clear this was something staff were aware of, they were able to discuss the person's condition and what they were doing to support them.

There was an induction programme in place. Staff were introduced to the day to day running of the home and completed training related to the care certificate to support the induction process. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff told us the induction programme provided them with a good understanding of the support people needed.

Staff received regular supervision and appraisals. The registered manager had delegated some supervision responsibilities to the nurses and team leaders. Staff told us they had received training before providing supervision. One staff member told us they felt they needed more training to make the experience worthwhile and this was being arranged. Staff told us they felt supported by the provider and manager and communication was very open.

Nutritional assessments were in place to identify where people may be a risk of malnutrition or dehydration and

Good

Is the service effective?

staff had a good understanding of people's dietary needs and preferences. People were positive about the food they received, they told us they had choices and enjoyed their meals. They also told us they had seen recent improvements in the food. Comments included, "The food is very good, we have a new head of catering who is excellent," and "There's a new chef, a nice chap, the meals have improved, there's more variety."

The chef had a good understanding of people's dietary needs such as diabetic or soft diets, and individual preferences. A visitor told us, their relative required a soft diet they said, "It's always prepared beautifully for her." People were able to choose where they ate their meals and we observed most people chose to eat in their rooms. The registered manager told us this was variable and dependant on how people felt each day. Some people's care plans informed staff where people would like to eat their meals. For example one care plan stated the person, "Felt more comfortable eating in their own room."

The mealtime was a pleasant social experience and staff made every effort to ensure that people could enjoy their meal and receive any help they needed. The dining area was not left unattended at any point during lunch. Tables were nicely set with condiments and placemats. Food was presented attractively with good portion sizes and those who wanted it were able to have a glass of wine. Staff asked people if they wanted any support and chatted to them while they were undertaking tasks. One person had a visual impairment; staff explained what was on their plate and asked if they required any support. The person asked for some more pepper and to eat with just a spoon, these were provided and the person was able to eat their meal. People were offered a choice of dessert but for those who did not want either of the choices staff suggested other alternatives that they knew the people liked. Hot drinks were served regularly throughout the day and after the meal.

People who ate in their rooms received their lunch in a timely manner, staff checked each room to see whether people had eaten or whether, for example, they had fallen asleep. We observed one person was supported to eat their meal and we observed the staff member engaged with the person throughout and at the person's own pace.

People were supported to maintain good health and received on-going healthcare support. People told us they were able to see a doctor if they needed to and health needs were addressed quickly to try to avoid deterioration. Comments included, "I've had the doctor out, they're lovely," and "The doctor comes in a lot." A visitor told us, "Any health problems are dealt with immediately, they'll call the doctor straightaway." Throughout the inspection we observed staff discussing people's ongoing health conditions. Where staff were concerned the doctor was contacted promptly for advice. Care plans showed people received support from other healthcare professionals for example a chiropodist regularly visited the home and people were supported to attend hospital appointments as they were needed. External healthcare professionals we spoke with told us staff provided good care to people and referred people to them appropriately and they acted on the advice given. This meant people received care and treatment from the appropriate healthcare professionals when they needed it.

Good

Is the service caring?

Our findings

People and their visitors spoke very highly of the caring and kind nature of the staff. They said there was a lot of respect and their dignity was maintained. People told us, "The carers are great, they're all good, they're very kind and helpful, they do so much for you." Other comments included, "I have every care I could wish for," and "The staff are fantastic."

Staff knew people well and treated them as individuals; they were able to tell us about their choices, personal histories and interests. People were involved in decisions about their day to day care and support and were able to decide what care and support they required. For example we observed staff asking people if they wanted to get up or would prefer longer in bed. We heard one staff member saying, "You stay there I'll come back later." Staff had encouraged one person to get up for a short while but then supported them to return to bed shortly afterwards. People told us they were free to follow their own interests and that they would be supported in that. They told us, "They wouldn't refuse anything you asked for." We observed people being cared for in an unhurried way.

Staff spoke to people in a warm, friendly and caring manner. It was clear they knew people well and spoke with them in a relaxed manner. We saw staff knocked on people's doors before entering. People confirmed this saying, "Staff always knock before they come in," and 'The staff are excellent, they tap on the door before they come in." People told us they were respected and their dignity was maintained. One person said, "They look after you well, I'm very happy about privacy and dignity here." A visitor told us, "Mum is treated with the utmost respect and kindness, they are so accommodating, I'm thrilled with the care. Her treatment is pure dignity, they honour her. I would so recommend this place because of the high quality of care and attention to detail."

Care plans informed staff how people liked to look. One care plan informed staff the person liked to look "Well presented." People were dressed in clean clothes, according to their individual tastes, and looked well kempt and well cared for. They told us the laundry service was good. A visitor told us their relatives clothes were, "Washed and ironed perfectly." One person said, "The laundry is excellent, it's lovely to get your clothes done for you." Both men and women had had their hair cut and styled and some women had chosen to have their nails polished. Staff told us about one person who was unwell. They explained this person liked to look "Immaculate" and they went on to say it was important this was maintained while the person was too unwell to attend to themselves. People's bedrooms had been personalised with items of their own furniture, pictures and ornaments. One person told us about their collection of ornaments which were displayed on their wall. This person enjoyed looking at and talking about these items.

People were encouraged to remain as independent as possible. Care plans showed, and staff told us, how they supported people. Enabling them for example to maintain their own personal hygiene with minimal support. People told us how they had become more independent since their health improved. One person said, "I wash and dress myself now." Another person told us how staff supported them to remain independent. They said, 'I go downstairs for lunch I walk down and they bring me back in a wheelchair, I try and get a walk everyday if I can."

People were supported to maintain and continue with their spiritual beliefs. One person said, "People from my church come and give me communion." Another person told us, "I'm a practising Christian and I have several visitors all connected with the church." We saw services were held at the home for those who wished to attend. We saw visitors were welcomed at the home. They were able to visit when they wished and were happy with the care their relative received.

A person who had lived at the home had recently passed away. We observed the registered manager in the dining area at the end of lunchtime. She told people quietly about the funeral arrangements for the person. She told people she planned to attend the funeral and arrange a time in the home on the same day when the person could be remembered. This was done in an open and sensitive way and gave people the opportunity to talk about the person who had passed away and who they clearly missed. This showed the registered manager had recognised that people would be missed by their friends in the home and allowed people a time to grieve and celebrate the person's life. This demonstrated that people received care from staff who know them well and respond to their individual needs in a caring and compassionate way.

Requires improvement

Is the service responsive?

Our findings

People told us they received care and support that met their needs and was personalised to their individual choices and preferences. They told us they were able to choose how they spent their day. People told us they were able to choose whether they spent time in their room or joined others in the lounge. They said they were involved in decisions about their day to day care.

People and visitors told us they were happy to raise complaints with the staff and knew they would be addressed. One person said, "I've never made one single complaint. But if I needed to I'd go straight to matron, she's so approachable." A visitor said, "Matron is lovely, I can always go straight to her if I have a problem, she'll listen, but then all the staff will too."

People received care which was personalised to reflect their needs and wishes because staff knew them well. People told us and we observed they were able to do whatever they wished during the day. We saw people getting up at times that suited them and spending time where they chose. Staff were updated about people's ongoing and changing needs when they came on duty and throughout the day. Staff told us communication was important to ensure people received the care they required.

Care records showed that when possible people or where appropriate their relatives were involved in care plans and care plan reviews. Throughout the inspection we observed staff talking to people's relatives updating them about any change in people's health or care needs. Staff saw this as an essential part of the care they provided. The care and support plans contained information about the needs of the individual. For example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and moving and handling had been completed. However, care plans were not personalised. There was information about people's care needs but not how they would like or required this to be provided. Care plans informed staff people required support with their personal hygiene but did not included details of the support. Some people required regular change of position to prevent pressure damage; care plans informed staff but did not describe how often this should be.

There were some areas where the information did not reflect the care and support people received. For example there was a fall risk assessment in place for one person however there was no care plan in place to provide guidance for staff. Another person had a wound on their leg, there were wound assessments in place which showed the treatment the person received but no care plan to inform staff what treatment was required and for example how often the dressing should be changed. In some care plans information was missing. One person had a detailed care plan in relation to their diabetes there was information for staff about what actions to take if the blood sugar level was too high or too low but there was no information about what the 'normal' level was for this person. Another person had difficulty swallowing and required their fluids to be thickened to reduce the risk of them choking however there was no information in the care plan about the consistency of the fluid.

When people's needs changed care plans were not always re-written, people's additional needs were written on the existing care plan. For example one person's care plan contained information about how staff could support the person to mobilise safely, this included the use of a mobility aid and appropriate footwear. The person's needs had changed and required the use of a hoist. This information had been added to the care plan but the previous information remained which may be confusing to staff. Not all information about people's care needs was in their care plans. We saw one person had lost weight and had been referred to a dietician. However, we saw this person had previously lost weight and there was no information about what action had been taken at that time. The registered manager told us people's medical information for example letters from people's doctors or dietician were stored in a separate folder however this information had not been included in the person's care plan. Some people had pressure relieving air mattresses in place and these must be set at the correct pressure to ensure optimum benefit. The pressure settings were checked daily however there was no guidance in the care plans or on the checklist about what the correct setting should be. The registered manager showed us the information was stored separately. There was no guidance to inform staff there was further information about people, which may be relevant and important. Whilst information about how to care and support people was available this was not always clearly documented or easy to find. Care

Requires improvement

Is the service responsive?

reviews took place but information was inconsistently recorded for example some staff had recorded the reviews on the care plans and others had recorded it in the evaluation part of the care plan. Although staff had a good understanding of people's individual needs the lack of clear documentation did not ensure people received consistent care or their needs were met.

We discussed our findings with the registered manager who told us they were aware of the issues. Staff had received training in relation to record keeping and person centred care planning and work had started to address these shortfalls. We identified these changes had not yet become embedded into practice and needed to be improved.

Activities staff recorded information about people's activities in a diary, this was not individual and did not reflect whether people had actively participated or enjoyed themselves. This is an area that needs to be improved.

There was an activities programme in place which people were able to join in with if they chose.

Some people were also happy with their own company and enjoyed their own pursuits, for example one person loved to read, another liked to listen to sport on the radio and some to watch TV. People told us they chose different group activities to get involved with when they wished. Comments included, "I go to the quiz on Fridays but don't join in with the other things," "There's plenty of things to do, an accordion player today, a pianist tomorrow," and "I do try and go to the activities it breaks the day up, then we have a cup of tea and a rather nice piece of cake." There was a library which the home shared with the supported living complex one person said, "The library here is excellent, there's all sorts of books and they're changed regularly."

The activities coordinators told us how they supported people who stayed in their rooms. They said even if people could not participate fully in some of the activities they would try to find a way of including people for example taking creative activities to people's own rooms and supporting them there. Activity staff told us they had information on people's past interests and skills. The provider had subscribed to a reminiscence newspaper, this was available to people in the lounge and copies provided for those who remained in their rooms. These would be used when talking to people to trigger memories or conversations. Both activities staff and care staff were responsible for ensuring people had enough to do and were able to participate in activities as they wished. Care staff spent time in the afternoons talking to people or playing games, for example dominoes. The registered manager had introduced the idea of evening activities. There were posters around the home to inform people of these. It included DVD's, reading and the opportunity to be introduced to other people at the home. It also reminded people snacks were available from the kitchen. As a result one person had invited a friend to come and play cards in the evening.

There was a complaints policy in place and we saw complaints that had been raised were dealt with appropriately in a timely way. People and their visitors said that they would have no hesitation in raising concerns or complaints. They said that the staff, and in particular the registered manager were very approachable and would help to resolve any issues. People told us, "'I'm happy to raise any problem. I speak to my key nurse about anything I need to or else go to matron, she's very approachable." People told us when they had made complaints these had been addressed and resolved to their satisfaction.

Good

Is the service well-led?

Our findings

People described the atmosphere in the home as, "Very happy', Homely" and "Friendly". People said: "I can honestly say I thoroughly enjoy it here, I'm lucky," "Everything I want I have." A visitor told us "It's absolutely fantastic." People knew who the registered manager was by name and all felt that she was eminently approachable and available to them. One person said, "She is lovely, very friendly, you'd never be frightened to talk to her; she's not a bit starchy." The registered manager clearly knew each person very well. Her plans for the future centred on improving people's experiences and making the home more homely. She clearly focused on individuals. We observed a lot of laughter and banter between staff and people as staff went about their work.

The registered manager had identified the systems in place for monitoring the management and quality of the home were not always effective therefore she was introducing new systems. She told us it was important any audit had a purpose and made sense to ensure it could identify where improvements were needed. Through the audit system and her own knowledge of the home the registered manager and provider had identified areas where improvements were required. There was an action plan in place and we saw areas where action had taken place and other areas where improvements were ongoing. Some areas had been addressed for example staff had received training and updates to ensure they had the appropriate knowledge and skills to look after people. Other areas, particularly in relation to record keeping, policies and developing a new fire evacuation procedure were still being addressed.

There was an open culture at the home and this was promoted by the registered manager who was visible and approachable. There was a clear management structure and staff were aware of the line of accountability and who to contact in the event of any emergency or concerns.

It was clear she knew people, staff and visitors well and everybody was happy to approach her and discuss any concerns. She was seen as approachable and supportive and took an active role in the day to day running of the home. People appeared very comfortable and relaxed with her and people were observed to approach her freely. Staff told us said they felt well supported within their roles and the registered manager was focussed on improving the service for people. One staff member told us, "She knows what she wants and goes for it, it's lovely knowing she wants what we want for people." The registered manager had a clear vision for developing and improving the service for people. This involved working with other organisations and included the supported living accommodation adjoin the home.

The registered manager had introduced new ideas where potential concerns had been identified. For example she had identified on occasions when people were coming out of the kitchen or the lounge there was a risk of colliding with others in the corridors. Therefore she had introduced a 'near miss' book where staff recorded any occasions where an incident almost occurred. These were then reviewed to identify if any action was required to prevent an incident happening.

People, their relatives and the staff were involved in developing and improving the service. We saw a recent survey which had been sent to staff, people and their relatives. Where individual concerns had been raised through the survey we saw the registered manager had responded to these individually. There were regular staff and resident meetings. Following a resident meeting the registered manager spoke to each individual who had not attended to gain their feedback and ideas. Staff told us they were happy to make suggestions and know they would be listened to. The registered manager had identified that surveys were not always the best way to gain feedback from people. Therefore she had introduced a monthly 'Tea with matron' activity. During this time she sat with people and chatted about what was happening at the home, what ideas people had and any concerns they may have. Staff and people told us this was very successful and it was something people enjoyed.