The Augustinian Nursing Sisters

The Augustinian Nursing Sisters Ince Blundell Hall

Inspection report

Ince Blundell Hall
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Date of inspection visit:
06 September 2017
07 September 2017

Date of publication:
13 October 2017

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

Ince Blundell Hall provides accommodation, support and nursing care for up to 22 people. The service is owned and managed by the Augustinian Nursing Sisters, several of whom have lived and worked in the service for many years. The service admits people for long term care but also offers short term support for people who require respite care.

This inspection was carried out over two days on 6 and 7 September 2017 and was unannounced.

At the last inspection in June 2016 we found the service in breach of three regulations the service was given a quality rating of 'Requires improvement'. We followed this up in November 2016 and found improvements had been made and all three breaches were met. The service remained 'Requires improvement' as we needed to ensure consistency would be maintained.

At this inspection we found consistent standards were being maintained, although there had been a recent change in the leadership of the home.

There was a new manager in post who had commenced working at the home two months prior to our inspection. The previous registered manager had left in June 2017. The manager was yet to register with the Commission (CQC). 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.

We found medicines were being safely managed. The administration records for some medicines such as external applications [creams] and prescribed 'thickeners' for drinks (for people with swallowing difficulties) could be further improved.

We looked at how staff were recruited and the processes to ensure staff were suitable to work at Ince Blundell Hall. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.

We found there were sufficient staff on duty to meet people's care needs.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training in-house. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety checks were completed on a regular basis so hazards could be identified. Maintenance was assessed and planned well so that people were living in a comfortable and safe environment.

The home was clean and there were systems in place to manage the control of infection.

Staff said they were supported through induction, appraisal and the home's training programme.

We found the home supported people very well to provide effective outcomes for their health and wellbeing. We saw there was regular and effective referral and liaison with health care professionals when needed to support people. Feedback from visiting health care professionals we spoke with was positive.

People we spoke with said they were happy living at Ince Blundell Hall. Staff interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people. We found a caring ethos throughout the service.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made. People felt involved in their care and there was evidence in the care files to show how people had been included in key decisions.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the managers of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice. Lunch time was seen to be a relaxed and sociable occasion.

There were limited social activities organised for people although most people did not see this as an issue. The home had employed an activities organiser who was starting work shortly.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. There were no complaints recorded in the past year.

The manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management systems continued to be developed in line with good practice.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

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.

Medicines were administered safely. Some administration records could be better developed and this was being considered.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

The home was clean and there were systems in place to manage the control of infection.

Is the service effective?

Good

The service was effective.

Staff told us they were supported through induction, appraisal and the home's training programme.

We found the service supported people to provide effective outcomes for their health and wellbeing.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

Staff displayed reassuring and effective communication when interacting with people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and monitoring of people's care evidenced an individual approach to care.

Social activities for people continued to be developed.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain.

Is the service well-led?

Good

The service was well led.

There was a new manager in post who provided an effective lead for the home and who had developed a positive culture of care in the home. The manager was in the process of applying for registration.

The vision and values of the service were strongly evidenced through the homes literature including the Statement of Purpose.

The managers were able to evidence a range of quality assurance processes and audits carried out at the home.

The Augustinian Nursing Sisters Ince Blundell Hall

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 checked whether the provider was 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 which took place over two days on 6 and 7 September 2017. The inspection team consisted of two adult social care 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.

Prior to the inspection we collated information we had about the service and contacted the local authority contracting team to get their opinions. We also reviewed other information we held about the home.

We were able to access and review the Provider Information Return (PIR) as the previous registered manager sent this to us as part of the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with six visiting family members. We spoke with eight of the staff working at the home including care/support staff and the Nominated Individual (senior manager) for the provider. The newly appointed manager was not present for the inspection as they were on leave.

We looked at the care records for four of the people staying at the home as well as medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and

the dining/lounge areas.

Good

Is the service safe?

Our findings

We spoke with people about whether they felt safe living at the home. People said they felt safe and comments included; "For my requirements, everything is perfect and I feel perfectly safe here", "I can't really complain about anything, including safety. Everything's very safe and secure here. I get help with a bath or shower to make sure I don't fall or anything", "I'm in safe hands, yes", "Without a doubt I feel safe" and "It's very safe here; everyone's so quiet and calm."

We looked at how medicines were managed at the service. We found medicines were managed safely. There was a new electronic administration of medicines system in operation. All staff administering medicines had received training on this system. Staff told us the system had many positive advantages in ensuring correct and safe administration. Prompts and warning messages indicated any precautions to be taken; for example in the timing of administration of paracetamol.

The system recorded the administration of external medicines such as creams and prescribed substances such as 'thickeners' for drinks; the latter used to thicken the consistency of drinks for people who had difficulty swallowing. The system recorded these medicines as given but only by nursing staff rather than the care staff who were actually applying the cream or making the drinks for people. The nominated individual for the service advised a recording system [cream charts and recording on fluid charts] would be used to record which staff administered these prescribed substances. Following the inspection we had confirmation these were now in use.

We asked what auditing mechanisms were in place to check if medication was being administered safely. Regular audits were being carried out by the manager. We saw audits of medicines in stock carried out weekly as well as monthly routine checks of all medicines when they were being 'signed' in when received. A weekly check of controlled drugs (CDs) was also made. Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

The nominated individual told us the new manager for the service was continuing to develop auditing processes in the home and would develop an overall medicines audit to compliment the audits undertaken by the supplying pharmacist to include other areas such as storage and policy development.

A number of medicines were prescribed as 'when required' (PRN). A record was kept of PRN medicines and staff were following protocols for PRN medicines. For example, when to give a PRN medicine and the duration. We found the PRN information included in the general care planning documentation and this was therefore not immediately accessible for staff when administered medicines. Nursing staff we spoke with said they would include this information in a separate care plan which would be accessible at the medication administration round. This information is important to help ensure consistent administration of PRN medicines.

People told us they got their medicines on time. Comments made included, "They have a regular round of

medicines and I don't think I ever miss out, "Yes, oh yes – always" and "Yes, and when I need pain relief I only have to ask for it."

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three files of staff employed and asked the nominated individual for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been completed. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We asked people if they thought there were enough staff on duty at all times to support everyone appropriately. Everybody asked these questions said they were satisfied with staffing levels and didn't feel they normally had to wait very long for support. Comments made included, "There's always someone, you just have to ring the bell. You don't wait long" and "They're very efficient here, so nobody is ever in need for very long." Most people said assistance and support was readily available but some commented on delays in staff response; these comments were related to the provision of call bells in the home rather than there not being enough staff.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was stable. One staff told us, "We all get on well and there's enough staff. The new manager is really good and supports us well." On the days of our inspections we saw there were two nurses and six care staff for to care for 16 people resident at the time. Duty rotas confirmed these numbers were consistent. Sometimes a senior carer would replace a nurse on one of the floors; there was always a nurse on duty. The nominated individual was also a daily presence in the home and the manager was also supernumerary to these staffing numbers.

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw comprehensive records of all of the routine environmental checks made in the home.

People described the way in which they used walking frames and wheelchairs to get about, often with staff support, and how these enabled them to do so safely. The lounges and dining areas were spacious enough to allow people to move unhindered, with or without support. Some grab rails were available in bathrooms, and lifting/support equipment was evident in bathrooms.

There was fire equipment in all areas and we saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home. This helps to ensure effective evacuation of the home in case of an emergency.

All areas were brightly lit by both natural and artificial lighting and had no deeply shadowed areas; some bathrooms/WCs were lit automatically on entry. The gardens were large and open to view from one side of the house. They could be reached via an exit with a ramp and had wide, flat pathways, sheltered areas and supportive seating; plants were safe to touch. A dedicated smoking room was available, although currently unused.

All maintenance / safety certificates were up to date and we saw records indicating when these needed updating. Overall there was good attention to ensuring safety in the home and on-going maintenance.

The staff we spoke with described how they would recognise abuse and the action they would take to

ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. There had been no reports of safeguarding concerns since the last inspection.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. There were no unpleasant odours. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. All shared bathrooms/WCs were very clean and appropriately equipped for hand washing, other than one, which had no soap or towels, and another that had a cloth hand towel rather than paper towels. We raised this with staff to address. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state.

Good

Is the service effective?

Our findings

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. People said, "I know [carer] very well and they know me; they know exactly how to help me and I trust them with that", "If there's anybody who's a bit new, they take a week or two to get used to things but the experienced ones help and so do we; there's never a problem with them knowing what they're doing", "My skin is perfect [in spite of medical condition] – no bed sores or anything like that – and that's down to proper nursing care", "They're hoisting [person] and they seem to know what they're doing; they're getting used to [person]" and "[Staff] seem very competent."

The Provider Information Return (PIR) sent to us before the inspection told us, 'We ensure that all staff have relevant training and skills sets to carry out their duty and provide the right care for the residents. We have on-going training and the opportunity for staff to develop their skills by doing an NVQ level 2 or 3 should this be crucial to their role'. We saw that a high percentage of staff had achieved formal qualifications at Level 2 or above NVQ or Diploma in Health and Social Care (16 in total). Some senior care staff had been given extra training in medication administration. We saw this had been well monitored and staff administering medication had also been assessed for their competency to deliver safe standards. This shows a good base of staff knowledge to help ensure effective care for people.

All of the staff we spoke with confirmed they felt supported by the homes training programme. One staff commented, "I feel very supported by management and staff since I started working here." Another staff member told us, "All my training is up to date – most staff had update training in March (2017) and we covered everything." Another staff member told us about their induction when they started work, "Induction was two weeks long. Covered absolutely everything. It was like two weeks of school." The staff member shadowed another senior staff for the first few weeks.
They also completed infection control training consisting of a 90 minute lecture and concluded with an assessment.

We looked at three staff files and these included copies of training certificates covering many aspects of care including safeguarding, moving and handling, medication administration and infection control. The nominated individual told us that the training was cross referenced to the standards in the Care Certificate which is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff support included supervision meetings conducted by the manager with individual staff. Staff we spoke with felt they were fully supported by the manager and could speak with the manager and other senior members of the staff team at any time.

During our inspection we reviewed the care of three people living at the home. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. One person we reviewed had experienced changing care needs over a space of time and these changes had been monitored by staff in liaison with the person's GP and other health professionals. We saw that all three

people were subject to regular, three monthly, reviews of their care which involved a GP review and included a review of medication.

Staff had sought advice from other external health care professionals to help oversee people's health and wellbeing or if there had been a change in a person's condition. This advice had been sought at the appropriate time and their guidance followed. For example, we saw staff were working with a nurse practitioner who was assessing a person for continued health care funding as their care needs had changed. The assessor told us staff were knowledgeable with the information provided and supporting documentation was very clear and precise.

We spoke with another visiting health care professional. They gave positive feedback regarding the care in the home and how well staff responded to any instructions or recommendations for care. We were told, "The staff are very good and will always carry out any instructions we leave."

We looked to see if the service was working within the legal framework of 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. 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).

None of the people in the home at the time of the inspection were under a DoLS authorisation. The nominated individual and nursing staff understood the criteria for applying for a DoLS authorisation.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. In one example a person with varying levels of mental capacity had previously been assessed regarding the need to administered medicines 'covertly' [without their knowledge or consent in their best interest]. We saw assessments and documentation which supported good practice in this area and made use of mental capacity assessments with good supporting care plans and liaison with health and social care professionals. The staff showed a clear understanding of the process involved in making a best interest decision for a person who lacked mental capacity.

Other examples included care files showing were people had consented to their plan of care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members].

We ate lunch with some of the people living at Ince Blundell. The dining room was an extremely pleasant place to eat, with large windows and views across the gardens. The tables all had one central leg, to support accessibility, and were circular, which promoted social interactions between people. All chairs were comfortable and provided safe support. All tables had been laid with a high level of attention to detail – cloths, place mats and napkins and attractive domestic cutlery and crockery.

The food served at the three-course lunch was very good and offered a choice of main course. A bowl of fresh fruit, and cheese and biscuits, were on each table for people to eat as they wished e.g. whilst waiting to be served or in place of starter/pudding. Drinks were available and offered during and at the end of the meal.

Everybody was served by the staff on duty, to differing degrees. Any support given was offered politely and sensitively. For example, a carer noticing that someone was eating with an inappropriate piece of cutlery intervened by offering a different piece without any other comment. Another person was given encouragement to start eating and then allowed to continue without support once it was apparent they were managing independently.

The meal was evidently a source of enjoyment and to some extent a social event by the majority of people. Several people chatted throughout, together and with me, and passed positive comments on the food they were eating and in general.

People were offered their meals in their rooms; these people were also supported appropriately.

We spoke with the chef, who explained records of people's needs and preferences were made daily by carers and shared with the kitchen each morning. A small number of people had more specific dietary needs; these were known to kitchen staff.

People commented; "I've no complaints at all. I'd say there's a good choice", "We get drinks two or three times in the day. The food's very, very good. I enjoy my meals" and "[The food is] perfect – that was a lovely cup of tea."

Ince Bludell Hall provides a relaxing and peaceful environment for people. We saw some positive adaptations to support people with disability. For example, colour schemes provided contrast between key aspects of corridors and bathrooms/WCs, supporting people with vision/cognition difficulties and the main garden was attractive and inviting, and easily accessible from the ground floor.

We did note that there was very little signage that would support people with finding their way or re-orientating themselves if they became confused or lost. There were also very few signs on doors indicating what the rooms were, other than bathrooms/WCs. This included people's own room doors, which carried numbers but no names.

Good

Is the service caring?

Our findings

We observed staff to be, without exception, very pleasant and to speak kindly and courteously to people when offering or giving support, or when serving food and drinks. Relationships were evidently good between everyone living and working at the home.

People told us; "I love it here – the staff are wonderful, all of them. Yes [they know me well] and that means they don't impose on me when I don't want support", "It's nice that they treat you like a friend and not just a patient. They're very accommodating; they know your likes and dislikes and don't impose anything on you" and "They're wonderful. Very kind indeed." A vising relative commented, "Excellent; that's one of the main reasons I chose Ince Blundell. To me the most important thing is that people are nice to [person]."

People who could mobilise independently were able to do so without unreasonable restriction. People's independence was also promoted through the provision of adapted cups at meal times for example. Several people had walking aids to hand, and we heard a carer explicitly reminding one person to use theirs.

In general we were told staff try and help people to be as independent as possible, "I have two sticks and I'm okay [getting around the home]. I do have help with showers - a fellow came to help me the other day" and "I use my walker to get about; I can go through to the conservatory on my own and have a walk outside. They [staff] are quite happy to let me do what I want, really."

The home was welcoming to visitors for example there were quiet seating areas throughout the home and drinks/biscuits provided. We saw very positive interactions between people and staff throughout the day, whenever support was being offered or provided. We also saw some staff taking opportunities between tasks to socialise/interact with people; for example, a carer seated themselves where one person was sitting alone in one of the seating areas, and engaged them in conversation; they were then joined by two other people.

We asked whether people's privacy was respected. We saw staff knocking on people's doors before entering and, as necessary, opening the door slightly to check they had permission to enter. One person said, "They're discreet – they wouldn't barge in if they thought you were getting dressed or something."

When we spoke with staff they came across as caring and interested in their work. Staff were knowledgeable regarding the people they supported.

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process; this was evident through signed consent forms and records of discussion with people and families.

We saw that people had access to advocacy support if needed. Leaflets and information were displayed regarding the local advocacy services. There were no people using this service at the time of the inspection but staff were able to give past examples; one person was engaged with the local advocacy support service

and was getting support regarding their finances.

Good

Is the service responsive?

Our findings

We asked people how staff knew what they liked/disliked, or about their interests, and if they could choose what they wanted to do, such as activities, life choices, people they want to be with. People told us they were able to make daily choices. They said they could choose how and where they wished to spend their day and what time to get up and retire at night. The home was very spacious and people were free to spend time in a number of areas including the extensive grounds.

People also told us they had a choice about their care staff; "Yes, you just ask; they're very, very good. I'm free to say no to males", "Not fussy [about who gives support] – it can be a man or a woman. It can be embarrassing either way but you're a person who needs attention...it's very nice, really" and "As far as I know, you can state a preference [for male/female carer] if you wish to."

Care records were completed and included personalised information about people such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs in more detail. These records, along with staff's daily written evaluation and notes meant care files contained important information about the person as an individual and their particular health and care needs.

Staff were aware of the importance of these records for monitoring people's health and welfare. We looked at a sample of these records and they were kept up to date by the care staff. For one person there was particular attention paid to fluid intake as the person had a urinary catheter which was important to monitor. We saw that daily care records recorded this carefully. There was good supporting documentation and records regarding the management of the person's catheter.

We saw care plans were regularly reviewed and people were consulted periodically about their care.

We asked what sorts of things the home provided to keep people interested, active or involved.

The PIR told us; 'Over the coming 12 months, there are going to be more activities devised. An activities co-ordinator will be working closely with myself and the residents to ensure that more activities are laid out in order to offer more variety and choice for residents'.

The nominated individual told us that the home were between activities coordinators and a new one was in the process of being employed and would start shortly.

There were no activities provided by staff to keep people stimulated or active at the time of the inspection, although the setting of the home itself, and the thoughtful provision and placing of outdoor and indoor seating (including in the lounge), promoted socialisation and conversation. The majority of people said they

were quite happy and didn't wish for any activities to be provided, whereas visitors asked about this said they would like to see more.

People we spoke to told us, "I go for a walk in the garden when [name] comes and I read my paper", "I listen to talking books and the radio, and I can walk in the grounds. I'm quite happy with that", "Not interested in 'activities'. I do like to go into the gardens if it's a nice day and if someone is around to push me round – I give them [carers] a heavy hint and they wouldn't dream of refusing you. There's a table with a shade we can all sit round and there's the conservatory", "I think there should be more activities and I think they [people] should be encouraged to mix more" and "I know they [the home] have tried it [getting people to socialise after Mass] and afternoon tea as well. People like to go to their own rooms; it's a preference thing."

People had access to a complaints procedure and this was available to people within the home. A person said, "I'd ask for the manager. I have only had to do so just the once, and it seemed to be dealt with properly." Another person said, "I had to draw something to staff's attention once previously [incident was described] and it has never happened since. I am aware of the complaints policy, yes. It's on a board somewhere here."

A system was in place to record and monitor complaints. There had been no recorded complaints since the last inspection.

Good

Is the service well-led?

Our findings

There had been a change in management of the home since our last inspection. The previous registered manager had left in June 2017 and a new manager had been appointed in July 2017. The new manager was applying for registration with the Care Quality Commission.

The new manager was not available at our inspection as they were on leave. We spent time with the nominated individual for the provider and senior staff in the home who were able to espouse a positive ethos of care in the home. The feedback from all of the people we spoke with as well as staff was that the new manager was providing positive leadership as well as good clinical skills and a solid knowledge base. The manager was described as supportive, open and consistent. The nominated individual also demonstrated a willingness to develop standards in the home and we saw they could reflect positively on the feedback we gave throughout the inspection.

We saw the homes philosophy was clear in some of the literature available for people; 'We hope our friendliness and approachability will allay any fears and enable our residents to settle into their new home happily and with confidence'. This philosophy was supported by the comments we received from people who told us how they found the atmosphere in the home friendly and relaxed. One person said, "It's very peaceful." Two other people commented, "Very loving and very calm" and "Quiet, peaceful, caring."

There was a clear management structure for the service from the providers (Trustees), senior managers (nominated individual) and (registered) manager. We were advised that, as part of further development of the management structure, a deputy manager was also being considered.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety, infection control [hand hygiene], accidents and falls, maintenance of equipment and routine checks for health and safety regarding the environment such as fire safety. The new manager had identified further developments needed and had, for example, contacted infection control professionals to develop an improved audit.

Members of the Board of Trustees also regularly visited the home. We were told these visits concentrated on speaking with people at the home and providing any feedback to the manager. There were no records of these visits and we discussed how a written report of the visit[s] could provide evidence of valuable feedback for the manager and link in with the overall quality assurance process. The manager of the home provided a report for the regular Trustee Board meetings.

We saw a series of surveys and meetings aimed at seeking feedback about the home from people living at the home and their relatives. A survey in May 2017 returned positive comments about the home and a high satisfaction rating. The feedback included positive comments regarding the 'relaxed atmosphere' and 'respect for each resident'. A resident meeting held in February 2017 was minuted and included discussion around recruitment of staff, standard of care and developing activities. The need for an activity coordinator had arisen as an action point and was currently being actioned. The manager had stated these meetings

would be more regular; at least monthly.

The manager was aware of their responsibility to notify CQC of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC rating. The rating from the previous inspection for Ince Blundell Hall was displayed for people to see.