HC-One Limited

Richmond House

Inspection report

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15 April 2019

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:

Richmond House is registered to provide accommodation with care and nursing support for up to 49 people. Several of the bedrooms are for use by people requiring intermediate care and support for a short period of time. The home is set within its own grounds with car parking facilities. The home is operated by HC-One Limited and is located in the Wigan area of Leigh.

People's experience of using this service:

We carried out this comprehensive inspection on 10 and 15 April 2019. At the time of the inspection there were 47 people living at the home, with 37 people receiving nursing care and 10 people receiving intermediate care. Intermediate care services provide support for a short time to help people recover and increase independence. It can also reduce the chances of people having to go in to hospital.

The service was extremely well-led. We received positive feedback from everybody we spoke with about management and leadership within the home.

The staff team spoke highly of the leadership at the home and said they felt supported in their roles.

The home and registered manager had won a number of awards where the exceptional leadership had been recognised, particular regarding End of Life Care.

The home had been invited to be involved in a number of 'Pilot' initiatives in the local area.

People said they felt safe living at the home, with staff demonstrating a good understanding about how to protect people from the risk of harm.

Staff were recruited safely, with appropriate checks carried out to ensure there were no risks presented to people using the service.

Maintenance checks of the premises and the servicing of equipment was carried out throughout the year to ensure they were safe to use.

There were enough staff to care for people safely and the staff we spoke with told us they felt staffing levels were sufficient.

People received their medication safely.

Accidents and incidents were closely monitored, with regular trends analysis carried out to ensure any re-

occurring themes could be identified in a timely way.

People's mental capacity was kept under review and deprivation of liberty safeguards (DoLS) applications were submitted to the local authority as required.

Staff received the necessary training and support to help them in their roles. Staff supervisions and appraisals were carried out and gave staff the opportunity to discuss their work.

People told us they liked the food available and we saw staff supporting people at meal times, if this was something they needed help with. Where people needed modified diets due to having swallowing difficulties, these were provided.

People living at the home and visiting relatives made positive comments about the care provided at the home. The feedback we received from people we spoke with was that staff were kind and caring towards people.

People said they felt treated with dignity and respect and that staff promoted their independence as required.

Complaints were handled appropriately. Compliments were also maintained about the quality of service provided.

There were a range of activities available for people to participate in, both in and out of the service.

For more details please see the full report either below or on the CQC website at www.cqc.org.uk

Rating at last inspection:

Our last inspection of Richmond House was in August 2016. The overall rating at that inspection was 'Good', with no regulatory breaches identified. The report was published in October 2016.

Why we inspected:

This inspection was carried out to check people who lived at Richmond House were still receiving a 'Good' level of care and support and to check that regulatory requirements were still being met.

Follow up:

We will continue to monitor information and intelligence we receive about the home to ensure good quality care is provided to people. We will return to re-inspect in line with our inspection timescales for 'Good' rated services, however if any further information of concern is received, we may inspect sooner.

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

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 remained Safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service remained Effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service remained Caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service remained Responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was exceptionally well-led. Details are in our Well-Led findings below.	**Outstanding** ☆

Richmond House

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

Inspection team:

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC) and an expert by experience. Our expert by experience had personal experience of caring for or living with people with care needs similar to those living at Richmond House.

Service and service type:

Richmond House 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The first day of the inspection was unannounced. This meant the service did not know we would be visiting on this day. However, we informed the registered manager we would be returning for a second day to complete the inspection and announced this in advance.

What we did:

Prior to the inspection we reviewed information and evidence we already held about the home, which had been collected via our ongoing monitoring of care services. This included notifications sent to us by the home. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also asked for feedback from the local authority and professionals who worked closely with the home. The feedback we received was positive.

During the inspection we spoke with the registered manager, seven care staff (from both the day and night shift), two nurses, one nursing assistant, 12 people living at the home, two visiting relatives and two visiting healthcare professionals.

We reviewed four care plans, four staff personnel files, six medicine administration records (MAR) and other records about the management of the home, to help inform our inspection judgements about the service.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse

● People living at the home and relatives told us they felt the home was a safe place to live. One person said, "I know people are around and there are people to help me if I need it". Another person added, "Just the environment makes it safe and it's secure, a locked building."

● Staff spoken with confirmed they had received training in safeguarding and were able to describe the different types of abuse that could occur and how to report concerns. Staff also told us they were aware of whistleblowing procedures and said they would not be afraid to report any poor practices if witnessed. A log of safeguarding incidents which had occurred within the home was maintained, with copies of any strategy meeting or case conference minutes available.

Assessing risk, safety monitoring and management

● Each person living at the home had their own risk assessment in place covering areas such as mobility, falls, skin care and nutrition. Where risks were identified, there were details about how they needed to be mitigated. Personal emergency evacuation plans (PEEP) were completed for each person and provided details about people's evacuation needs in an emergency.

● People at risk of skin breakdown had appropriate equipment in place such as pressure relieving cushions and mattresses. Relevant professionals were also involved as necessary, such as district and tissue viability nurses. Records were also maintained by staff when they helped people to change position in bed to relieve the pressure on their skin.

● People with reduced mobility had relevant equipment in place such as wheelchairs and walking frames. People were wearing appropriate footwear which would help them to walk in a safe way. Hoists were used for any transfers where staff were unable to do this safely on their own and we saw staff explaining to people exactly what they were doing when using the hoist, which kept them calm. Where people spent time in bed and may be at risk of falling out, bed rails were in use. Crash mats were also used on people's floors so that if they did fall from bed, the risk of injury would be reduced.

●We looked at how the premises were being maintained. Safety certificates were in place and up to date for areas such as gas safety, electrical installation, emergency lighting, firefighting equipment, fire alarms and legionella. We checked people's bedroom windows and saw they were fitted with window restrictors to reduce the risk of people falling out or attempting to leave the building in an unsafe way.

Staffing and recruitment

● Enough staff had been deployed to safely meet people's needs. Staffing levels consisted of 10 staff during the day and six at night (a combination of both nurses and care staff). A dependency tool was used, and this determined how many staff were required based on people's care needs. Staff told us they felt people's care was never compromised as a result of low staffing levels at the home. One member of staff said, "Sometimes we get staff sickness, but that is usually covered quickly. When we have everybody in, there are enough staff. "Another member of staff said, "We work well together as a team and I feel there are enough staff. We never struggle to get things done."

●Staff were recruited safely, and we found all relevant checks had been carried out prior to them commencing their employment. This included completing application forms, attending interviews, ensuring written references were provided from previous employers and carrying out disclosure barring service (DBS) checks. Where any concerns were identified as part of the recruitment process, risk assessments had been put in place, demonstrating how any risks would be managed.

●People living at the home had also been involved with the recruitment process of new staff and had been able to ask questions during the interviews.

Using medicines safely

● We found people's medication was administered, recorded and stored safely. Medicines were stored securely in a locked treatment room which could only be accessed by staff. People's medication administration records (MAR) were completed accurately.. We observed staff giving people their medication during the inspection and explaining the reasons it needed to be given if people were unsure.

● Staff had received training regarding medication and displayed a good understand about how to ensure people received their medicines safely. Staff competency assessments were completed to ensure staff had the correct skills and knowledge.

● A medicines fridge was available to help keep medicines at the correct temperature. Controlled drugs were in use and staff carried out a stock check to ensure all controlled drugs could be accounted for. These were signed for by two staff when administered to confirm they had been given.

Preventing and controlling infection

● We found the home was clean and free from odours with robust infection control and cleaning processes in place. Bathrooms and toilets contained hand washing guidance, along with liquid soap and paper towels. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons, to minimise the spread of infection. We observed domestic staff cleaning the home throughout the day and ensuring peoples bedrooms were fresh and tidy.

Learning lessons when things go wrong

● Systems were in place for when things went wrong. Accidents and incidents were monitored closely, with details recorded about actions taken to prevent re-occurrence.

● Following a coroners inquest, where the home had been challenged about providing the correct seating to

a person, a new system had been implemented where a photograph of each piece of seating was taken to ensure it was working correctly and safe to use. People living at the home and relatives had provided feedback that this gave them an increased feeling of safety.

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

People's outcomes were consistently good, and people's feedback confirmed this.

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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

● Staff confirmed training had been provided in MCA and DoLS and demonstrated a good understanding about when DoLS applications needed to be made and when any decisions needed to be taken in people's best interests.

● DoLS applications had been submitted where required, such as if people had been assessed as lacking the capacity to consent to their care and treatment. Mental capacity assessments were undertaken and were decision specific about people's abilities to make their own choices regarding their care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The care and support people needed to receive from staff had been captured as part of the admission process and was recorded within their care plans. Reviews of people's care took place and involved people's families where necessary.

● Life story documents had been completed and provided information of importance about people from before they moved into the home.

● Care documentation explained people's choices and how they wished to be cared for and supported. People and relatives we spoke with, said they were consulted about the care provided and felt involved.

Staff support: induction, training, skills and experience

● Staff completed regular training to ensure they had the knowledge, skills and support to carry out their

roles and these records were detailed on the training matrix. An induction programme was provided when staff first commenced employment to ensure they had a thorough understanding of what was required within their role. The induction was based around the care certificate which is used if staff had not worked in a care job previously and must be used by care providers.

● Additional training had also been provided in areas such as venepuncture. This enabled people to have venous samples obtained at the home rather than in hospital. This is a diagnostic procedure used to insert a catheter into a specific vein and remove blood samples for laboratory analysis.

● NVQs were also provided up to level five and this enabled staff and in particular nursing assistants to increase their competency in areas such as monitoring insulin levels and setting up PEG feeds. The care assistant development programme had also been completed by four senior care assistants and enabled them to develop in their roles and become nursing assistants. This had been undertaken by the now deputy manager, who had started their career as a care assistant.

● Staff spoke positively of the training provided and said enough was available to help them in their role.

● Staff supervisions and appraisals were carried out and gave staff the opportunity to discuss their work. Staff told us these took place consistently and were a good opportunity to discuss their work and any concerns.

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

● People and relatives we spoke with were complimentary about the meals provided. One person said, "It's good. I've got plenty of options and they never run out of choices." Another person said, "You can always tell them what you don't want and they'll find you something else. You can either have the set menu or pick something from the other."

● Staff supported people to eat and drink at meal times, as required. Other people were able to eat independently, and this was something that was promoted by staff.

● We saw people received food and drink of the correct consistency, such as fork mashable, when they had been assessed as being at risk of choking and aspiration. Staff were aware which people were at risk and the recommendations they needed to follow.

● People's weight was regularly monitored. Where people had lost weight, we saw they had been appropriately referred to other health care professionals, such as the dietician service for further advice.

● The home had two separate dining rooms (up and downstairs) and we observed the meal time experience in each. Tables were set in advance of the meal and people had access to any condiments and cutlery they required. People were offered the choice of what they would like to eat and were asked if they would like second helpings once they had finished.

● People's fluid intake records showed high levels of fluids were consumed by people. During the inspection, we spoke with several people in their bedrooms and noted they had large jugs of water to help themselves stay hydrated.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live

healthier lives, access healthcare services and support

● People had access to a range of medical and healthcare services, with support to make and attend appointments provided by the home. The home had recently registered with Leigh family practice and they visited the home each week to check on people's health and existing medical conditions.

● Other professionals, including district nurses, podiatrists and opticians regularly visited the home to assist people with their care and offer advice.

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

● When walking around the home, it was not always easy to identify which people were living in which bedrooms. This was because the bedrooms were not always numbered and people's names and photographs were not displayed on the door. The registered manager told us they had previously been advised to take these down by other health professionals who visited the home.

● We recommend this is something the home explores further ahead of our next inspection

Ensuring consent to care and treatment in line with law and guidance

● People had been able to give written consent where possible and this was recorded in their care plan. Where people were unable to give their own consent, this was done by relatives who acted in their best interests.

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

People were supported and treated with dignity and respect; and involved in their care

Ensuring people are well treated and supported; respecting equality and diversity

● People and their relatives spoke positively about the standard of care provided and that staff treated people well. Staff were described as being kind, caring and considerate. One person living at the home said, "The care I get here is brilliant." Another person said, "Great, brilliant, they're kind hearted. I love it here they always take me to the cemetery on the anniversary of my dad's death". A third person also told us, "I am treated very well and they are very kind."

● Staff were observed to be kind, caring and patient in their interaction with people, taking time to engage in conversation and share a laugh and a joke with people, which showed the positive relationships they had formed. We observed staff sitting with people quietly in the lounge area, or helping them to walk around the building safely.

● People looked well cared for, were clean and were wearing clean clothes. People's hair had been brushed and their finger nails were trimmed and clean. Staff maintained records of when people's personal care had been attended to. Several people living at the home liked to have their hair washed and trimmed regularly and we observed people being supported to use the homes hair salon during the inspection.

●People's equality, diversity and human rights needs were taken into account and recorded in their care plan. Staff told us people would be treated equally regardless of their age, gender, race and religious beliefs. Several people living at the home and staff had attended Wigan Gay pride which demonstrated the homes commitment to inclusion, diversity and equality.

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

● People said they felt involved in the care they received and were given the opportunity to be involved in decisions made about the home. One of the homes lounge areas had previously been refurbished and people had been shown samples of the wall paper, so they could make choices about the colours used in the room. Another person's bedroom had been decorated following consultation with the maintenance person. One relative said, "They discuss the care plan with us every few months which is good."

● Resident meetings were held so that people could express their views about the care and support they received. People told us they could raise any issues of concern and felt listened to. Following feedback from relatives and people living at the home, the frequency of these meetings had changed from monthly to quarterly due to poor attendance. The meetings were based on themes and included cheese and wine and

around the world, taking into account a range of different cuisines.

● Questionnaires had been sent, seeking people's views and opinions about the service. An electronic device was also available in the main reception area and this allowed people living at the home and their relatives to provide any additional comments about the home.

● Reviews of people's care took place and we saw people living at the home were invited to be involved in these decisions where possible.

● Staff had devised an information pack containing the latest CQC report, information on activities, current newsletter, service user guide and how to make a complaint. This ensured people had all the relevant information they may need about the home. A local MP often visited the home and people were given the opportunity to speak with them to share their views.

Respecting and promoting people's privacy, dignity and independence

● During the inspection we observed staff treating people with dignity and giving them privacy if they needed it. People told us they felt well treated and were never made to feel uncomfortable or embarrassed. We observed staff knocking on people's doors before entry and then closing them behind them. Doors were always closed when personal care was in progress.

● Staff were knowledgeable on the importance of promoting independence. Powered wheelchairs were requested as needed and maximised people's independence within the community. Staff had assisted people with this process and had pre-planned routes to shops to enable positive risk taking. Arrangements had also been made with local shop keepers, who agreed to support this person when they arrived at the shop, to enable them to gain access safely.

●Following the refurbishment of the kitchen area, a satellite kitchen had been installed and enabled people who were able, to make themselves a drink or a light snack. One person had recently celebrated their birthday at the home, with refreshments and a cake provided.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●Each person living at the home had their own care plan in place and we reviewed four of these during the inspection. We noted they were completed with good detail and provided information for staff about the care and support people needed.

● People's care plans contained person-centred information about their life histories and included details regarding their childhood, employment, school years, hobbies and interests and details about their family.

● Care plans contained information about people's communication and if they required the use of any equipment such as glasses or hearing aids. Where any sensory equipment was needed, we observed these were being worn by people during the inspection. The service was meeting the requirements of the accessible information standard (AIS). This is used to ensure people with any particular sensory impairments have their needs met by staff. The home had previously used interpreter services where there had been communication difficulties between staff and people who lived at the home.

● People's likes, dislikes and what was important to the person were recorded in their care plans. During the inspection we saw many examples of where people received care that was based around their own personal choices. Some people had hobbies and interests outside of the home and had been supported to attend these in the past by staff.

● People were encouraged to maintain relationships and there were opportunities to visit friends and family in the community. One person enjoyed visiting a friend of theirs at another care home in the area. Richmond House had its own Facebook account and this enabled relatives to contact people living at the home if they were ever anxious or worried about them.

● There were different activities available for people to participate in if they wished and these were mainly facilitated by the home's wellbeing coordinator. People we spoke with and their relatives confirmed this was the case and that a large variety of activities were always on offer if people wanted to take part. Some of the activities available included chair exercises, bingo, games, baking and sing along.

●During the inspection, local children had visited the home the take part in an 'Easter egg hunt' which we were told was well received by people living at the home. A game of dominoes was also arranged and this was well attended. The home had a mini bus and trips out to local areas of interest took place, based on where people wanted to go. The bus was also used for personal trips such as transport to family gatherings and weddings.

● Individual proformas had been completed for each person and this provided a 'Snap shot' proffered past times, the kinds of things they enjoyed doing and how they liked to be supported by staff.

● The home had made use of technology to enable a person to speak with their relative who was very unwell. They were unable to see each other in person due to the travel distance, however staff arranged for them to have a skype call so that they could see each other on screen.

● Another person living at the home had been declining to get up from bed despite the best efforts of staff. Staff were aware that this person was passionate about motorbikes and therefore arranged for a local motor bike club to visit the home. The person then agreed to get up from bed and had enjoyed seeing the bikes in the car park and meeting the bikers themselves. Staff took photos of the occasion, showing the person's delight.

Improving care quality in response to complaints or concerns

● People knew how to provide feedback about their experiences of care and information about how to make a complaint was displayed on the main notice board.

●. A central log of complaints had been kept and we noted responses had been provided both written or verbal. A range of compliments had also been received, where people had expressed their satisfaction about the service provided.

End of life care and support

● The home had good systems in place to care for people approaching the end of their life, with various policies and procedures used to ensure people received the right support. Monthly resident status meetings were held to discuss any decline in physical health. This helped to identify any decline in well-being and helped ensure everything was in place as people approached end of life, for example advanced care plans, statement of intents and anticipatory medicines. Staff acknowledged they had only one chance to get it right, therefore people were able to die in their preferred place of care, surrounded by their loved ones and familiar faces with comfort and dignity.

● The home had implemented several initiatives for people living at the home and their relatives when delivering end of life care. This included hampers which contained various toiletries to allow people to freshen up if they had stayed at the home overnight. A fold away bed had also been purchased, which allowed relatives to sleep in the same bedroom as their loved ones if they wished.

● Advanced care plans (ACP) were used and enabled people and their families to plan and make important decisions about their care when approaching end of life. Statement of intents (SOI) were requested from people's GP's when staff noticed a decline in people's health and wellbeing. One person who had resided at Richmond House had attended a conference at Leigh Sports Village to approximately 100 professionals to speak about their advanced care plans and the impact this had on them.

● A 'comfort tool' was used which was developed by Wigan and Leigh Hospice. This enabled staff to monitor for any signs of pain or discomfort people may experience. A 'sunset sign' had also been developed and was used to indicate to staff that the person in the room in which the sign is displayed is at the end stages of life and prompts them to go about their work in a sensitive and quiet manner.

● Staff working at the home had completed training provided by Wigan and Leigh Hospice. Some of the modules in the training consisted of the definitions of palliative care, dignity, communication skills, advance care planning, spirituality, recognising dying and the symptoms during end of life. The home had also been involved in a pilot scheme for 'Hospice care in your care home'. The initiative was designed to ensure people were not admitted back into hospital for end of life care and that comfort and pain management was maintained and coordinated positively at Richmond House.

Outstanding ☆

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

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

●The home was managed by an experienced registered manager who had worked at the home for approximately 25 years. They were supported by a deputy manager and stable staff team who had also worked the home for long periods of time. This allowed for staff to develop good working relationships and get to know the people they cared for well.

● The high level leadership within the home had been consistently recognised within the local community and as a result, both the home registered manager had won a number of awards, particularly regarding End of Life Care.

● At the Wigan and Leigh Hospice annual awards event, the registered manager had won 'Manager of the year' for the past three years (between 2016 and 2018). The home also won 'Care home of the year' in 2016 and 2018, whilst winning the award jointly in 2017.

● Additionally, the home won a national award with Caring UK for End of Life Care in 2017. The home was also shortlisted as finalists in 2018 for two categories in the Caring UK awards for End of Life team and care home team of the year. These nominations demonstrated the excellent work done to ensure people experienced outstanding end of life care.

● The registered manager and the home itself had been offered the opportunity to be involved in a number of initiatives and pilots in the local area. One of these was the 'Trusted assessor' programme which was aimed at reducing hospital admissions, meaning people had poor health and social care experiences. The use of the Trusted Assessor can reduce the numbers and waiting times of people awaiting discharge from hospital and help them to move from hospital back home, or to another setting faster.

●The home were involved with another project called 'Red bag'. When people may become unwell, or are assessed as needing hospital care, care home staff can pack a dedicated red bag that includes their standardised paperwork, medication, a day-of-discharge clothes and other personal items.

● A third initiative was the 'Teaching care home pilot', with the home being put forward to participate by the local authority. This aimed to empower staff in care homes and ensure the future sustainability of the workforce in the sector. The pilot has five centres of excellence across England which share learning and

best practice and help to strengthen leadership and care culture in care homes.

● The staff team also spoke of the positive culture within the home that was open and inclusive. All the staff spoken with said staff worked well together and supported each other to provide high quality care to people.

● The feedback we received from the staff team was consistently positive about the leadership that was in place at the home. The staff team described management and leadership as Outstanding. One member of staff said, "The manager has worked here for a long, long time and the home is very well managed. The manager has always been very good with me and I feel very well supported." Another member of staff said, "The home is very well managed in my opinion and there is good support from the deputy manager. The support is very good." A third member of staff added, "Management is very good. The home runs really well."

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

● People at all levels understood their roles and responsibilities and the manager was accountable for their staff and understood the importance of their roles.

● Statutory notifications were submitted to CQC as required where any safeguarding incidents, serious injuries, or expected/unexpected deaths had occurred. This meant we could respond accordingly.

● As of April 2015, it is a legal requirement to display performance ratings from the last CQC inspection. We saw the last CQC report was displayed in the main reception area and was available for all to see. The rating were also displayed on the HC-One website.

Continuous learning and improving care

● A range of quality assurance systems were in place at the home to ensure the quality of service was being monitored effectively both at managerial and provider level. The HC-One 'Corner stone' system was used, containing a series of organised documents where paperwork could be easily located. This included audits of medication, care plans, health and safety, infection control and accidents and incidents and the dining experience. Out of hours checks were also undertaken such as during the night. 'Resident of the day' audits were completed and provided and in-depth review of their care plan and the care they received.

● Staff meetings were held monthly and could be attended by both day and night staff. Staff told us they felt listened to and that any concerns were acted upon. Staff hand overs took place between each shift and enabled staff to understand how people were and if any actions needed to be completed relating to their care and support. Monthly hospice managers meetings and provider forums were attended regularly by the registered manager. These meetings enable lessons learned and good/poor practice to be shared.

●Kindness in Care awards were given to the staff team to recognise and celebrate their efforts and boost morale within the team.

Working in partnership with others

● The home worked in partnership with other organisations. This included a range of other healthcare professionals in the area, such as district nurses, social services, hospices and local hospitals.

● The home had also worked closely with the local speech and language therapy (SALT) team develop and evaluate a 'Feed at risk' tool. This gave people with the capacity to make their own choices and decisions the opportunity to eat preferred foods of their choice which might otherwise place them at risk of choking and aspiration.

● This had been of benefit to one person at the home was previously 'Nil by mouth' and received their nutrition through a PEG feed. The feed at risk protocol was put in place and this person was now able to eat a normal softer diet. They were also able to have a meal with their relative each day as they used to do when living at home.

● A number of community links had also been developed and this included local schools and nurseries. People living at the home also visited local dementia cafes, where people living with dementia could meet up for a coffee.