Astley Grange Homes Limited

Astley Grange

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Astley Grange provides nursing care for up to 30 adults with a range of complexity of physical and mental health needs. The provider is Astley Grange Care Homes Ltd. The home is situated on a busy main road into Bolton, which is close to shops and other local amenities. Car parking is available at the front of the home. There were 26 people accommodated at the home on the day of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was first registered in April 2018.

At the last inspection of November 2017, the service was rated as requires improvement for four breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Regulation 12 (2) (d) for a lack of staff training in fire procedures and exposed hot water pipes. Regulation 12 (2) (g) for unsafe medicines administration, Regulation 13 for not reporting a safeguarding incident. Regulation 15 some areas of the home needed cleaning and of Regulation 18 (1) for not having sufficient staff to meet people's needs. The service sent us an action plan to show us how they would improve. At this inspection the service had improved and there were no breaches.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff were safe to work with vulnerable adults. There were sufficient staff to meet people's needs.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and homely in character.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business contingency plan for any unforeseen emergencies.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well nourished.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of their responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work related issues and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed.

There were sufficient activities to help keep people stimulated which would be further improved when the new activities coordinator commenced work.

People were treated in accordance to their age, gender, sexuality and religion.

Plans of care were individual, person centred and reviewed regularly to help meet their health and social care needs.

Visiting was unrestricted so that people could remain in contact with family and friends.

Audits, surveys and key worker sessions helped the service maintain and improve their standards of support.

People thought the registered manager was approachable and supportive.

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.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Managers understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS.

People were given a nutritious diet and said the food provided at the service was good.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

Is the service caring?

Good

The service was caring.

We observed staff had a kind and caring approach to people who used the service.

People were encouraged and supported to keep in touch with their family and friends.

We saw that people were offered choice in many aspects of their

lives and encouraged to remain independent.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns and people told us they felt confident they could raise any issues.

People were able to join in suitable activities if they wanted to.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

All the people and staff we spoke with told us they felt supported and could approach managers when they wished.

Astley Grange

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 and was conducted by one adult social care inspector on the 11 July 2018.

We requested a provider information return because the service would not have had sufficient time to complete it. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. Prior to the inspection we contacted the local authority, CCG and Healthwatch Bolton. The CCG and local authority both said the service were working well with them to maintain standards.

We spoke with three people who used the service, a relative, a visiting professional, the registered manager, deputy manager, a registered nurse, the provider and two care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at three care records and the medicines administration records for eight people who used the service. We also looked at the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

People who used the service told us, "I feel safe, nobody bothers me" and "I feel safe. The staff are here to look after me" and a relative commented, "We think she is 100% safe."

From looking at the training records and talking to staff we saw that staff had been trained in protecting people from abuse. Staff had access to a safeguarding policy and procedure. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy, which is a commitment by the service to encourage staff to report genuine concerns with no recriminations. The staff we spoke with were aware of safeguarding issues and said. "I am aware of the whistle blowing policy. I would go to one of the managers or social services if I saw anything" and "I have done safeguarding training. There is a whistle blowing policy we can use to report abuse and I would be prepared to use it if necessary." There were systems in place to protect people from abuse.

There had been two safeguarding referrals and we saw the registered manager had investigated and where necessary taken the appropriate action to minimise any further incidents.

At the last inspection of November 2017, the service was in breach of the regulations for not having sufficient staff on duty. The staff we spoke with at this inspection said there were enough staff on duty to meet people's needs. There were two more care staff on duty than at the last inspection. On duty on the day of the inspection we saw that the registered manager, deputy manager, a registered nurse, a senior care staff member and four care staff provided care. There was also a person dedicated to doing the laundry, a cook and assistant cook, a domestic assistant and maintenance person. The duty rota confirmed this was the normal level of staff. We observed that call bells were answered quickly at this inspection.

We looked at four staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member had a criminal record or been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and were safe to work with vulnerable adults.

We saw that the electrical and gas installation and equipment had been serviced. There were other certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing, the lifts and fire alarm system. Hot water outlets were checked by the maintenance person to ensure water was delivered at a safe temperature. Windows had a restricting device to prevent accidental falls and radiators did not pose a risk of burns. We checked some water hot water outlets and they were safe.

Hoists and lifting equipment was serviced and staff trained to use them correctly.

At the last inspection fire drills and emergency procedures were not being undertaken regularly. At this inspection we saw they were held regularly to ensure the equipment was in good working order and staff knew the fire procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. A copy of the PEEP was retained at the entrance hallway to pass to the fire service in an emergency. There was also a 'grab bag' which contained equipment such as a torch and high visibility jacket to aid staff if required.

There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a gas or power failure. This document contained the details of which organisation to call depending upon the type of emergency and staff contact details who could be called in to assist. This ensured staff were given advice on how to keep the service running in an emergency.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

People who used the service and visitors said the home was clean and tidy. On the day of the inspection we toured all communal areas of the home and several bedrooms. We saw the home was very clean, uncluttered and did not contain any odours that people may find offensive.

There were policies and procedures for the control and prevention of infection. The training records showed most staff had undertaken training in the control and prevention of infection. Staff we spoke with confirmed they had undertaken infection control training.

The laundry was sited away from any food preparation areas and only soiled linen was kept there awaiting washing in colour coded bags. Colour coded bags showed staff which laundry may be contaminated. When the laundry was washed it was taken to a separate room to be taken back to people's bedrooms. The washing machines had a sluicing facility for contaminated waste. Staff had access to personal protective equipment including gloves and aprons and there were hand washing facilities around the building for staff to use to help prevent the spread of infection. The registered manager conducted infection control audits and checked the home was clean and tidy.

We looked at three plans of care during the inspection. We saw there were risk assessments for moving and handling, falls, tissue viability (this is to prevent pressure sores) and nutrition. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service. We saw that where necessary professionals we called in to provide information and guidance, for example speech and language therapists (SALT). We saw the risk assessments helped people keep safe and did not restrict their lifestyles.

At the last inspection there were some issues around the safe administration and storage of medicines. We looked at the past issues and saw they had been rectified. This included the cleanliness of the room medicines were stored in.

We looked at eight medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home which helped staff check the numbers of medicines people had. There was a photograph on each MAR to help staff identify the correct person. All staff who administered medicines had been trained and had their competencies checked to ensure they maintained good standards.

Medicines were stored in a locked room and the trolley was securely attached to the wall and only staff who needed to had access to the keys. The temperature of the medicines cupboard and dedicated fridge was checked daily to ensure medicines were stored to manufacturer's guidelines.
We checked the controlled drugs cupboard and register. Controlled drugs are stronger medicines which need more stringent checks. We saw that two staff had signed for the administration of controlled drugs which is the correct procedure. We checked the numbers of controlled drugs against the number recorded in the register and found they tallied.

Any medicines that had a use by date had been signed and dated by the staff member who had first used it to ensure staff were aware if it was going out of date and there was a safe system for disposal. Any handwritten prescriptions were signed by two staff which is the recommended safe method.

There was a signature list of all staff who gave medicines for management to help audit any errors. The service had a copy of the National Institute for Health and Clinical Excellence guidelines 2017 for administering medicines in care homes. This is considered to be best practice guidance for the administration of medicines.

There were clear instructions for 'when required' medicines should be given. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24-hour period, the route it should be given and what it was for. This helped prevent errors. We also saw a note on the front sheet of the records telling staff the preferred way a person liked to take their medicines.

We saw that topical medicines such as ointments were recorded in the plans of care. The service used body maps to show staff where to apply the medicines.

The medicines system was audited by staff weekly and managers regularly to spot for any errors. Staff retained patient information leaflets for medicines and a copy of the British National Formulary to check for information such as side effects.

Good

Is the service effective?

Our findings

People who used the service told us, "The food is very good although I am going out to McDonalds with my family today" and "The food is good. I have just had my tea. Sandwiches and fruit and cream." A relative said, "They built up our relative since coming here. [Our relative] is maintaining weight now and they always come around with drinks."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. The plans of care contained details of any special needs a person had with their intake of food and drink and specialist help and advice sought where needed.

The dining room contained sufficient furniture to enable people to take their meal in a social setting. Tables were laid with cloths and cutlery and people had access to condiments to flavour their food. There was a menu board to remind people what meals were on offer. The menu worked on a four-weekly cycle.

We spoke to the cook who was aware of any special diets that needed to be served. The service catered for special diets such as soft or for people with diabetes. We saw the cook was given the information to provide the diets. The food served at this home was mainly home cooked and sourced locally, where possible, which meant deliveries were regular and food fresh.

We saw that the food looked hot, nutritious and plentiful. People who required support did so in an individual and dignified manner. There was a choice of meal and the cook said people could have something else if they did not like what was on the menu. On the day of the inspection people had a choice of beef casserole with chips and veg or a jacket potato with a choice of fillings. There was a dessert and people could have a drink of their choice with their meals.

People had what they wanted from the normal range of breakfast foods, including a cooked option, the main meal was at lunch time and a lighter tea was served in the late afternoon and included a dessert. A supper was available for those who wanted it. Drinks were served at mealtimes and when people asked for one. On the day of the inspection we saw that there were cold drinks and ice lollies to keep people hydrated in the very warm weather. We saw people had a drink of their choice often during the day.

We saw the kitchen was clean and tidy. The service had recently been inspected by the environmental food agency and given a five star very good rating which meant the ordering, storage and serving of food was safe. This also showed the cleaning schedules were maintained in the kitchen.

We saw there were good supplies of fresh, frozen, canned and dried foods. Fresh fruit was served from the drinks trolley and as a dessert. We saw one person eating a banana which he had asked for and got.

The cook recorded the meals served to provide an audit trail should any problems arise. Each care plan showed a person's dietary needs, referrals made to a Speech and Language Therapist (SALT) if required and people's weights were recorded to see if they were gaining or losing weight.

We looked at what consideration the provider gave to 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).

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. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005). We saw that the service assessed each person's mental capacity.

Following the mental capacity assessment, we saw that a best interest meeting was held for people who did not have the mental capacity to take their own decisions and are attended by the person where possible, family members if appropriate, staff from the home and professionals from other organisations. This meant that any restrictions to a person was taken in the least restrictive way and if possible in a way the person preferred. People had access to an independent mental capacity advisor or advocate. These are professionals who act independently for people to protect their rights. Three people who did not have family continued to get support from an advocate.

People who used the service told us, "I have a nice room. I don't spend much time in it because I like to go out" and "I like my room and there is everything I need. The room is like my own little bit of home."

We toured the building on the day of the inspection visiting all communal areas and eight bedrooms. We saw the home was reasonably well decorated and fittings and furnishings provided people with a homely atmosphere. At the past inspection fire escape routes had been blocked with equipment but we saw that this was not the case at this inspection. Pipes which needed to be lagged were now safe. We saw there was a system of reporting and having faults fixed. On the day of the inspection the decking area was being painted.

People had the choice of a shower or a bath and there was equipment available to assist people with mobility needs.

Bedrooms had been personalised to people's tastes and we saw that people could bring in items of their own, we saw one person liked their own bedding.

There was a secure garden area and seating for people to sit in during good weather.

A new member of staff we spoke with said, "The induction has been very useful and I have been well supported." Staff new to the care industry were enrolled on the care certificate which is a recognised induction program. All staff were given the homes induction which included training around safeguarding, moving and handling and mental capacity before they worked with people who used the service. The induction also taught staff key policies and procedures and gave staff time to be introduced to other staff and the people accommodated at the home. Staff were then supported by more experienced staff. The induction process helped new staff gain the confidence to work with vulnerable adults.

Staff told us they thought they received enough training to look after the people who used the service.

Comments included, "I am up to date with my training. I don't mind the online training. I am down to do the nursing assistant course with the CCG" and "They always ask if we want any training at supervision." A relative said, "Staff are well trained."

We saw from looking at the training records, staff files and when talking to staff that training was ongoing. Training included the MCA, DoLS, first aid, fire safety, food safety, nutrition, medicines administration, moving and handling, infection control, health and safety, safeguarding, the care of people with behaviours that may challenge others and fire awareness. Most staff had completed a recognised course in health and social care and end of life care. Trained nurses had received training around their practice which included enteral feeding, the care of pressure areas, catheter care and the use of syringe drivers. Training gave staff the competence to provide the care and support people needed.

The registered manager was completing Quality and assurance training with Bolton Council which would help them maintain and improve standards at the home.

Staff received a yearly appraisal and regular supervision. Staff told us they had regular supervision with a manager and they had the opportunity to bring up their own needs including training. We saw the records that showed supervision was ongoing and enabled managers to assess staff performance. A staff member said, "We have regular supervision. We can bring up our needs in supervision and they ask if we want any more training."

We saw the service liaised well with other organisations and professionals. Each person had their own GP and had access to professionals such as specialist nurses, hospital consultants and speech and language therapists (SALT). People were also supported to attend routine appointments with opticians, dentists and podiatrists. On the day of the inspection a member of the CCG staff told us, "I am amazed at the progress my client has made. The staff are very knowledgeable and the care is good. My client has made such good progress they will be going home soon and that is a surprise."

The service had introduced technology into the home. The care plan system was computerised. The service also used a hand held computer tablet which they could use to contact professionals, for example a person's GP, to cut out the need for a visit if possible. With people's permission the tablet could transfer live pictures and the conversation to see what the problem was and treatment started as soon as possible.

Good

Is the service caring?

Our findings

People who used the service told us, "The staff are very nice and kind. The staff look after me. Some of the younger ones are a credit to the home" and "The staff look after me, we have a laugh and they are good carers." A visitor said, "The staff are lovely, very good and caring. We have recommended the home to others." Other people we spoke with said they were happy at the home.

Staff we spoke with said, "I would be happy for a member of my family live here. It is a caring care home with a family atmosphere. We all get on together. I do it because I care about people. I get satisfaction out of it and like it when I know I have done a good job" and "My relative was here so I have recommended the home. I enjoy the work. I like looking after people and like to make them happy. I have always done this work and like it here." Staff were motivated and thought they worked well as a team.

One person who used the service said, "I can have a walk round and go out on my own." Plans of care showed what a person could or do or where prompting or assistance was required by staff. For example, with any personal care or how able they were to eat independently. People could go out to the shops unescorted if they were assessed as safe. This showed the service tried to help people remain independent as much as they could.

A person's communication needs were recorded in the plans of care. In one plan of care it showed how the service had recorded a person's abilities to communicate in a non-verbal way. The plans made it very clear the person could only communicate using facial expressions and staff had to be patient and wait until they understood what the person wanted. In this way staff delivered care in the way the person wanted.

We observed staff during the inspection. We saw staff were kind, attentive and professional with good humoured exchanges heard with people and staff laughing. We saw staff sat talking to people who used the service as well as assisting them with personal care and support. Staff were able to communicate with people in non-verbal methods because they knew them well.

Plans of care showed people had been consulted about their known choices and preferences. For example, we could see one person had said they preferred a shower and records showed this is what the person had. Other choices included people's preferred food and drink, the usual times they liked to get up and go to bed and one person liked to have a snack before bedtime and music to be played on a low volume. The service were currently photographing the meals they served at the home. This would enable staff to show people who did not communicate verbally the choices on offer. We were present when a staff member came to the deputy manager to say a gentleman did not wish to be shaved. The deputy manager told the staff member to record the refusal but go back later and ask again.

We saw staff were discreet when they needed to assist people and were careful to keep doors closed. When they went to assist a person, staff knocked on their bedroom door. We did not see any breaches in people's privacy which helped protect their dignity.

All records were stored confidentially in an office and staff were taught about confidentiality and data protection topics. Staff were also informed about not putting confidential information on social media.

In the plans of care we saw that a person could, if they wished, ask for the same sex of staff they wished to look after them. There were also details of personal choice such as if a person wished to use make up or the colour of nail varnish they liked. People were asked what activities they would like to attend which meant they were suitable to their age and gender. Plans of care showed people were asked if they had any religious needs. There was a regular church service which people could attend if they wished to and have Holy Communion if this was the way they practiced their faith. There were other denominations who came into the home on a one to one basis. There were no current people with any ethnic or cultural needs. The service responded to the equality and diversity needs of people who used the service.

We saw that visiting was open and a visitor said staff were welcoming to them. We saw that people received their visitors in the communal areas but could go to their rooms if they wished privacy.

Some people had an advocate and the registered manager said people who wished to could vote in an election. We were told this was usually by postal vote but they would be prepared to take someone to the polling station if they wanted to go. Voting and the use of an independent advocate helped protect people's rights.

Good

Is the service responsive?

Our findings

The service used technology to assist in the running of the home. The service was connected to a Wi Fi system and could use computer tablets to connect to a professional such as a GP to help diagnose an illness without the need for a visit. The advantage of this system is the speed of diagnosis of minor ailments such as a rash. With the permission of the person the doctor can see the rash on the screen. The plans of care were computerised. This type of system reminds staff when care needs should be updated or risk assessments and the plan reviewed. Managers could audit the system and follow up on any out of date records.

The activities coordinator had left the service unexpectedly and a new member of staff was waiting for the necessary checks before commencing this role.

The service provided a range of activities people could attend, which were advertised on a notice board. Activities included watching football, pamper sessions, reading, quizzes, arts and crafts, music and exercise, playing dominoes and card games, gardening, going out with staff, family and independently to shops or places of interest.

We also saw people were sat with staff having a one to one chat or playing cards. One to one chats were held with people who were unlikely to be able to contribute to an activity or did not want to attend. There were also comfort dolls to help people remain calm and a robotic cat to entertain people who liked cats.

External entertainers came into the home occasionally and the community came into the home, for example schoolchildren came in and sang for people who used the service. There were regular barbecues in the garden and special events laid on during the year, such as Easter and Christmas. The summer fair was being planned and people and their families were involved in the arrangements. If people wished they could attend activities suitable to their age and gender.

Staff attended a handover at the start of their shifts. These sessions gave staff the chance to pass on any relevant information about a person to each other to ensure there was good communication around any appointments and/or report on a person's health and well-being.

Prior to someone being admitted to the home each person was assessed by the registered manager at home or hospital. The assessment was based around the care plan so that details could be easily transferred onto the computer. Information was gained from the person if possible, relatives and professionals involved in the person's care. The local authority or CCG also provided an assessment which we saw was within the person's documentation. We saw that the assessments were thorough and enough information was gained to decide if the service could meet the person's needs at the home.

The plans of care were computerised and we saw that they were easy to access read and update. Plans of care showed us what level of support people needed and how staff should support them. Each heading, for example personal care, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. Each person's day was

recorded with what they had done and how they had been. We saw that people had access to professionals if it was noted that a person's needs were changing. We saw in one plan a person had required input from a Speech and Language Therapist (SALT) and in another had attended a hospital appointment.

Plans of care informed staff of the abilities of each person; what they could do for themselves and what they needed assistance with. People were encouraged to perform the tasks they could manage to remain independent where they could.

Each person was issued with a copy of the complaints procedure when they were admitted. There was also a copy visitors could access. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of other organisations including the local authority and complaints Ombudsman. There had not been any formal complaints since the last inspection but we could see they had been investigated and a suitable outcome sought.

Most staff had undertaken end of life training which meant they could support people and their families when their illness deteriorated. We also saw in the plans of care that people's end of life wishes were recorded. The plan included who the person wanted at the funeral, burial or cremation, the funeral director of their choice, the type of ceremony, who they wanted to make the arrangements and what they wanted to be remembered for. It also showed where they wanted to spend their last days and if the family wished to be informed in the middle of the night. The deputy manager said they would make space and comfortable furniture available if family members wished to stay at the home during this difficult time. There was an area of the garden that was used for remembrance for family members who wished to use it. Family members could add something to the garden they thought was appropriate and always come back and reflect upon their loved one.

The registered manager held regular meetings with families and people who used the service. We saw that following the last meeting of May 2018 relatives were asked to tell staff if they brought in food in case their family member was on a varied consistency diet, updated everyone on any staffing issues, told the meeting of the various outbreaks in Bolton and how best to protect themselves and asked if anyone had any concerns. People could have their say and we could see that action had been taken from past meetings to improve the service. Improvements included, some areas of the home were redecorated, the porch was replaced for easier access and windows replaced when people said they were draughty with further replacements scheduled.

Good

Is the service well-led?

Our findings

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was first registered in April 2018.

We asked people who used the service, staff and a family member if they thought the home was well-led. People who used the service said, "You can get hold of any staff including the managers" and "I can talk to the managers when I need to. They are always flying around." A visitor said, "Our relatives care has been excellent. The managers are very approachable and you can talk to them."

Staff we spoke with said, "The managers are very supportive. There is a good staff team" and "The managers are very supportive and have an open door policy."

The service liaised with other organisations. The registered manager attended best interest meetings with Bolton Clinical Commissioning Group for topics such as how best to safely administer covert medicines or the use of thickeners. We saw evidence that from the meeting the registered manager had contacted a GP to update them about fluid thickening agents. The registered manager also held meetings with the primary care trust and other care home managers to discuss outbreaks and information sharing. They watched films and were tested on their knowledge on useful topics. The registered manager was also taking a leadership in care homes course which was designed to give the manager tools and information to improve the home to benefit people who used the service. The registered manager will gain the diploma in the health and social care of adults, younger people and children when completed.

Staff meetings gave staff the chance to have their say about the home was run. Items on the agenda on the meeting of July 2018 included personal care and tissue viability observations, completing all paperwork accurately, infection control, a reminder not to block fire exits, safeguarding, staffing updates, infection control and tidiness. The staff we spoke with said they could contribute to the meetings if they wished.

The registered manager undertook many audits to check how the service was performing. The audits included health and safety, medicines administration, infection control, plans of care, the level of cleanliness, accidents and incidents, specific reportable incidents like pressure sores and the environment. We saw where any shortcomings were spotted the service completed a plan to show who was responsible for remedy and when it had been completed. The service completed a monthly audit to the local authority which helped give an overall view of how the service was performing. This showed the registered manager had systems in place to maintain and improve standards in the home.

We also saw various reports from other organisations, for example, the local fire service, infection control and the local authority. We saw that any actions that had been recommended had been completed. We asked the local CCG and Bolton MBC for their views of the service. Both organisations had visited the service to see how they were performing and they told us the service had worked hard to implement new systems

and meet the requirements of the CQC.

We saw the registered manager reported any incidents that affected the running of the service or involved people who used the service in line with our regulations. The service displayed their rating in the home and on their website.

There was a recognised management system which staff and people who used the service were aware of so they knew who to approach if they wanted advice or guidance.

The service had a statement of purpose which told other organisations the details of the organisation and registered manager, the organisational structure of the service, the aims and objectives, who can use the service, staff and training and the services and facilities on offer at the home.

We looked at some policies and procedures which included medicines administration, alcohol and drugs misuse, confidentiality, data protection, equal opportunities, whistle blowing, infection control, safeguarding, complaints, controlled drugs, clinical policies for example the use of syringe drivers, privacy and dignity and mental capacity. The policies were available for staff to follow good practice guidelines.

The service sent out regular satisfaction surveys. The surveys were completed monthly around different topics such as hairdressing or care. The surveys we looked at were positive but it was hard to produce a summary because of the frequency and different topics. We said it may be better practice to devise one survey which covered most topics and develop a summary to show how the service responded to the views of others.