Palmgrange Limited

Clairleigh Nursing Home

Inspection report

104 Plaistow Lane
Bromley
Kent
BR1 3AS

Tel: 02084601527

Date of inspection visit:
25 April 2018
26 April 2018

Date of publication:
18 May 2018

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

This inspection took place on 25 and 26 April 2018 and was unannounced. Clairleigh Nursing Home is a 'care home'. People in care homes receive accommodation and nursing, or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Clairleigh Nursing Home accommodates up to 30 people. There were 25 people living at the home at the time of our inspection.

At the last comprehensive inspection in March 2017 we found breaches of regulations because risks to people were not always accurately assessed or managed safely and because the provider's systems for monitoring the quality and safety of the service were not always effective in identifying issues or driving improvements. Following that inspection the provider wrote to us to tell us the action they would take to address our concerns. At this inspection we found that staff had addressed the issues we had identified, in line with the provider's action plan.

The service had a registered manager in post. 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.

At this inspection we found risks to people had been assessed and staff worked to manage identified risks safely. People were protected from the risk of abuse because staff were aware of the action to take if they suspected abuse had occurred. People's medicines were securely stored and safely administered. Medicine administration records were up to date an accurate.

The provider followed safe recruitment practices. Staffing levels were determined based on an assessment of people's needs and there were sufficient staff deployed to keep people safe. The registered manager reviewed incidents and accidents when they occurred, and acted to reduce the likelihood of recurrence. Staff were aware of the steps to take to reduce the risk of infection when supporting people.

Staff were supported in their roles through an induction, training and regular supervision. People were supported to maintain good health and had access to a range of healthcare services. Staff worked to ensure people received consistent joined up care between different services. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff sought consent from people when offering them assistance and worked in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where people lacked capacity to make decisions for themselves.

The living environment at the service met people's needs. People were supported to maintain a balanced diet and most people spoke positively about the food on offer at the service. Staff treated people with dignity and respected their privacy. People were involved in making decisions about their care and

treatment. Staff treated people with care and consideration. People's needs were assessed to ensure the home was able to meet their needs. They received care and support which reflected their individual needs and preferences.

People were able to maintain the relationships that were important to them. The provider offered people a range of activities in support of their need for social stimulation. Staff provided people with appropriate care and treatment at the end of their lives. The provider had a complaint policy and procedure in place which informed people on the steps to take to raise a concern. People and relative were aware of how to complain and expressed confidence that any issues they raised would be dealt with appropriately.

The service worked in partnership with other agencies including the local authority. People and staff told us the service was well run and spoke positively about the registered manager. Staff attended regular staff meetings to discuss the running of the service and the responsibilities of their roles. The provider had systems in place to monitor the quality and safety of the service and acted to make improvements where issues were identified. People's views on the service were sought through meetings and an annual survey and they told us they felt improvements were being made under the registered manager.

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.

People were protected from the risk of abuse. Staff received safeguarding training and were aware of the action to take if they suspected abuse had occurred.

Risks to people had been assessed and staff acted to manage identified risks safely.

Staff were aware of the action to take to reduce the risk of infection.

People's medicines were stored and administered safely. Records relating to the administration of people's medicines were up to date and accurate.

Staff reported and recorded the details of any accidents and incidents. The registered manager reviewed accidents and incidents records, and took action where required to reduce the risk of repeat occurrence.

There were sufficient staff deployed at the service to meet people's needs. The provider followed safe recruitment practices.

Is the service effective?

Good

The service was effective.

People's needs were assessed using nationally recognised guidance and standards.

Staff sought consent when offering people support. The provider complied with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where people lacked the capacity to make decisions for themselves.

People were supported to maintain a balanced diet.

Staff were supported in their roles through training, regular supervision and an annual appraisal of their performance.

People were supported to maintain good health and had access to a range of healthcare services when required.

The provider worked to ensure people received joined up care across different services.

Is the service caring?

Good

The service was caring.

People were treated with care and consideration by staff.

Staff treated people with dignity and respected their privacy.

People were involved in day to day decisions about their care and treatment.

The provider provided people with information about the service through a service user guide and regular newsletter.

Is the service responsive?

Good

The service was responsive.

People received care and support which reflected their individual needs and preferences.

The service offered people a range of activities in support of their need for social stimulation.

People were supported to maintain the relationships that were important to them.

The provider had a complaints policy and procedure in place which gave guidance on how to raise concerns. People knew how to make a complaint and expressed confidence that any issues they raised would be addressed.

Staff provided people with appropriate care and support at the end of their lives.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager in post who had a good understanding of their responsibilities under the Health and Social Care Act 2008.

The provider had systems in place for monitoring the quality and safety of the service which helped drive improvements.

People's views were sought through regular meetings and an annual survey.

People and staff spoke positively about the registered manager and the management of the home.

Staff were aware of the responsibilities of their roles and told us they worked well as a team.

The provider worked with other agencies to ensure people received good quality care.

Clairleigh Nursing Home

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.

The inspection took place on 25 and 26 April and was unannounced. The inspection team consisted of one inspector who visited the service over both days and an Expert by Experience on who visited the service on the first day. 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 reviewed the information we held about the service. This included notifications received from the provider about deaths, accidents and injuries, and safeguarding allegations. A notification is information about important events that the provider is required to send us by law. We also sought and received feedback from a local authority commissioning team who visited the service. The provider completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to provide some key information about the service, what the service does well and any improvements they plan to make. We used this information to help inform our inspection planning.

During the inspection we spoke with nine people and four relatives to gain their views on the service. We also spent time observing the support staff provided to people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, and eight staff including the clinical lead, two nursing staff, the activities co-ordinator and a chef. We also reviewed records, including five people's care plans, six staff recruitment files, staff training and supervision records and other records relating to the management of the service including the provider's policies and procedures, audits and minutes from meetings with staff people and relatives.

Good

Is the service safe?

Our findings

At our last inspection of the service in March 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to people had not always been accurately assessed and staff had not always acted to ensure risks were managed safely. Following that inspection the provider wrote to us to tell us the action they would take to address our concerns. At this inspection we found that risks had been assessed and action taken to manage identified risks safely.

Staff had conducted risk assessments relevant to people's needs in areas including moving and handling, falls, skin integrity, the use of bed rails and malnutrition. These had been reviewed on a regular basis to ensure they remained up to date and reflective of people's current conditions. The assessments also identified control measures for staff to help reduce the level of risk to people. For example, where one person had been assessed as being at high risk of developing pressure sores, their risk assessment identified the need for them to use a pressure relieving mattress which we saw was in place and set up correctly according to the person's current weight at the time of our inspection.

People told us they felt safe living at the home. One person said, "I'm quite happy; they [staff] know what they're doing." Another person told us, "I feel safe here; there are no problems with that." Staff were aware of the details of people's risk assessments and how to support them safely. For example, we observed one staff member repositioning one person before they ate, in line with the guidance in their care plan, in order to reduce the risk of them choking. In another example staff we saw staff had been treating a wound one person had suffered in line with guidance from a Tissue Viability Nurse and records showed that the wound was successfully healing.

The service had arrangements in place to deal with emergencies. Staff were aware of the action to take in the event of a fire or medical emergency. Regular checks had been made on fire safety equipment, including the fire alarm, and staff had taken part in regular fire drills. People had personal emergency evacuation plans (PEEPs) in place which gave guidance to staff and the emergency services on the support they required to safely evacuate from the service if necessary.

At our last inspection of the service in March 2017 we found improvement was required to the provider's recruitment practices because it was not always evident that they had attempted to seek professional references from previous employers where personal references were in place. At this inspection we found the provider had made improvements and followed safe recruitment practices. Staff files contained details of each staff member's previous employment history as well as confirmation of checks having been made in areas including staff identification, criminal records checks and references from previous employers to help ensure that staff were of good character. Checks had also been made on the registrations of clinical staff to ensure their suitability for their roles.

There were sufficient staff to support people safely, although people and relatives had mixed views on staffing levels. One person told us, "[The staff] are very good and always around." Another person said, "I have a call bell and the staff come and check on me when I use it." However a relative told us, "I don't think

there are enough staff here. If [their loved one] uses the call bell, they'll come and check but you can then wait for help if it's not urgent."

The registered manager told us, and records confirmed that they used a dependency tool to help determine staffing levels based on the level of support people required. Records also showed that the actual staffing levels reflected the planned allocation, although the clinical lead had needed to step in to cover the unexpected absence of a nursing staff member on the first day of our inspection. We noted that staffing levels had recently been increased on the afternoon shift which staff told us had helped when allocating them to support people in different parts of the home. Staff told us they were happy with the current staffing levels. One staff member said, "We're able to support people when they need without rushing."

Medicines were managed safely. Medicines were securely stored and could be only accessed by staff who had received training and assessment of their competency to administer medicines. Regular temperature checks had been conducted by staff on the medicines storage areas, including the medicines refrigerator, to ensure medicines stocks remained within a temperature range which was safe for effective use. The provider had appropriate systems in place for receiving people's medicines and disposing of any unused medicines safely.

Staff completed medicine administration records (MARs) when administering medicines to people and these were up to date an accurate at the time of our inspection. People's MARs also included a copy of their photograph and details of any known allergies, to help reduce the risks associated with medicines administration. There was also guidance in place for staff to follow to help ensure any medicines that people had been prescribed to take 'as required' were administered appropriately when needed.

People told us they received appropriate support with their medicines. One person said. "I get my medicines at the right time four times a day." Another person told us, "I trust the staff who to my medicines." We observed staff assisting people to take their medicines safely during our inspection, for example, by giving one person tablets individually and encouraging them to take a drink in between each one, or by repositioning another person so that they were more upright to minimise the risk of them choking.

People were protected from the risk of abuse. The provider had a safeguarding policy and procedure in place which gave guidance to staff on how to identify and report any incidents of abuse. We also saw safeguarding information on display within the home for people and relatives, to help raise their awareness of the reporting procedures. Staff had completed training in safeguarding adults. They were aware of the type of abuse and signs to look for which may indicate abuse had occurred. One staff member told us, "If I suspected anyone had been abused then I'd immediately report it to the manager. I can also report to CQC, social services or the police if I need to."

Staff were aware of the action to take to reduce the risk of infection when supporting people. One staff member told us, "I always make sure I wear gloves and an apron when supporting people with their personal care and I wash my hands before and after helping them." People confirmed that staff wore personal protective equipment (PPE) such as gloves and aprons when supporting them. The service had a cleaning schedule which was carried out by domestic staff and which included periodic deep cleans of rooms. Senior staff also conducted checks on cleaning and infection control audits to help minimise the risk of infection.

Staff were aware of the providers systems for reporting and recording any accidents and incidents which occurred at the service. The registered manager maintained a log of accident and incident records which included information of any action which they had taken to reduce the risk of recurrence. For example

where one person had suffered from a number of falls over a short period of time, records showed that their care plan and risk assessments had been reviewed and updated, and a referral had been made to the falls clinic to get further professional advice.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

At our last inspection in March 2017 we found improvement was required because the provider did not have effective systems in place to identify conditions placed on people's DoLS authorisations. At this inspection we found improvements had been made in order to address this issue. The registered manager was aware of the process for seeking authorisation to deprive a person of their liberty where this was in their best interests. We saw DoLS authorisations had been sought appropriately where required and where authorisations had been granted, any conditions had been met.

Staff told us they sought consent from people when providing them with care and treatment. One staff member said, "I make sure I explain the support I'm planning to give people and make sure they're happy before doing anything. If someone didn't want my help, I would try and encourage them or leave them for a while and try again later, but I would never do anything against someone's wishes."

Staff received training in the MCA and DoLS and were aware of the process for making specific decisions in people's best interests where they lacked capacity to do so themselves. People's care plans contained documented mental capacity assessments and best interests decisions where decisions were more significant, in line with the requirements of the MCA. For example, records showed that a best interests decision had been made in consultation with staff, a GP and a pharmacist to administer one person's medicines covertly in order to ensure they consistently received their medicines as prescribed.

People spoke positively about the competence of the staff supporting them. One person said. "They [staff] know what they're doing." Another person told us, "I'm getting the help that I need; they [staff] are lovely." A third person commented that staff were competent when using a hoist to transfer them.

Staff went through an induction when starting work for the service which included a period or orientation, reviewing the provider's policies and people's care plans, and time spent shadowing more experienced colleagues. The registered manager told us she was in the process of setting up the Care Certificate for new staff to complete during their probation period, although this was still in progress at the time of our inspection. The Care Certificate is the benchmark that has been set for the induction standard for new social

care workers.

Records showed staff also completed training which was refreshed periodically in a range of areas considered mandatory by the provider including safeguarding, moving and handling, health and safety, infection control, food safety and first aid. Staff also completed training in areas relevant to the specific needs of the people they supported, for example in subjects including dementia, stroke awareness and diabetes. Nursing staff confirmed they had received training in clinical areas including wound management, and the registered manager showed us their plan for further clinical training to be provided in areas including venepuncture and catheterisation.

Staff told us they felt competent to perform their roles with the training they had received. One staff member told us, "The training has been good; some has been face to face and other areas have included tests that we have to pass to ensure we understand what we've been learning. I feel confident to do my job." Another staff member told us, "We get training that's relevant to the support the residents need. For example, we've recently been trained on how to use a nasojejunal feeding tube as a resident has one fitted."

Staff were also supported in their roles through regular supervision and an annual appraisal of their performance, and nursing staff supervision included reflective discussions on their clinical practice when supporting people at the service. One staff member told us, "I attend regular supervision meetings; they're a good opportunity to discuss any issues I may be having personally and whether I need any support to do my job."

People's needs were assessed before they moved into the home to help ensure the service's suitability to meet their needs. The provider used nationally recognised guidance and standards such as Waterlow scoring when assessing risk of people developing pressure sores, or the Malnutrition Universal Screening Tool (MUST) to help determine whether people were at risk of malnutrition. These assessments were used to identify people's support requirements in their care plans and were reviewed on a regular basis to ensure they remained up to date and reflective of people's current needs.

People were supported to maintain a balanced diet. People's care plans included assessments of their nutritional needs and included information about their likes and dislikes, any known food allergies, and any support they required to eat and drink. We saw referrals had been made to healthcare professionals where risks associated with eating and drinking had been identified by staff. For example, one person at risk of malnutrition had been referred to a dietician for advice and we saw guidance in another person's care plan from a speech and language therapist (SALT) on how their meals should be prepared to reduce the risk of them choking. Kitchen staff knew people's dietary requirements and had access to records identifying people's individual needs, including for example, which people required soft or pureed diets.

Most people spoke positively about the food on offer at the service. One person said, "The food is pretty good and there's more than enough." Another person told us, "The food is nice; the meal earlier was very enjoyable." However one person also commented, "I don't enjoy the meals; they're produced in a large canteen." We observed the lunchtime meal on both days of our inspection. Meals were served promptly and staff were on hand to provide support to people where required. People also had access to equipment such as plate guards which enabled them to eat independently with minimal assistance. We also noted that people were offered a choice of drinks at different points during the day and snacks were available upon request, or for people to help themselves to, including a range of fresh fruit which we observed people enjoying on both days of our inspection.

People were supported to access a range of healthcare services in order to maintain good health. People's

care plans included records of healthcare appointments with a wide range of healthcare professionals including GPs, dieticians, SALTs, Tissue Viability Nurses (TVNs), Opticians and dentists. One person told us, "The staff will call a doctor if I need one." A relative said, "They [staff] manage any appointments and [their loved one] has seen a GP regularly." Staff explained that they monitored people's health conditions and made referrals to healthcare services where required. A GP who visited the home on regular basis told us that staff were prompt in informing them about any concerns relating to people's health and that they had a good working relationship with the nursing team.

Staff also worked to ensure people received joined up, effective care across different services. For example, people's healthcare appointments were diarised in order that staff were aware of any support they required to attend and we saw staff following up on a reminder in the diary during our inspection to book transport to enable one person to attend an upcoming hospital visit. In another example, we noted any expected healthcare professional visits were discussed as part of the senior staff daily morning meeting, to ensure the service had people appropriately prepared and ready to attend.

People told us the home was comfortable and met their needs. They were able to bring their own furniture to put in their rooms if they wished and we noted that rooms were personalised for example with pictures hung up on the walls. There were facilities for people to spend time together or privately and the home had a garden for people to enjoy in good weather.

Good

Is the service caring?

Our findings

People and their relatives told us that staff treated them with kindness and consideration. One person said, "They're a nice bunch and we get on well; they're always checking that I'm OK." Another person told us, "They [staff] make a fuss of me." A relative commented, "The staff are caring; some of them in particular are absolutely lovely." Another relative told us, "The staff are treating [their loved one] well from what I've seen; [their loved one] is more relaxed and happier since moving in."

We observed staff treating people in a caring manner during our inspection. For example one staff member moved promptly to support a person who was displaying signs of confusion, offering them friendly encouragement as they walked together a communal area, then sitting and chatting with them for a while until they became settled. In another example we observed another staff member enquiring after a person's well-being, offering to reposition them because they appeared uncomfortable and then providing them with assistance which was positively received.

Permanent staff knew the people they supported well. They were familiar with people's daily routines and their preferences in the way they received support. They were also aware of the details of people's life histories and family backgrounds, and told us this information helped them develop strong relationships. It was also evident from their conversations with people that they had a good understanding of the things that were important to them. For example, we heard one staff member talking to a person about a picture hanging on their wall and it was clear from the conversation that this had particular significance to them.

The registered manager told us that they discussed people's diverse needs with them as part of their initial assessment. Care plans included information about people's cultural requirements and spiritual beliefs and staff told us they were committed to supporting people's needs with regard to their disability, race, religion, sexual orientation and gender. Spiritual support was available to people at the home through visits from a local church and one person attended their own preferred place of worship. Kitchen staff confirmed they were aware of people's culturally specific dietary requirements and told us they prepared their meals accordingly.

People were involved in decisions about their care and treatment. Staff told us they sought to offer people choices wherever possible when offering them support. One staff member said, "You develop a routine with the residents as you get to know them, but I still let them choose what they want to do. For example, if they want to get up and dressed before breakfast then that's what we'll do, but if they decide they'd rather have breakfast in bed before getting washed, then we'll do that instead; it's their choice." We observed staff offering people choices during our inspection, for example where they wished to spend their time, or in the activities they took part in. One person told us "Nobody makes us do anything we don't want; I can do what I like."

Information was available to people about the home in a service user guide. This included information on the support people could expect to receive from the service, the home's facilities and details on how they could make a complaint. The home also produced a regular newsletter which provided update to people on

any service developments, as well as information about upcoming entertainment or important events.

People and relatives told us that staff respected their privacy and treated them with dignity. One person said, "They [staff] always knock on my door before coming into my room." Another person told us, "The staff respect your privacy as much as they can." A relative said, "The staff have been polite and respected the residents' privacy when I've been here." Staff were aware of the steps to take to ensure people's privacy was respected. One staff member explained, "If I'm supporting someone to wash or dress, I always make sure the door and curtains are closed. I'll explain to them what I'm doing to make sure that they're happy but will also just chat with them throughout so that they feel comfortable." We observed staff knocking on people's doors before entering their rooms and speaking with people in a friendly but respectful manner throughout our inspection.

Good

Is the service responsive?

Our findings

People received personalised care which met their individual needs and preferences. One person told us, "The staff know what I need help with; we have a routine which works well." A relative said, "We were involved in the assessment at the start and the nurse or the manager check with us to make sure we're happy with the support [their loved one] is getting. They'd make any changes we wanted I'm sure if we thought there was a better way of doing things."

People had care plans in place which had been developed based on an assessment of their needs. The care plans contained guidance for staff on the support people required in a range of areas including personal care, continence, mobility, eating and drinking, and night time support. These were reviewed on a regular basis to help ensure they remained up to date and reflective of people's current needs. Care plans also included information about people's life histories, their likes and dislikes, hobbies and interests, and their preferences in the way they received support.

Staff worked to meet people's preferences in the support they received. For example, records showed that staff had worked with the local hospice and a speech and language therapist (SALT) in developing a care plan for one person who was fed enterally, in order to meet their expressed wish to be able to taste food on occasion. Staff were also aware to report any changes in people's conditions to the management team so that their needs could be reassessed and care plans updated if required.

The service provided a range of activities for people in support of their need for stimulation and to reduce social isolation. Activities included quizzes, arts and crafts, reminiscence discussions, musical activities and pampering sessions. The home had a cinema room and library available for people's use and the provider also arranged for entertainers including singers and musicians to visit the service periodically. The provider had recently employed a new activities co-ordinator who told us she was in the process of developing the activities programme further with a view to expanding the one to one activities on offer at the service. We observed people taking part in a quiz, playing games and enjoying musical entertainment during our inspection and noted that the interactions between people and the activities co-ordinator were lively and engaging. One relative told us, "The activities co-ordinator is great and tries to get everyone involved, spending time with the residents in their rooms if they don't want to take part in the group activities."

People were supported to maintain the relationships that were important to them. Relatives told us they were welcome to visit the home when they wished. One relative said, "I pop in regularly and can come and go as I please." Another relative said, "The staff are always happy to see us and there are facilities for us to help ourselves to drinks if we want them."

People received a copy of the provider's complaints procedure when they moved into the home which provided them with guidance on what they could expect if they raised any concerns. This included details of the timescale in which they could expect to receive a response as well as the process for escalating any unresolved complaints if needed.

People and relatives told us they were aware of the provider's complaints procedure and had confidence that any issues they raised would be taken seriously. One person said. "If I was unhappy I'd speak to the manager, or the deputy or one of the clinical staff; they're all approachable." A relative told us, "I know how to complain and have raised issues we've had with the manager when necessary; she listens and has always tried to address things." The registered manager maintained a log of any complaints the service received, which included details of any investigation and the action taken to resolve the issues, as well as a copy of their response. We spoke with one relative who'd complained about the quality of the care provided to their loved one and they confirmed that they were satisfied with outcome to their complaint.

Staff provided responsive support to people at the end of their lives. People's care plans included information about their end of life preferences where they had chosen to discuss this with staff and we noted that some people had Do Not Attempt Resuscitation orders (DNARs) in place where they, or their relatives where appropriate had agreed with a GP that this was in their best interests.

The home held an accreditation from the Gold Standards Framework, which is a nationally recognised standard in the provision of end of life care. Staff held regular meetings with the local hospice team to review people's end of life needs in order to ensure the appropriate level of support would be available in a timely manner when required. The registered manager also showed us a copy of a bereavement guide which provided guidance to relatives on the steps taken when a person passed away, including for example where they would need to go to register a death.

Good

Is the service well-led?

Our findings

At our last inspection of the service in March 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider's systems for monitoring the quality and safety of the service were not always effective in identifying issues or driving improvements. Following that inspection the provider wrote to us to tell us the action they would take to address this issue. At this inspection we found that the provider had acted to make improvements in line with their action plan and that the service was compliant with regulatory requirements.

Senior staff conducted checks and audits in a range of areas including people's care plans, medicines, falls, infection control, and checks on the environment and equipment used at the service. We saw action had been taken to address any issues identified during audits. For example, sections of one person's care plan had been rewritten where a recent audit had identified it as lacking sufficient detail. In another example we noted that personal protective equipment (PPE) had been ordered in response to the findings of a recent infection control audit, and staff and people confirmed PPE was readily available and used at the service when we spoke with them.

The home had a registered manager in post who demonstrated a good understanding of the requirements of being a registered manager and their responsibilities under the Health and Social Care Act 2008. They were aware of the different types of events they were required to notify CQC about and records showed they had submitted notifications appropriately where required.

People and their relatives spoke positively about the registered manager and the management of the service. One person said, "Things work well for me here; the important thing is the staff are very good." Another person described the help the manager had given them in arranging furniture for them that met their needs, commenting, "Love her; she is lovely." A relative told us, "I have confidence in the manager; if I had any problems her door is always open." Another relative said, "The manager is excellent; easy to talk to and wants the best for the residents. She makes all the difference."

Staff told us that the registered manager was a visible presence in the home, offering them support and clear leadership. One staff member said, "The registered manager operates an open door policy; there's no problem in speaking with her if you need to and she checks with us on each shift to see if there's anything we need support with." Another staff member told us, "The registered manager is brilliant; she's supported me through some personal issues and the residents love her; you can talk to her anytime."

We observed staff working well as a team during our inspection, communicating clearly and offering each other support throughout both days where needed. One staff member told us, "We all work well as a team. If anything became an issue I think we'd feel able to discuss it openly and sort it out, but there's no problems at the moment." Another staff member said, "We all want to make sure we provide the residents with good quality care and as a group, I think we're all happy here."

The manager held regular meetings with staff at different levels to discuss the responsibilities of their roles

and the effective management of the service. Areas discussed at a recent meeting included call bell response times, people's care plans and checking that pressure relieving equipment was correctly set up to meet people's individual needs where required. The registered manager also held a daily morning meeting with senior staff to help ensure they were aware of any day to day issues or events. Areas discussed at the meeting on the first day of our inspection included progress with maintenance work, a reminder for clinical staff to attend a meeting looking at people's nutritional needs, any external appointments people had and an update on any clinical issues. One staff member told us, "The meetings are a good way of making sure we know what's going on from day to day and reminding us any support the residents might need."

The provider sought feedback from people through regular meetings and an annual survey. Areas discussed at a recent meeting included an update on the progress of building works that were being carried out at the service, activities and an update on staffing. The registered manager told us, and records confirmed that they had only recently received the responses to the annual survey, but they would be looking to analyse the feedback and put an action plan in place to address any identified issues. We reviewed a sample of the returned surveys which showed people were experiencing positive outcomes whilst living at the service.

People and relatives also told us there had been service improvements in the time since the registered manager started working at the service. One person said, "I think things are better now. Staff come quicker than they used to when I use the call bell." A relative told us, "I think the manager's improving things. The staffing team has improved and there are more familiar faces."

The provider worked in partnership with other agencies in order to delivery good quality care to people. Records showed that the registered manager engaged with local authority commissioners and was open to their views on the running of the service. We spoke with a staff member of the local authority contract monitoring team who had recently visited the service and they spoke positively about the registered manager and the running of the service.