

# Roche Healthcare Limited

# Fieldhead Park

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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

The inspection of Fieldhead Park took place on 22 and 24 August 2017. We previously inspected the service on 26 November 2013; we rated the service Good. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Fieldhead Park Care Home is registered to provide personal and nursing care and accommodation for 54 older people. The home has two units; one unit provides personal care and accommodation for older people, the second unit provides care for people who have been assessed as needing nursing care. Within this unit six beds were allocated for use by the intermediate care team; this is a service which aims to prevent admission to hospital or to provide a period of rehabilitation following a hospital stay.

The service had a registered manager in place. 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.

People told us they felt safe. Care plans contained a range of risk assessments and included details of how moving and handling equipment should be fitted and used. There was a system in place to ensure the premises and equipment were suitably maintained. Personal Emergency Evacuation Plans were in place and regularly updated however, plans did not record evacuation routes if people were situated in areas other than their bedroom.

There were safe recruitment procedures in place and we observed staff met people's needs in a timely manner. There had been recent increases to the ancillary staffing hours to meet people's changing needs and demands on the service.

People's medicines were kept, mainly in locked units in their bedrooms. We saw staff administered people's medicines safely although the management and recording of people's creams needed to be improved to ensure an accurate record was retained.

New staff were supported in their role and existing staff received on-going training and management supervision.

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.

People spoke positively about the meals provided at Fieldhead Park. People were provided with a choice of meals, hot and cold drinks. Staff assessed people's nutritional risk regularly and care plans reflected people's individual needs in regard to eating and drinking. When required, staff kept a record of the food and fluid people consumed.

Everyone we spoke with told us the staff were caring and kind. Staff knew people well and were pro-active in ensuring they respected people's privacy and dignity. People were offered choices in regard to their daily activities and were enabled to retain their independence. The registered manager had begun to involve people and their families in the care planning process.

There was a range of activities for people to participate in and feedback regarding this was positive. Activities included; trips out in the local community, games, quizzes and exercise classes.

At the time of the inspection a new care planning system was being introduced. The care plans we reviewed were person centred and recorded an adequate level of detail to enable people to receive care and support which met their needs.

Where a complaint had been received, we saw the registered manager had investigated the issues raised and responded to the complainant with their findings.

People and their relatives spoke positively about the day to day management of the home.

There was a system of governance in place to monitor the quality of the service people received, these included, internal audits, the submission of a monthly manager report to senior managers and audits of the home by senior managers. However, we have made a recommendation about further improvements to the governance structure. Regular staff meetings were held and feedback was gained by way of surveys from staff and relatives.

## 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 was not always safe.

People felt safe.

Risk assessments were in place but further work was needed to ensure they were robust and included all aspects of peoples care and support.

The recruitment procedure was safe and there were adequate staff to meet people's needs.

The management and recording of the application of creams needed to be improved.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Staff received on-going supervision and training.

Staff respected people's right to make unwise decisions.

People were offered a choice of meals and drinks.

People received input from external healthcare professionals when required.

**Good** ●

### Is the service caring?

The service was caring.

People told us staff were caring and kind.

People were supported by staff who knew them well.

People's privacy and dignity were maintained.

**Good** ●

### Is the service responsive?

The service was responsive.

**Good** ●

People were provided with a range of activities to participate in.

Care plans were person centred and provided adequate detail to enable staff to provide peoples care and support.

People's concerns and complaints were recorded and acted upon.

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**Is the service well-led?**

The service was well led.

There was an experienced registered manager in post.

There was a system of governance in place and audits were completed on a regular basis.

Regular meetings were held with staff and feedback surveys had been completed by staff and relatives.

**Good** ●

# Fieldhead Park

## 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 inspection took place on 22 and 24 August 2017. The first date was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in caring for an older person. One inspector also visited the home again on 24 August 2017. This visit was announced and was to ensure the manager would be available to meet with us.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with eleven people who were living in the home and seven visiting relatives. We also spoke with the registered manager, a senior nurse, a nurse, three care assistants, the cook, activity organiser and two ancillary staff. We reviewed four staff recruitment files, six people's care records and a variety of documents which related to the management and governance of the home.

# Is the service safe?

## Our findings

Everyone we spoke with told us they felt safe.

Staff were able to describe different types of abuse and told us they would report any concerns to the senior person in charge of the shift or the registered manager. Staff we spoke with were also aware of the whistleblowing procedure and how to use this. A whistle blower is someone directly employed by the registered provider who reports concerns where there is harm, or the risk of harm, to people. One member of staff told us "If you see something that may be wrong, you tell someone, something needs to be done. I know I could call head office." We saw from the registered manager's training matrix, safeguarding training was to be refreshed every three years and all staff listed had completed within this timescale.

Each of the care plans we reviewed contained a variety of risk assessments. These covered, for example, falls, mobility and skin integrity and were reviewed and updated at regular intervals. One of the care plans we reviewed detailed the specific equipment the staff were to use to support the person to a standing position, during the course of the inspection we observed staff move this person using the correct equipment and techniques. We also reviewed the care plan and risk assessments for two people who required the use of a hoist. We saw the records provided an adequate level of detail including detail of how the sling should be applied and attached to the hoist. There were also a document which contained a number of generic instructions for staff in regard to the safe use of a hoist and how to reduce any anxiety felt by the person being hoisted. However, there were not always risk assessments in place for each item of equipment used by people. For example, one person required the use of a specialist chair but there was no risk assessment in place. We raised this with the senior nurse and on the second day of the inspection they showed us a risk assessment was now in place. It is important that risk assessments are in place that are specific to the individual and the equipment they use, this reduces the risk of harm to either the person or staff supporting them.

Staff told us there was no one who currently lived at the home who suffered regular falls. Staff told us, and we saw, a range of equipment to reduce the risk of falls, the risk of injury from falls and to alert staff in the event someone fell. This included, low beds, sensor mats and crash mats. People's skin integrity was also assessed regularly and staff told us no one had any pressure ulcers. Staff were able to tell us how they supported people who may be at risk of developing a pressure ulcer, including, ensuring people were re-positioned regularly, bed sheets were not creased and people's feet did not rub against the frame of their bed. Some people were provided with pressure reducing cushions and mattresses although we were unable to locate where staff recorded the correct setting for people's individual mattresses. We raised this with the senior nurse and they told us this was not currently recorded but they assured us they would make this information available for staff. It is important to ensure pressure mattresses are set correctly to ensure they are effective.

We saw evidence external contractors were used to service and maintain equipment, for example, gas appliances, electrical wiring and the fire system. We also evidenced the passenger lift and hoists had been serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Although we

were unable to locate the most recent LOLER for the slings, this was emailed to us after the inspection. Records evidenced regular internal checks were completed on a range of equipment including emergency lighting checks, wheelchairs, bedrails and the nurse call. These records were neatly organised ensuring we could access relevant information easily. This demonstrated there was a system in place to ensure the premises and equipment were suitably tested and maintained.

To adequately manage the risk of falls from windows suitable control measures need to be put in place. We saw window restrictors where in place however, we identified two windows where the restrictor still enabled the window to open to 120mm; this is above the Health and Safety Executives' current recommendation of 100mm. The registered manager told us this had already been identified by the registered provider and new restrictors had been ordered and they were awaiting delivery.

Staff were able to tell us what they were to do in the event the fire alarm was activated and we saw equipment within the home to assist staff in the event they needed to evacuate people. Personal Emergency Evacuation Plans (PEEP) were kept in the office and the senior nurse told us they were updated frequently due to the turnover of people in the intermediate care beds. A PEEP is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. We reviewed the most recent PEEP document which recorded the person's name, room number and listed the possible escape routes from their bedroom. However, the PEEP did not record evacuation routes from other areas, for example, if the person was in one of the communal area. We also noted the PEEP for one person recorded they were independent with their walking stick, however, upon further discussion with the registered manager it was identified that this person may require verbal prompting from staff in an emergency situation. The registered manager told us they had identified that the format for recording PEEP's needed some adjustment; however, at the time of the inspection this had not been actioned.

Feedback from people regarding staffing levels at the home was positive, one person said, "All I have to do is press the button and they come straight away. I never press the button twice, I always know someone comes." Staff did not raise concerns regarding the staffing levels at the home, one staff member said, "There are enough staff, if someone is sick, we are offered extra hours or we use agency staff." Another staff member said, "Yes there are enough staff, I don't feel under pressure."

The registered manager told us they completed a monthly review of people's dependency and the results of this were used to assist in the planning of the staffs' duty rota. They also said that that ancillary staffing hours had recently been reviewed and as a result changes were being implemented. This included the addition of catering hours over the tea time period and additional laundry hours. They said this was in response to increasing demands on these departments. This was confirmed when we spoke with a member of the ancillary team, they said, "There has been a change to the hours recently, it is much better now." This demonstrated the registered manager was responsive to the demands placed upon staff and had reviewed the staffing and skill mix accordingly.

We checked staff had been recruited in a safe way and that all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in place. We reviewed the recruitment files of four staff and saw application forms had been completed and a record of the interview questions and answers had been retained and two written references had been received. A Disclosure and Barring Service (DBS) check had also been completed. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. A regular check was completed on the professional qualifications of nursing staff employed at Fieldhead Park. This showed the registered manager ensured staff members were continuing to meet the professional

standards that are a condition of their ability to practice.

People told us they received their medicines on time.

Each of the care plans we reviewed contained a medicines care plan which recorded information about the medicines the person was prescribed and the support they needed to manage their medicines. Most of the medicines people were prescribed were kept in a locked cupboard in their bedroom, other medicines were stored in a treatment room. We observed medicines being administered by two staff, this was done safely. For example, staff checked they had the correct medicine before they administered it and cupboards where peoples medicines were kept and the treatment room where kept locked when not in use.

We checked four individual medicines and found the recorded number of administrations tallied with the medicines stock. One person was prescribed three medicines which they could take 'as required' (PRN); we saw a protocol was in place. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. The senior nurse told us the night staff administered some medicines which needed to be administered before breakfast. We reviewed the medicine record for one person who required a medicine to be administered before they ate but we saw staff did not record the time the medicine was administered. Recording this information provides clear evidence the medicine has been administered in line with the prescribing instructions.

We found the procedure for the management of creams was not robust. One of the care workers told us the nurse would advise them if people needed cream to be applied and where they were to apply it. We asked them if they documented when they had applied creams, they told us they recorded this in people's daily notes. One person medicine administration record (MAR) recorded they were prescribed a cream however; there was no topical medicine administration record (TMAR) where staff could record when they had applied this. Another person had a TMAR for Cavilon cream but their MAR recorded they were prescribed Mediderm. A third person had Daktacort cream prescribed, this was written on both their MAR and TMAR but the dates of administration did not tally on the records and the cream could not be located in their room. We brought this to the attention of the registered manager and the senior nurse, when we returned for the second day of the inspection we saw a notice on display to request relevant staff attend a training session in regard to the management of creams.

The senior nurse told us they regularly completed an assessment of staff's competency to administer people's medicines. We reviewed the personnel files of two staff who were responsible for administering medicines. We saw evidence in both files that their competency to administer medicines had been recently assessed and they had completed formal training. This ensures staff have the knowledge and skills to administer medicines safely.

## Is the service effective?

### Our findings

One of the staff we spoke with told us they had completed a programme of induction which included training and shadowing a more experienced member of staff and we saw evidence of this in their personnel file. We also saw evidence they were being supported to complete the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This showed new staff were supported to develop into their role.

We saw evidence in each of the staff files we reviewed, that staff had completed training in a range of topics, including moving and handling, fire safety, food hygiene, mental capacity and equality and diversity. The registered manager told us training was provided via e-learning followed by a competency and knowledge check to ensure training had been embedded. We saw evidence of this in the personnel file of staff member who had only recently employed. The registered manager's training matrix evidenced the training staff had completed and when they were due to attend refresher courses. These actions helped to ensure staff had the appropriate knowledge and skills to perform their job roles.

Staff also told us they received regular management supervision and an annual appraisal. One staff member said, "I had mine the other week with [name of supervisor]." The senior nurse told us they were responsible for completing the supervision for the nursing staff and they received supervision with the registered manager. Each of the four staff files we reviewed contained evidence of regular management supervision and their most recent annual appraisal. Regular supervision enables managers to monitor staffs' performance and development needs, ensuring staff have the skills and competencies to meet people's needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us four people who lived at the home were subject to a DoLS authorisation and a further one was awaiting assessment by the local authority.

The staff we spoke with had a basic understanding of the MCA. One staff member said, "It is about; do you have capacity to say your needs and wishes. If they you don't, we have to use best interests, that is about doing what is right for them." Another staff member said, "All the people here have capacity to make basic daily decisions." The registered manager and the senior nurse had a clear understanding of the principles of the MCA and ensuring where people lacked capacity, decisions were made in a person's best interests.

Following the inspection we reviewed the training matrix, this evidenced all staff listed had completed training in MCA and DoLS within the previous three years. This was in line with the timeframe set by the registered provider.

One of the care plans we reviewed contained an assessment which evidenced the person lacked capacity to safely manage their medicines. We also saw evidence that the staff had involved the person's legal representative and a family member in making the decision that it was in the person's best interest for the staff to manage their medicines on their behalf. Following this process ensures staff are acting in accordance with the legislation and associated Code of Practice.

We also reviewed the care plan for a person who was reluctant to maintain their personal hygiene or follow the advice of healthcare professionals, for example, to reduce the risk of them developing pressure ulcers. We saw a capacity assessment had been completed and care plans and risk assessments recorded they had the capacity to make these decisions. This showed staff respected people's right to make unwise decisions.

Everyone we spoke with was positive about the quality of the meals at Fieldhead Park.

The cook was aware of people's likes and dislikes and told us they were able to cater for specialist diets for example, vegetarian or diabetic. We saw a white board in the kitchen which clearly recorded room numbers, people's names and information for example, allergies or pureed diets.

On the residential unit the dining tables were neatly set out and looked welcoming with linen table cloths, flowers and napkins along with a range of condiments. The catering staff took the lead on serving the meals and the staff were seen to be very calm and patient. Where people were in their own rooms, meals were delivered to them on a tray and the meal was covered to prevent contamination and retain heat. Menus were clearly displayed and people were seen referring to this during the morning to make their choices, if people did not prefer the main menu on offer staff offered an alternative.

On the nursing unit, the main communal area did not have a dining table; this meant people ate their meals in their bedrooms or on tables while sat in easy chairs. The registered manager explained this area was undergoing a programme of refurbishment; however, a dining table was put in the communal area for the second day of our inspection.

On both units we saw people we offered regular hot and cold drinks throughout the day. People were offered a choice of meal, although the meal was plated up by staff which reduced people's ability to choose the components of their meal. People were supported to eat and drink and staff asked them if they had had enough or if they would like more before removing their plates.

Staff recorded the dietary and fluid intake for some people who lived at the home. We reviewed a random sample for one person and saw staff consistently recorded the meals and snacks they had eaten; although the record did not require staff to record the quantity of food the person was offered. We also noted staff recorded when they added a prescribed substance which thickened the person's drinks to reduce the risk of them choking.

People were weighed at regular intervals and their nutritional risk assessed. We saw the registered manager logged this information on a monthly report which they submitted to the registered provider. We noted the report recorded if people's weight had increased or decreased from the previous month but the reader was not able to review people's weights over a longer time frame other than by reviewing each individual report. We raised this with the registered manager; they told us that as they gathered the data from people's care

records they reviewed their weight and nutritional information for a number of months. This is important so as to ensure people who may lose or gain small amounts of weight over an extended period of time are identified as being a potential nutritional risk.

Care plans recorded peoples support needs, for example, one care plan recorded the person needed a beaker with a lid and a straw to enable them to drink independently. When we observed the person we saw they had their drink on the table beside them as described in their care plan. Another care plan recorded the person preferred a soft diet as they did not like to wear their dentures. This showed care planning reflected peoples individual needs.

People had access to external health care professionals, including doctors, district nurses, podiatrists and speech and language therapists (SALT). We saw evidence of this in each of the care plans we reviewed. This showed people received additional support when required for meeting their care and treatment needs.

Fieldhead Park is a converted property. There were a number of accessible communal lounges and dining rooms and people were free to use these as they wished. People's bedrooms were personalised, containing photographs, ornaments and items of personal significance. There were gardens for people to use and an enclosed paved area between the buildings where people could sit if they wished.

## Is the service caring?

### Our findings

Without exception everyone told us the staff were kind and caring.

Staff spoke to us about the people they supported, with empathy and in respectful manner, for example, referring to people by name. One member of staff said, "The best thing about the role is interacting with the residents and helping people." A member of the ancillary team told us, "The other day a service user was upset, I sat and had a chat with them, I gave them a blanket and a teddy to cuddle."

The staff and people who lived at Fieldhead Park looked comfortable together; there was a lot of laughter and friendly 'banter' between people. Staff clearly knew people well; this was evident in our observations of staff and reviewing people's records. Staff told us they worked predominantly on one unit; they also told us if agency staff were used, they tried to ensure the staff who came to the home had been before. This meant people were supported and cared for by staff who knew them well.

During the time we spent at the home we observed all the staff to be kind, caring and professional. Staff chatted with people as they passed them in corridors and as they entered communal areas. We observed staff supporting a person to transfer using a hoist, when the person was seated they covered the person's legs with a blanket, checked they were comfortable and gave them the nurse call before they left them. People were consistently offered choices, for example, what to eat and drink and where to sit. Staff told us people made their own choice regarding the time they got up and went to bed. One staff member said, "It is about what they want, their own routine."

There was a regular church service held at the home. This demonstrated peoples religious needs were respected and facilitated by staff.

People's privacy and dignity was respected. Staff knocked on doors and called out to the person before they entered their bedroom or toilet areas. We also saw each person's door had a small laminated notice attached to it. Staff told us this was for staff to use so other staff would know that personal care was being provided and they should not enter the room unnecessarily. One of the staff we spoke with said, "We take people to their bedrooms for personal care, we close the door. We knock before we go in rooms and we use the little signs (laminated note on bedroom doors to indicate if personal care is taking place) they work really well." However, we did note some people had finger nails which were not clean. We told the registered manager about this observation at the time of the inspection.

We saw staff enabled people to retain their independence, for example we saw a person using a plate guard at lunchtime. This enables a person who may only be able to use one hand to eat, to eat without staff assistance.

Confidentiality was maintained. For example, care records were stored in a locked room; this ensured they were not accessed by people who may not have the authority to do so. During the course of the inspection we heard staff speaking discreetly to people and we did not hear staff discussing people's needs in

communal areas.

The registered manager told us they were taking steps to encourage people and their relatives to become more involved in the care planning process. They told us they had sent a letter to people and their relevant family member to ask them how often they wanted to be invited to discuss their care plan. They showed us a matrix on the office wall which recorded the requests of the people's relatives who had responded. We spoke with one relative who confirmed they had received a letter and returned a form to the registered manager regarding this; they also told us they had recently attended a review where they had discussed their relative's care plan with the member of senior staff.

## Is the service responsive?

### Our findings

People spoke with enthusiasm about the activities at Fieldhead Park.

Without exception, people said that they took part in, and enjoyed, a wide range of activities and outings. Recently there had been trips to the local canal for a boat ride, a day out at the coast, local church lunch clubs, the Yorkshire Wartime Experience and various other minibus outings. People enjoyed community schools performing concerts and plays. On the first day of inspection we observed people were enjoying one to one manicures, some people were attending the local church lunch club and a game of carpet bowls took place at the home, in the afternoon.

There was an effective activities co-ordinator who was committed to the activity programme being enjoyable and beneficial; they were knowledgeable about the physical and psychological benefits of activities on people's wellbeing. Each person has an activity record where the activity co-ordinator noted people's personal preferences with regard to involvement in activities.

At the time of the inspection the home was in a period of transition as the registered provider was implementing a new care planning system in the home. The senior nurse told us they had been allocated a number of shifts where they were not counted on the staffing numbers to enable them to implement the new documentation.

The care files we reviewed all contained a variety of care plans regarding the care and support people needed. Two of the care plans we reviewed were in the new style, we found they were organised and information was easy to locate. The divider for each section of the file contained a variety of prompts and references, which staff could refer to when drafting a person's care plan. For example the section for sleep prompted staff to consider the environment, positioning and drinks, their corresponding care plan recorded 'likes desk lamp on overnight and one pillow under their head'. Another plan noted 'staff to elevate right arm, otherwise it fills with fluid and becomes painful'. The person was in bed on the day of the inspection and we saw their right arm was laid on a pillow to elevate it slightly. This showed that care planning was person centred and included details which were relevant to people's individual needs.

One person had recently been reviewed by a speech and language therapist (SALT) and we saw the information from this review had been added to their care plan. We also they had a detailed care plan regarding a specific medical condition, this included the signs and symptoms staff were to observe them for. This information enhances staffs' knowledge and increases the opportunity to identify potential medical concerns at an early stage.

We reviewed two peoples care plans which were in the new format and we saw not all section had been fully completed, however, we saw a note had been kept at the front of each care plan to inform and remind staff which records were still outstanding.

People told us they knew how to raise a concern.

We reviewed the complaints log and saw seven complaints were listed. The log recorded the date of the complaint, the name of the complainant, a summary of the concerns raised and the action taken. We reviewed one of the complaints and saw evidence of the investigation and a copy of the outcome letter the registered manager had sent to the complainant. On this occasion there was also evidence the registered manager had made further contact with the complainant to see if they were satisfied with the response they had received. This demonstrated where people raised a concern, they were listened to, and the matter was investigated and responded to.

## Is the service well-led?

### Our findings

Staff were positive about the management of the home. One staff member said, "It is a lovely place to work, any problems, [name of registered manager] deals with the straight away." Another staff member told us the nursing staff were "Brilliant." The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met. The registered manager was professional, but open and honest throughout the inspection process. They openly acknowledged the support of other staff members employed at the home and their contribution to the running of the home, "I couldn't do my job without my staff."

The senior nurse told us they completed a range of audits in the nursing unit. They said the audit form for the care plans had been updated and was to be implemented when the care plans were in place. They also told us other staff were involved in the auditing process for example, infection prevention and control, medicines, the environment and cleaning standards and mattress audits. Where issues were identified we saw staff recorded the action they had taken to rectify the matter.

The registered manager told us they completed a monthly report and sent this to the senior management team on a monthly basis. We reviewed the previous three months and saw the report included people weights, skin integrity, falls and the input of other relevant health care professionals. This ensured the senior management team were updated regarding peoples support needs at the home.

The registered manager told us senior managers visited the home on a regular basis. We saw the audits completed by one of the senior managers which had been completed at regular intervals throughout the year; their report included a review of the premises, environment and equipment and recorded their findings and action taken. We reviewed three audits completed by another senior manager in May, June and July 2017. Each report included a care plan audit and provided feedback of the action needed, we saw the registered manager had signed and dated each point to evidence action had been taken. The report also contained a section 'summary of other relevant information to check' and listed a variety of areas for review, for example, meetings, audits, safeguarding alerts. But there was no evidence to suggest these areas had been reviewed on two of the three audits. We brought this to the attention of the relevant senior manager and they assured us they would consider this for future audits.

However, the audits and reports had not identified the issues we have identified in the Safe section of this report. We recommend that the service seek advice and guidance from a reputable source, to ensure systems of governance are robust.

The registered manager told us accidents and incidents were recorded and the document was passed to them for review and analysis before being filed in the person's care records. They also told us the home had recently become involved in an initiative operated by another healthcare provider to look at further ways in which falls and the risk of falls could be further reduced. This meant the registered manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people living within the

home.

Staff told us meetings were held at regular intervals and we saw evidence of meeting minutes recorded from a variety of meetings. We saw meetings were frequently held for different staff teams, for example, the catering team, night staff and team leaders. Staff meetings enable the registered manager to monitor the service and review the standard of care and support for people living at the home. We also saw a staff survey had been completed in March 2017. Although the number of surveys issued was not recorded, we saw 22 had been returned. The majority of the feedback was positive and the registered manager told us some of the changes to ancillary staffing hours had come about from the survey feedback.

We asked relatives if they had been asked for their feedback about the home. The registered manager told us surveys were due to be distributed to people in September 2017 but they showed us the results from a relative's survey in February 2017. We saw 10 surveys had been completed, questions covered a number of topics, including; 'how to complain' and 'do you feel listened to', however, there was no record of the number of surveys distributed, a summary of the findings or details of how the feedback had been shared with people. Following the inspection we discussed this with the registered manager and they assured us they would consider these points for future surveys.

We also asked if meetings were held for residents and relatives. The registered manager told us they did not hold formal meetings at the home, they explained the focus was on social events and gatherings rather than a formal meeting. We saw the last recorded meeting was August 2016 when there had been a 'taster session' to enable people to try different foods that were being considered for the menu. Following the inspection we shared people's feedback with the registered manager to enable them to reflect on this feedback and implement possible changes in the future.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster on display in the reception area which displayed the ratings from the previous inspection and a link to the inspection report was also available on the registered provider's website.