HC-One Limited

Hollymere House General Nursing Home

Inspection report

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13 July 2018

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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 took place on 12 and 13 July 2018 and was unannounced. The service was last inspected on 14 July 2015 when we rated the service 'good' overall and in all the five key questions. At this comprehensive inspection we have rated the service 'good' overall but rated the safe question as 'requires improvement.'

Hollymere House 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.

Hollymere House provides accommodation and nursing care for up to 48 people. At the time of our inspection there were 42 people living at the home.

There was 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 were complimentary about the care they received at Hollymere House.

There were mixed views about staffing levels. We found that people were receiving appropriate care, however staff were very busy and there were sometimes delays in meeting people's needs. The management team were reviewing staffing levels and the deployment of staff. Recruitment of new staff was underway.

Checks were carried out during the recruitment process to ensure only suitable staff were employed.

Risks associated with people's care and support needs were assessed and guidance was in place to support staff to keep people safe. However, we noted that people did not always have access to their call bells.

Overall medicines were managed safely. However, we found some minor shortfalls in medicines management.

Staff understood their duty to protect people from harm and abuse. Appropriate procedures were followed to report any safeguarding concerns.

The home was clean and well maintained.

People were supported by staff who were suitably trained and supervised.

The registered manager and staff were aware of their responsibilities and acted in accordance with the

Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. (DoLS).

People's nutritional and healthcare needs had been assessed and were met. People were positive about the food on offer and staff supported people to have sufficient to eat and drink. Staff were responsive to changes in people's physical and mental health needs.

Overall, staff were caring and treated people with dignity and respect.

We found that people's oral hygiene needs had not always been addressed.

Care plans addressed each person's individual needs, including what was important to them, and how they wanted to be supported. However, daily records were not always complete and accurate. This was being monitored by the management team.

People could take part in a range of activities. They were cared for in a way that took account of their diversity and values. People's end of life wishes were discussed and recorded.

People told us that they felt able to raise any concerns or complaints, however the provider's complaints procedure was not clearly displayed at the home.

The registered manager understood his responsibilities and had built effective links with other professionals. He had a vision for the service and told us that since coming into post a number of changes have been implemented to make improvements to the care provision.

Staff told us that the manager was approachable and supportive, but some staff felt their concerns were not always acted upon. People and relatives were positive about the management of the home.

The provider had effective systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were very busy and people reported delays in their needs being met at times. Staffing was under review with the management.

We identified some minor shortfalls in the safe management of medicines.

Staff understood safeguarding procedures and concerns were reported appropriately.

Risks to people were assessed and action taken to mitigate any risks. People did not always have access to their call bells.

Risks associated with the safety of the environment and equipment were identified and managed appropriately.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well-led.

Hollymere House General 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.

This inspection took place on 12 and 13 July 2018 and was unannounced on day one. The inspection team consisted of two adult social care inspectors, a specialist nurse advisor 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

Before the inspection, we looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. We received a Provider Information Return (PIR) from the registered manager, before our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. The latest visit was in 2015 and was positive about the service.

During the inspection we spoke with 13 people who lived at the home and five relatives/visitors, to seek their views. We also spoke with 12 members of staff including two nurses, five carers, one nurse assistant, the registered manager, the regional manager, the well-being coordinator and the maintenance person.

As some people living at Hollymere House were not able to tell us about their care experiences, we used the

Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of six people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at Hollymere House. They said, "I feel safe because there are key pads and alarms on the doors"; "The people round and about make me feel safe" and" It's a very good home, it's clean and the nurses are very kind they help you if you need help."

We reviewed staffing rotas and spoke to staff and people living at the home. There were mixed views about staffing levels and people said there were busier times when they waited longer for assistance. One person told us, "They come as soon as they can. If they are busy you have to wait your turn. If I want something urgently they shoot around and get it.". We found that people were receiving appropriate care, however staff were very busy and there were delays in meeting people's needs at times.

At the time of the inspection there were 42 people living at the home. There were eight care staff, a nursing assistant and two nurses on duty in the day, and a nurse and four care workers at night. There was also a hostess on certain days between 10 am and 4pm, who supported with meals and drinks. Rotas showed that the numbers of staff had been maintained using bank staff and agency workers. There were occasions when the planned number of staff were not on duty which was due to short notice absence and the registered manager explained that all efforts were made to provide cover at these times.

Some staff felt they could do with more staff especially in the morning. The majority of people on the first floor required two staff to assist them with moving them safely and with personal care.. We observed that some people were not supported to get up until late morning One person commented," They woke me at 8:00am the other day but it was 11:55 before they got me dressed." We also saw that positional turns were delayed for one person. Staff told us that meeting personal care needs was sometimes delayed when staff were required to oversee the dining room or during staff breaks. The hostess role was felt to be effective but was not in place every day.

A staffing tool was in place to determine the number of staff required to the dependency levels of people using the service. We could not see how the dependency considered the layout of the building and impact where people needed support to meet their continence needs. The registered manager told us that this was a guide and was under review. The regional manager was visiting the home on the day of the inspection to review staffing levels. Options for increasing the cover during the busiest times and better deployment of staff were being considered.

New staff were being recruited and we saw that recruitment checks were underway for a number of potential staff. The registered manager told us that where agency staff were used they aimed to use the same regular agency staff, so that there was as much consistency as possible.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with

vulnerable people.

Risks associated with people's care and support needs were assessed and guidance was in place to support staff to keep people safe. Risks assessed included moving and handling, nutrition and hydration, continence, falls and the risks associated with specific medical conditions. Where people were identified as at-risk care plans had been implemented to ensure that these were minimised, such as for food intake or skin integrity. We saw for example, where people were at risk of choking they had appropriate risk assessments in place and staff had also rehearsed how to respond to a choking incident. The Herbert Protocol had been implemented for a number of people. The Herbert Protocol is a national scheme being introduced by the police and other agencies, which encourages care staff to compile useful information, which could be used in the event of a vulnerable person going missing.

Several people were nursed in bed and we saw that people had access to call bells. However, we found two examples where people's call bells were out of reach. One person expressed some frustration as they been taken to their bedroom but staff had not ensured they were able to access the call bell. We raised this issue with the registered manager.

Overall, we found that people received their medicines safely. We observed part of the medicines round and found that the nurse had a good understanding of the safe handling of medication. Medicines were stored safely in line with requirements in locked trolleys and in a clinic room with a separate controlled drugs cupboard. Room and fridge temperatures were recorded daily. All storage was neat and tidy. All staff with responsibility for administering medicines had received the appropriate training and undertook regular medication competency assessments. Medicine audits were carried out on a regular basis to ensure the records were properly completed.

However, we found some minor short falls in medicines management which were raised with the registered manager. When we returned on the second day, action had been taken to address some of the issues identified. Where people were prescribed medication on PRN (as required) basis there were clear and comprehensive protocols in place. However, there was no overarching protocol for which medicine to use in the first instance if people were prescribed more than one medicine in a similar group, such as pain relief. Furthermore, where people were prescribed pain relief on a PRN basis, their records did not indicate how their pain was assessed. It is good practice to use formal assessment tools such as the numerical pain scale to guide staff, especially where people were unable to express this.

Some people were prescribed medicines which should be given in the morning around 30-60 minutes before food to ensure they are effective. It was noted that the home did not have consistent arrangements in place to ensure these specific administration instructions were always followed. For people who received their medication and nutrition through a percutaneous endoscopic gastrostomy (PEG) tube there were comprehensive guidelines in place for safe administration, including how to position the person. However, instructions or records to evidence that staff were monitoring the catheter site were not in place. The guidelines state that this should be checked at least daily to detect early signs of infection or other problems

There was no evidence to demonstrate how the home worked with the GP surgery to ensure robust systems were in place to review people's overall medication regimes. There were examples of people having numerous prescriptions in lace which had not been reviewed. Following the inspection, the registered manager confirmed that arrangements were in progress to review this as required.

The provider had policies in place for safeguarding vulnerable adults and whistleblowing. Staff

demonstrated a good level of understanding and could clearly describe the steps they would take to protect people from abuse. Staff told us that they had access to a whistleblowing help line. We saw that information was on display throughout the home about how to raise any safeguarding concerns. The registered manager was appropriately notifying CQC and the local safeguarding of any concerns which were of a safeguarding nature and understood their responsibilities around reporting concerns.

We saw that accidents and incidents, along with any pressure ulcers and weight loss or gain were monitored. Accidents and incidents were recorded by staff. The registered manager reviewed these monthly for trends and patterns to consider whether further action was required to prevent re-occurrences where possible. The registered manager held a monthly "clinical indictors" review with a nurse. This enabled them to cross check that any areas of clinical risk, such as weight loss, skin conditions and health issues had been identified and action taken to manage the risks.

The management team held quarterly health and safety meetings where and safety issues, were discussed and actions required identified. We saw for example that a vacuum cleaner was frequently used and the lead posed a potential tripping hazard. This had already been identified and the registered manager was in the process of providing alternative equipment.

We found that the registered manager would act to learn lessons and make improvements if things had gone wrong. For example, a new system had been implemented following an issue related to fluid intake. The registered manager had instigated a clinical walk around to review charts during the middle of the day, this ensured that where people were not on target, action could be taken before the end of the day.

The home employed a maintenance person who ensured that risks associated with the safety of the environment and equipment were identified and managed appropriately. A fire risk assessment had been completed and regular fire alarm checks recorded. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP).

Health and safety checks had been undertaken to ensure safe management of utilities, these included amongst others water and legionella checks, electrical appliance testing, regular checks and maintenance of moving and handling equipment, and the lift. There had been a recent problem with one of the water tanks which had been reported and was being addressed. There was an emergency plan which informed staff what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the home.

When we looked around the home, we saw that it was clean and well maintained. Personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home and staff wore these where required. Staff had also undertaken training in infection control.

Good

Is the service effective?

Our findings

People and their relatives told us staff provided effective care. Comments included, "I feel safe because there are plenty of staff around and they are all knowledgeable."; "They take (name) to the doctor when she needs it and they take her to the hospital for hearing tests" and "The food is very good."

People received sufficient to eat and drink and staff acted to address any concerns. The registered manager explained that there had been a focus on the quality of the food. The food offered was varied and all made on site using fresh ingredients. We sampled a soft diet which was tasty and well presented.

We observed lunchtime on the upper floor, which was a pleasant experience. The tables were set with napkins and condiments. There were sufficient staff to support people and a welcoming environment was created. We saw that people requiring encouragement to eat received this in a sensitive and timely manner. We saw that one person didn't like their food option and was quickly offered an alternative which they then enjoyed. There were jugs of juice in each of the lounges and in individual bedrooms and staff were observed to encourage residents to drink. During the afternoon ice cream was served.

Staff understood about people's dietary requirements because this was recorded in care plans and updates were received at shift handover. Where people had specific dietary requirements, for example a soft diet, this was noted in care plans and kitchen staff were made aware. This enabled the service to mitigate risk of inappropriate or unsafe food being served.

We looked at two care plans in relation to nutrition and hydration. We saw that food and drink intake and weights were monitored regularly in accordance with people's needs. This enabled staff to highlight any risk associated with poor eating, drinking and weight loss. We noted in one person's care plan they needed to be continually observed at mealtimes and saw that staff followed this guidance. Referrals were made to health professionals in a timely manner when weight loss had been identified.

Staff had appropriate skills and knowledge to provide effective care and support. Staff confirmed that they received an induction which included a week or more of shadowing experienced staff and completing mandatory training. However, the induction period was not documented within the staff files. We spoke to the registered manager who told us that an induction booklet had been designed and was ready to be used for any new staff employed.

Staff undertook regular training and certificates were available to demonstrate that staff were trained in several areas including, moving and handling, safeguarding, fire safety, infection prevention and control, mental capacity and emergency procedures. One staff member told us that all the training was completed online apart from moving and handling which was face to face. The registered manager kept records which alerted him to when staff needed to renew their training. We noted that specific end of life training was not offered even though the service provided this care. We discussed this with the registered manager who told us they had made links with the local end of life partnership with a view to providing support and training in this area.

We saw staff received regular supervision and this was documented. One staff member told us they received one to one supervision every three months but two staff members could not recall when they last had a supervision session. However, we saw records of supervisions meetings. We discussed this with the registered manager who told us that staff may not always recognise supervision, as these were now being held in a more supportive way to discuss people's training and developments needs rather than simply to highlight any areas of concern.

People's physical and mental health needs were assessed on admission to the home and reviewed on a regular basis. We saw that assessments were available within people's care records. The registered manager usually met people and provided information about the home before they moved in. We observed that people, had equipment needed such as profile beds, pressure relieving air mattresses, bed rails with safety covers and sensor equipment.

People had access to ongoing health care services. Referrals to health professionals were noted in care plans, along with healthcare professionals' communication logs. We saw that people visited or received visits from the optician, dentist, district nurses and other healthcare professionals. One person with diabetes had recently attended the eye clinic for their annual screening. Care records demonstrated that staff were responsive to changes in people's physical health needs. We spoke with two visiting health professionals who gave positive feedback about the service and told us staff made time for their people and understood their needs well.

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 make particular decisions, any made on their behalf must be in their best interests and the least restrictive option.

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). 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.

We observed that staff sought consent to carry out interventions where people required support. For example, we heard staff ask, "Can I help you with that?". Whilst people and relatives were consulted with as part of the care planning process, we found that people had not always signed their consent within the care plans. We discussed this with the registered manager who confirmed that action would be taken to ensure that all documentation was signed appropriately.

Where people lacked capacity to make decisions, mental capacity assessments had been completed and where appropriate best interest decisions had been made. DoLS referrals had been made to the local authority where required. Staff could tell us the principles of the MCA and DoLS. One person told us that mental capacity is the "ability in that moment for that person to make a decision" another told us "We deem someone to have capacity unless assessed otherwise". This showed a good understanding of the MCA. The registered manager was very knowledgeable about the MCA and provided an example where they had challenged a situation, with a health professional, which ensured that the person's human rights were protected and further assessments were undertaken.

People's needs were met by the design and decoration of the home. Adaptations were made where

necessary to meet people's needs. The environment was accessible for people living with a disability. The home was well decorated and there was a display at the front of the home which was linked to areas of interest, for example the World Cup, which was taking place at the time of inspection. Rooms were personalised and people who lived there had their own photographs and furniture if they wished. One person had their door painted a colour that was important to them to help them recognise it.

The layout of the building was such that there were a few small lounge areas, they were decorated in a homely way with a selection of furniture. Therefore, people had a choice of where to sit and there were busier or quieter areas available. We spoke to the registered manager and asked how staff effectively supervised people over different rooms. He explained that this can created a challenge to staff and this was an area he is keen to develop. There was a secure garden which had been renovated with support from a voluntary organisation.

Good

Is the service caring?

Our findings

People who lived at Hollymere House told us they felt well cared for. They commented, "The care they provide meets my needs, I am treated with dignity"; "The care here is A+, everyone is really caring and the staff are good" Visiting relatives told us, "Staff are very caring and hardworking" and "The staff are very caring (name) gets lots of attention."

During the inspection we observed how well staff interacted with people. We saw that staff were kind and caring in the way they approached people. The atmosphere was friendly and people living at Hollymere House looked comfortable and content in their surroundings. We observed numerous examples of interactions between staff and residents which were warm and respectful and staff had obviously built positive relationships with people.

However, one person did comment that, staff could be very nice but that some staff could be more caring than others. During the inspection we found that one staff member could have spoken with people in a kinder manner, we raised this with the registered manager. There were numerous thank you cards on display and compliments that staff had received about the service.

The registered manager demonstrated that he knew each person living at the home individually. One person had a condition which meant they found it difficult to locate their bedroom. The registered manager knew they were a football fan and had contacted the chairman of the club to find out the original colour of the kit. They arranged for the person's bedroom door to be painted in that colour and the person was now able to locate the bedroom without assistance.

In another example, staff had enabled a person to fetch their pet dog to live with them at the home. After the person had passed away one of the care staff had adopted the dog and brought him to work with them. People living at the home appeared to really enjoy having the dog around and it kept itself busy visiting people in their bedrooms.

Overall, we found that people were well-groomed and appropriately dressed. During the inspection staff supported people to have their nails filed and polished if they wished. People told us that they were supported to have regular baths or shower and we observed staff offering this choice during the inspection. However, we were concerned that people's oral hygiene needs may not always be met. We saw that one person did not have any toiletries or a toothbrush available in their bedroom. We raised this with staff who could not demonstrate that the person had been supported with oral hygiene. A toothbrush and other toiletries were immediately provided, as a stock was available within the home. We saw other records relating to oral hygiene which had not always been competed by staff to demonstrate that they had provided this care. We raised this with the registered manager to address.

People and their relatives told us they were involved in care planning and there were details of people's lives documented in their care plans. We saw that people choices and wishes were taken into consideration by the staff. One person had expressed the wish to visit a seaside town. The person told us how staff had

arranged this for the following week and were really looking forward to it.

People's diverse needs were considered. Care plans included people's cultural and religious preferences. Members of the local religious community visited the home which enabled people to practise their faith. Equality and diversity was included within the provider's mandatory training requirements to ensure people were cared for without discrimination and in a way that respected their differences.

People told us and we saw that staff were good at respecting people's privacy and dignity. Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly and sensitively. Staff spoken with could explain the approach they took to maintain people's dignity such as knocking on bedroom doors and keeping people covered. Staff were observed when bedroom doors were closed to always to knock and identify themselves on entering the room.

Relatives were able to visit without restriction. One visitor told us how they visited the home twice daily and were made to feel welcome.

Good

Is the service responsive?

Our findings

People and their relatives said staff were responsive to their needs. They told us, "The carers have been brilliant," and "The wellbeing coordinator is so caring, I always feel welcome."

Each person had a care plan in place which outlined their care and support needs. Staff told us that they had access to these care records and were also informed about changes to people's needs in daily handover meetings. The care plans were personalised stating how people liked to dress, the food they liked and preferences for bathing/ washing and sleeping. Staff spoke about people in a very person-centred way, demonstrating they knew people's individual likes, dislikes and preferences. Staff commented, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right." The records reviewed indicated that people and family members had been involved in their care planning and reviews where appropriate.

In one example we saw that a person was deemed to be at high risk of falls, their care plan gave guidance to staff to remind the person to use their walking stick because they tended to forget. The records showed that following any recorded falls they were placed under additional observations and physical monitoring. The person had diabetes and their care plan contained a detailed rescue plan.

However, we found that accurate daily records were not always kept demonstrating the care people were receiving. We found some instances where there were gaps in records relating to continence care and positional changes not being completed for people who had been assessed as requiring this level of input. We checked with one person who told us they had been supported with their continence needs, but we found that staff had not recorded this. The registered manager told us that this had been identified and that in some cases staff had forgotten to sign the records. An audit had been introduced to check and ensure that records were completed appropriately. This was ongoing.

Staff considered people's communication needs. As part of their assessments people were asked whether they had any specific communication needs, which was recorded. Care plans contained information in relation to supporting effective communication with individuals. This included information on any communication aids such as glasses or hearing aids that the person might require. We saw that staff had supported one person to use speech and picture boards as they had been unable to communicate verbally and staff had been working with health professionals to support the person to improve their speech. The registered manager knew about the Accessible Information Standard which aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. There were notices on display which advised people that information could be provided in alternative formats.

People could take part in person-centred activities and were encouraged to maintain hobbies and interests. The home had a well-being coordinator who arranged activities during the day. Both floors had an activity board and posters which displayed the activity plan for the next three to four weeks. During the inspection we saw that a church service was held and supported by people from the church. Following the service tea

and coffee was served and general discussions were held which people were enjoying. Other activities on offer included, bingo, arts and crafts, baking and "pets as therapy" visits. The wellbeing coordinator also undertook one to one room visits for people who remained in bed. There were books and magazines in the lounges and a game of dominoes was played during the day

Links had been made with the local community and the wellbeing coordinator arranged for people to come into the home such as entertainers. During the inspection we saw that children from a local nursery visited and spent time with people living at the home. We saw they were smiling and happily enjoying the children's company.

People's care records showed that they had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. People also had 'advanced care plans' in place and where appropriate their relatives had been included in planning their care in the event of their deterioration. One person had been supported by staff and people from a local church to ensure that they were never left alone during their final hours, as was their wish.

The registered provider had a complaints policy and procedure, but this was not clearly displayed. We raised this with the registered manager. Everyone spoken with felt confident should they have any issues or concerns that they could complain to either the manager or the deputy manager and were able to name them.

The registered manager logged any complaints, which were documented with any actions taken to resolve them. There had been four complaints so far during 2018, which had been fully investigated and appropriate responses were provided.

Good

Is the service well-led?

Our findings

We found that the service was well-led. People and relatives told us they knew who the registered manager was and were positive about the management of the home. Comments about the manager included, "The manager is approachable" and "The managers, you don't see them a lot, but if you have a complaint you go and see them, they get it sorted." One professional told us they found the registered manager to be very approachable and visible around the home.

There was a registered manager in place. He was available throughout the inspection and engaged positively with the inspection process. He demonstrated good knowledge of all aspects of the home including the needs of people living there and the staff team. The registered manager understood his responsibilities and had built effective links with other professionals. He had a vision for the service and told us that since coming into post a number of changes have been implemented to make improvements to the care provision.

Staff views were mixed regarding the management of the service. Some told us that the manager was approachable and would listen to any concerns. One person commented. "He is very supportive and is so person centred and all for the residents. He speaks to staff and residents and he actively encourages staff to offer ideas to improve care in the home". However other staff told us they did not always feel listened to or that action was taken to address their concerns, some did not feel appreciated in their role.

We saw that staff were consulted with and kept up to date with information about the service through monthly staff meetings and an annual staff survey was also undertaken. Daily flash meetings were held, along with other regular meetings such as health and safety reviews. The registered manager told us that HR (human resources) surgeries had recently been held with all staff to provide them with the opportunity to raise any concerns or issues they may have about the service.

The registered manager had regular contact with people and their relatives, his office was based in the reception area and we saw that he had built effective relationships with people and visitors. Relatives told us that they could raise any concerns and felt they would get a positive response. In the reception area there was a computer screen which enabled people and visitors to make comments about the service. Regular residents and relatives meetings were held, which enabled people to provide feedback about the service. Following feedback received facilities had been made available to allow relatives to make themselves hot drinks.

We looked at the arrangements in place for quality assurance and governance. There was a home calendar to ensure that monthly audits were undertaken, these included infection control, catering and falls. A quarterly "falls team" meeting was held to analyse any falls and establish any further action was required. Further audits were carried out for medicines and care records. The registered manager was required to provide a monthly "key care indictors" report to the provider which covered areas such as infections, wounds and falls. We saw from the records that the regional manager undertook bi-monthly visit to the

home and reported on several areas. Any action following these visits were added to the home's improvement plan,

The registered manager worked in partnership with other organisations to promote continued learning and improvement. He attended regular managers network meetings and worked with the local CCG to take part in new initiatives. The provider held local governance management meetings to share any learning such as safety alerts with the staff team.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that the registered manager had made the appropriate notifications to CQC as required. The current CQC rating was displayed as legally required on the registered provider's web site and within the home.