The Royal Masonic Benevolent Institution Care Company

Prince George Duke of Kent Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 12 and 13 October 2017 and was unannounced. Prince George Duke of Kent Court is a nursing and residential home providing accommodation and support for up to 78 people. There were 58 people living at the home at the time of our inspection. This was our first inspection of the service under the current registration.

There was a registered manager in place at the time of our inspection. 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 that staff had received training and supervision in support of their roles, although improvement was required to ensure nursing staff consistently received clinical supervision and training specific to their roles, in support of people's clinical needs. The registered manager was aware of the need to make improvements in this area and we saw plans in place to address these concerns.

There were sufficient staff deployed at the service to meet people's needs, and the provider followed safe recruitment practices. People had mixed views about agency staff used by the service at short notice, but agency usage was reducing, with new staff having recently started work at the service and further new staff working through the recruitment process at the time of our inspection.

Medicines were stored, administered and recorded safely and appropriately. Risks to people had been assessed and staff were aware of the action to take to manage risks safely. People were protected from the risk of abuse because staff knew the types of abuse to look out for, and the action to take if they suspected abuse.

Staff sought consent from people when offering them support and followed the requirements of the Mental Capacity Act 2005 (MCA) where people lacked capacity to make specific decisions for themselves. The provider had also sought to ensure that people were also only lawfully deprived of their liberty in accordance with the Deprivation of Liberty Safeguards (DoLS) where this was in their best interests.

People were supported to maintain a balanced diet and were offered a choice of meals each day. The service catered for any specialist dietary requirements people had and followed guidance from healthcare professionals where appropriate, to ensure people were supported to eat and drink safely, and had sufficient nutritional intake. People were also supported to access a range of healthcare services when they needed them.

Staff treated people with care and consideration. We observed staff interacting with people in a friendly and attentive manner. People's privacy and dignity were respected by staff. They were involved in decisions about their care and treatment. The service provided appropriate end of life care to people and sought

feedback from people about their preferences for treatment at the end of their lives.

People had care plans in place which were person centred and reflected their individual needs and preferences. Care plans were reviewed on a regular basis to ensure they were up to date. The service offered a range of activities for people to take part in and people told us they enjoyed the activities on offer.

The provider had a complaints policy and procedure in place which provided people with guidance on how to raise concerns. People told us they knew how to make a complaint and expressed confidence that the registered manager would address any issues they raised.

People and staff spoke positively about the registered manager and the management of the service. They told us the management team was a visible presence in the home, and looked to lead by example. Staff spoke positively about improvements that had been made to their ways of working since the arrival of the registered manager.

The provider sought people's views through regular meetings and the use of surveys. We saw examples of improvements having been made at the service as a result of people's feedback. Staff also conducted a range of checks and audits on aspects of the service which helped identify issues and drive improvements.

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.

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

Risks to people had been assessed, and action taken to manage areas of identified risk safely.

People's medicines were stored, administered and recorded safely.

People were protected from the risk of abuse because staff were aware of the signs of abuse and action to take if they suspected abuse had occurred.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported in their roles through training and regular supervision. However improvement was required to ensure nursing staff consistently received clinical supervision and appropriate training in support of people's clinical needs.

Staff sought consent from people when offering them support. The provider complied with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

People were supported to access a range of healthcare services when required.

Is the service caring?

Good

The service was caring.

People were treated with kindness and consideration, and their privacy and dignity were respected by staff.

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

People received appropriate end of life care and support.

Is the service responsive?

Good

The service was responsive.

People had been involved in developing care plans which reflected their individual needs and preferences.

The provider offered a range of activities for people to take part in, in support of their need for stimulation and social engagement.

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

Is the service well-led?

Good

The service was well-led.

People and relatives spoke positively about the management of the service and told us the registered manager was available to them should they wish to raise any issues or offer feedback.

Staff told us that improvements had been made to the ways in which they worked across the service and told us they received good support from the management team.

The provider had systems in place to identify any potential issues or areas requiring improvement across the service and we saw action had been taken to address any problems which had been identified.

The provider sought people's views about the service and looked to make improvements as a result of any feedback received.

Prince George Duke of Kent Court

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 12 and 13 October 2017 and was unannounced. The inspection team consisted of two inspectors, a nurse specialist and an expert by experience on the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned to complete the inspection on the second day.

Prior to our inspection we reviewed the, information we held about the service. This included any notifications about injuries, deaths and safeguarding. A notification is information about important events that the provider is required to send us by law. We also contacted a local authority responsible for commissioning the service to obtain their views. The provider had also completed a Provider Information Return (PIR) prior to the inspection which we reviewed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help inform our inspection planning.

During this inspection we 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 also spoke with five people individually and a further twelve people as a group, as well as seven visiting relatives, and a visiting podiatrist and GP to gather their views.

We spoke with the registered manager, deputy manager and 14 staff. We reviewed ten people's care records, nine staff recruitment records, staff training and supervision records, and other records relating to the management of the service including audits and the provider's policies and procedures.

Good

Is the service safe?

Our findings

There were sufficient staff deployed at the service to safely meet people's needs, although the feedback we received from people and relatives about staffing levels was mixed. One person told us, "The staffing is adequate and I'm getting the support I need. They always come if I use my call bell." Another person said, "There are not enough [staff] now," although they also confirmed that staff were available to support them at the times they required assistance. One relative commented, "[There is] quite a high staff ratio and always staff around." However another relative told us, "You sometimes hear the buzzers [call bells] going for a long time."

The registered manager determined staffing levels based on an assessment of people's needs. Records showed that the staffing levels within the service reflected the planned allocation, and we noted that a recent increase had been made to the staffing level in the residential part of the home to help ensure people received the support they required promptly. Call bell monitoring information was not available for review at the time of our inspection due to an IT issue, although records showed that the registered manager was in the process of taking action to address this problem. We will follow up on this at our next inspection. We observed a good staff presence throughout our inspection and that staff were attentive to people's needs. One staff member told us, "I think there is plenty of staff; we are never short staffed. We always have time during the day to sit down and talk to the residents and we are encouraged to do so."

Two people also told us that they felt there was a high level of agency staff used at the service, although another person and a relative both said that they thought agency usage had recently reduced. Another relative told us there were, "Adequate [staff] numbers and retention; I'm seeing the same faces." The registered manager told us, and records confirmed that agency staff usage had reduced due to an ongoing recruitment drive, and we noted that there were further new staff preparing to start work at the service during the coming weeks.

The provider undertook appropriate recruitment checks on new staff before they started work. Staff files contained completed application forms that included details of each staff member's full employment history, a health declaration, criminal records checks, checks on identification and, where applicable, checks to ensure they were authorised to work in the UK. Nursing staff files also contained confirmation of their professional registration. These checks helped to ensure staff suitability for the roles they were applying for.

People were protected from the risk of abuse. Staff had received training in safeguarding adults. They were aware of the types of abuse that could occur and the signs to look for that might suggest a person had been abused. The provider had safeguarding procedures in place which provided guidance to staff on the steps to take if they suspected an incident of abuse had occurred and staff demonstrated a good understanding of these procedures. They were also aware of the provider's whistle blowing policy and told us they would report any concerns they had to external bodies, for example CQC or the local authority, should they feel the need to do so. However, all of the staff we spoke with expressed confidence that any allegations they raised would be dealt with appropriately by the registered manager.

Records showed risks to people had been assessed in a range of areas including the risk of falls, moving and handling, malnutrition and risks associated with their skin integrity. These risk assessments were reviewed on a monthly basis or more frequently if staff identified changes in people's conditions, to ensure they remained up to date and reflective of their current needs.

Identified risks to people were safely managed. For example, we saw pressure relieving equipment was in place where risks to people's skin integrity had been identified, and where required wound management records showed the steps taken to promote healing and prevent further damage. In another example we saw people's food and fluid intake was monitored where they were at risk of malnutrition or dehydration to ensure they were being appropriately supported with their intake. Staff we spoke with were also aware of the risks to the people and how to support people safely. For example one staff member was aware of the need to monitor one person's blood sugar levels due to their health condition and records showed these checks had been made to ensure the person received appropriate and safe support.

Records of accidents and incidents were maintained by staff and these were monitored by the registered manager to identify trends and reduce the risk of recurrence. Where repeat accidents had occurred, we saw people's risk assessments had been updated and action had been taken in an effort to improve safety. For example, where people had been identified as repeatedly suffering from falls we saw the registered manager had taken a range of steps to reduce reoccurrence including making referrals to a falls clinic for one person and putting additional staff in place to support another.

Routine checks were carried out by staff on the safety of the premises and any equipment, including checks on hoists, lifts, electrical appliances, and gas safety. The provider had procedures in place on dealing with emergencies. People had emergency evacuation plans in place and staff were aware of the procedures to follow in the event of a fire or medical emergency. Records showed that staff carried out regular fire drills and checks on fire safety equipment and systems. A fire alarm test was carried out during our inspection and we noted that fire doors closed automatically, as required as part of the test.

Medicines were managed safely. One person told us, "The staff help me with the medicines I've been prescribed and I get them on time." However, another person explained that there were occasions when staff may have been dealing with emergencies which meant a delay in the medicines round, telling us, "If it gets to half an hour, I go to enquire." We discussed the medicines rounds with the registered manager who told us that they had recently made adjustments to the way staff worked on shifts to reduce the risk of administering staff being disturbed during medicines round. Administering staff confirmed these changes had been made and we observed staff supporting people with their medicines in a timely and relaxed manner during our inspection.

Medicines were stored securely at the service in cupboards only accessible by authorised staff. Where medicines required refrigeration, they were stored appropriately within medicines refrigerators. Checks were made on the temperature of medicines storage areas and refrigerators to ensure they were stored within safe temperature ranges. Records showed staff responsible for administering medicines had received training on the safe management of medicines which included an assessment of their competency. The provider also maintained records confirming any unrequired medicines were disposed of appropriately.

We saw medicine administration records (MARs) were in place for each person which included a copy of their photograph, details of any allergies or swallowing difficulties they may have to help reduce the risks associated with medicines administration. MARs also listed people's current medicines and were up to date, showing people had received their medicines as prescribed. Where people had been prescribed medicines to take 'as required' we saw protocols in place giving guidance to staff on how these should be offered to

people. We observed staff following this guidance when supporting people with their medicines during our inspection.

Requires Improvement

Is the service effective?

Our findings

People told us their needs were met by competent permanent staff but expressed less confidence in the training agency staff received. One person told us, "They all [permanent staff] have a lot of training, but don't train agency staff." Another person said, "The permanent staff are excellent and know what to do. Agency staff are not so good and you have to direct them, but there has been a reduction in the number of them working." Relatives told us that they considered staff to be competent in the way they support people at the service. One relative said, "The staff are brilliant and do a good job supporting the residents."

The registered manager told us, and records confirmed that they reviewed the profiles of any agency staff prior to their working at the service when considering their suitability. The registered manager also explained that agency workers went through a brief induction when starting work at the service and this was confirmed by one agency staff member who told us, "I started last week. I was shown care planning system; I was assigned a resident to care for and shadowed another more experienced member of staff. That has really helped them to get to know the residents and how the home works." We also saw care planning and risk management summaries were in place relating to people's needs, which were provided to agency staff so they were aware of the support people required. Records also confirmed that the service was in the process of recruiting more permanent staff which would further reduce the need to use agency workers.

Permanent staff completed an induction when they started work for the service which included a period of orientation, reviewing policies and procedures, shadowing more experienced staff and completing training considered mandatory by the provider. Where new staff had no experience of providing care to people they were required to complete the Care Certificate, which is the nationally recognised induction of staff working in social care. Records showed that staff had received training in a range of areas, including infection control, safeguarding adults, moving and handling, food hygiene, health and safety, first aid, and dementia awareness. This training was refreshed periodically to ensure staff remained up to date with best practice.

Staff told us that the training they received gave them the skills to support people at the service. For example one staff member explained that the dementia training they received had been helpful, telling us, "The training made me look at things differently and from the point of view of the person living with dementia. I think I have a far better understanding of the condition now."

Records also showed that nursing staff had received some training specific to their roles, including catheterisation and the administration of medicines. However, improvement was required to ensure that nursing staff consistently received appropriate clinical training. For example, we reviewed the records of five nursing staff and found that only two of them had received training in pressure area care. We also found that improvement was required to ensure nursing staff were supported in their roles through clinical supervision, as this had not always happened consistently during the previous year.

We raised these issues with the registered manager who confirmed they had already identified these issues. Records showed that the registered manager and provider had been looking at options for making improvements in this area which were to be rolled out following our inspection. We will follow up on this at

our next inspection of the service.

Whilst improvement was required with regards to clinical supervision, all of the staff we spoke with told us that they received regular one to one supervision and said they were well supported by the registered manager. One member of staff said, "I get regular supervision and I had an annual appraisal last year." Another member of staff said, "I'm supervised regularly. We've discussed any issues I might have had or areas in which I could improve, as well as any options in terms of career development." Records confirmed that staff received regular supervision and an annual appraisal of their work performance.

Staff were aware of the importance of seeking consent from people when offering them support. One staff member of staff told us, "I always check that people are happy with what I'm doing. If they didn't want my help, I'd try again later but it's there decision." Another staff member said, "I wouldn't force anyone to do anything if they didn't want to."

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. The registered manager and staff were aware of how the MCA applied to their roles. They explained that many of the people using the service had capacity to make decisions for themselves and knew to ensure that people received support to make their own decisions wherever possible. However, where people lacked capacity to make decisions for themselves staff followed the principles of the MCA. Where required, mental capacity assessments and best interests decisions had been made regarding specific decisions, for example the use of bed rails.

The registered manager was aware of the conditions under which a person may be considered to be deprived of their liberty and had submitted applications to the relevant local authorities seeking authorisation to people of their liberty where this was in their best interests. Where these applications had been assessed, we saw DoLS authorisations had been granted. We reviewed a sample of the DoLS authorisations currently in place and found that any conditions placed upon them had been met.

People were supported to maintain a balanced diet. The comments people and relatives made regarding the food on offer at the service were mixed. One person told us, "I'm not keen on the food; it's like school dinners although they do try to cater for our preferences." Another person told us, "If you don't like the options on the day, they will make you something else; my family think it's first class." A relative said, "I think the food is brilliant; there's a variety and the salads are nice. There's also plenty of fresh fruit."

People's care plans included assessments of their dietary needs and preferences, including information about their likes and dislikes, and any food allergies they had. This information was also available to kitchen staff to inform their meal planning. Where required, professional advice had been sought to ensure people were supported to eat and drink safely. For example, where people had been assessed as being at risk of choking, or as having swallowing difficulties, we saw referrals had been made to a speech and language therapist who provided guidance for staff on how these issues should be managed. Staff we spoke with were aware of people's individual support needs when eating and drinking.

We observed how people were support by staff during a lunchtime meal. The atmosphere in the dining room was relaxed and staff were on hand to support people where required. The manager explained that they had changed the pattern of the handover between staffing shifts to enable a greater number of staff to be available to support people during the lunchtime meal and we saw this to be the case. People were offered a choice of meals and we saw pictorial menus were available on the dining tables to help support their decisions.

We observed examples of people being given choices about what they ate. For example one person decided they did not want to eat what was initially served to them so staff discussed alternative options with them to determine what they would prefer. We also saw that where people preferred to eat in their rooms they were able to do so, and were supported by staff where this was required.

People were supported to access a range of healthcare services in order to maintain good health. One person told us, "A GP visits every week so we see them if needed." A relative said, "The district nurses come in regularly [to see their loved one]." Records showed that people received support from a range of healthcare services including GPs, community nurses, dentists, chiropodists and physiotherapists. On the day of our inspection, one person was visited by a physiotherapist and we saw staff providing them with relevant information regarding the person's current condition. Another person was visited by a podiatrist who told us, "The staff here are helpful; they are knowledgeable about people's needs and I've had no problems." We also spoke briefly with a visiting GP who confirmed that staff kept them informed of people's current health.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and considerate. One person said, "The staff have been wonderful; very compassionate. They've been quick to act when I've been upset and couldn't do enough for me." Another person said, "The staff care; they're very patient with us." A relative described the home as having a, "Holistic family approach." They told us staff were, "Always kind and courteous; happy to chat."

Throughout our inspection we observed staff to be consistently caring in their approach when supporting and engaging with people. Whilst the service was busy, staff ensured they gave people the time and attention they required and the atmosphere at the service during both days was relaxed and friendly. People were comfortable in the presence of staff and responded positively to the support and encouragement they received. Where people showed signs of confusion or distress, staff moved quickly to reassure them and it was clear from their interactions that they had developed strong relationships and knew each other well.

People told us they were treated with dignity and that their privacy was respected. One person told us, "They [staff] always knock on my door before entering my room." Another person said, "My privacy is respected; there had been no issues." We observed staff knocking on people's doors before entering their rooms during our inspection. Staff also described the steps they took to ensure people were treated with dignity and respect their privacy. One staff member told us, "I always make sure the door and curtains are closed when supporting people with personal care. If I'm helping them to wash, I'll make sure they're covered as much as possible and encourage them to be independent where they are able. For example, I will give them a flannel so they can wash their face and arms, or will put toothpaste on their toothbrush and encourage them to brush their own teeth."

The registered manager confirmed that the service sought to support people with regards to their disability, race, religion, sexual orientation and gender. However, they also explained that at the time of the inspection the predominant support people required in these areas was in regard to their faith and this was confirmed by the people we spoke with. People told us their need for spiritual support was met. One person said, "Ministers come in from various local churches; Methodist, Baptist and Church of England. I see my own minister from my local parish church." We also saw that regular church services were conducted in a chapel attached to the home which people were able to attend."

People were involved in making decisions about their care and treatment. Staff told us they involved people in day to day decisions wherever possible through direct discussion or by offering people choices. People confirmed that this was the case. One person told us, "I let the staff know what I want. For example, if I wanted a lie in and breakfast in bed, I'd let the staff know and they'd arrange it." Another person said, "The staff are led by me; I make the decisions about what I do and when, and they respect that." We observed staff offering people choices during our inspection. For example, one staff member supported one person to sit outside in an armchair as this was their preference and we saw another staff member offering another person a choice of activities.

The provider also supported people and relatives to better understand the conditions their loved ones were

living with. For example, the registered manager told us that they had arranged for one person living at the service to attend a training session with staff about understanding a condition their loved one was living with. This was confirmed by a relative we spoke with who told us, "They [staff] did dementia training and asked [their loved one] to attend which was really useful."

People received appropriate end of life care and support. Records showed people's end of life needs and preferences had been discussed with people and relatives and healthcare professionals, where appropriate. The home engaged with the local hospice whose staff visited the service in support of people's end of life needs, and the service was accredited by the Gold Standards Framework which is a nationally recognised accreditation for the provision of end of life care.

Good

Is the service responsive?

Our findings

People could not always recall having discussions about the planning of their care although one person told us, "We discuss the help I need. They review things to make sure I'm happy." Relatives also confirmed that staff had discussed people's support needs with them and their loved ones. One relative said, "We talk about any changes [to their loved one's condition]; there's a written plan that I know we can look at if we want to."

People's needs were assessed prior to admission to the home to determine whether the service could meet their needs. Staff then undertook a further assessment of people when they moved into the home in order to develop their care plan and identify any areas of risk which required management. The care plans we reviewed covered a range of areas including eating and drinking, continence, moving and handling and people's personal care support requirements, as well as with regard to people's individual medical conditions, such as diabetes or the safe management of catheters.

Care plans also contained information about people's life histories, their likes and dislikes, hobbies and interests and descriptions of their preferred daily routines. Records confirmed that care plans were reviewed on a regular basis to ensure they remained reflective of people's current support needs. Staff also completed progress notes for each person which gave a summary their condition, the support they received and any activities they took part in each day.

Staff were aware of the details of people's care plans as well as their preferences in the way they received support. For example, one staff member demonstrated a good understanding of the areas in which the people they supported needed help. They were aware of the details of people's life histories and which family members visited regularly which they explained helped them to develop trusting relationships with people in support of their individual needs.

People were supported to maintain the relationships that were important to them. Relatives and people's friends were able to visit people when they wished. One relative told us, "I'm welcome whenever I want and pop in most days." Another relative said, "I can and do visit regularly, and am always welcome." Throughout our inspection we saw friends and relatives being welcomed by staff in a friendly and familiar manner when they visited.

The service offered a range of activities that people could be involved in to support their need for social engagement and stimulation. Planned activities included quizzes, reminiscence sessions, flower arranging and discussions on current affairs, as well as visits from musicians and talks on subjects of interest such as local history. One person told us, "There are lots of organised activities, but no pressure to be involved if you don't want to." Another person said, "The activities are good. They keep us occupied." A relative commented, "They [staff] come up with a good variety of things for people to do."

On both days of our inspection we noted that people were positively engaged in planned activities. For example we observed some people enjoying a flower arranging session whilst happily chatting with staff

and each other. In another example, we saw one staff member spending time with a person on a one to one basis, going through a photo album together and discussing their memories. A member of staff who had recently started working at the service told us, "It's great that we get time to sit and talk with the residents. The majority of our working day centres on interacting with people here. I never got to do that where I worked before."

People and relatives told us they knew how to make a complaint and expressed confidence that any issues they raised would be dealt with appropriately. One person said, "I'd speak to the relevant member of staff if it was a minor issue, or someone in the office if it was more serious. Any minor issues I've raised have been dealt with." A relative explained that they'd complained about the attitude of a member of staff when their loved one first moved into the home and told us this had been, "Resolved immediately."

The provider had a complaints policy and procedure in place which gave guidance to people on how they could raise a complaint and what they could expect in response; including the timescales for any investigation and how their concerns could be escalated if they were unhappy with the outcome. Records showed that earlier in the year there had been some delays in responding to complaints within the timescale stated in the provider's procedure. However, this issue had been addressed since the arrival of the new registered manager who had sought to address any issues raised promptly and to the satisfaction of the person or relative who had complained.

Good

Is the service well-led?

Our findings

People and relatives told us the service was well-led. One person told us, "I think the manager is excellent; she doesn't miss anything." Another person said, "The new manager is very good; definitely trying to make improvements." A relative described the registered manager as being, "Very approachable and proactive." Another relative commented, "The management team do a good job and respond quickly to any issues." These comments were reflective of the views of all of the people and relatives we spoke with.

There service had a registered manager in post who had been registered as the manager during the month prior to our inspection. The registered manager had previous experience working as a registered manager of a residential and nursing home, and demonstrated a good understanding of the requirements of being a registered manager and their responsibilities under the Health and Social Care Act 2008.

The provider had submitted a Provider Information Return (PIR) prior to the inspection which demonstrated an understanding and awareness of the current challenges for the service. For example, the PIR identified the importance of the service continuing to recruit more staff and this issue was reflective of the views of the people we spoke with. We noted that the registered manager and provider had been making progress in addressing this issue in the time since they had submitted their PIR, with more new staff having started and further staff in the recruitment pipeline.

Staff spoke positively about the management of the service and the open culture they worked in. One staff member told us, "I like working here. We have a very good staff team and the teamwork is very good. The manager listens to us during team meetings. For example at one meeting we told her that we couldn't always get access to gloves and aprons as they were locked in a store room. She made sure these were easier for us to access as a result." Another staff member said, "The registered manager has been fantastic since starting. She leads by example and is available to talk to when needed. Our team working has improved and there's a greater focus on working in the home as a whole rather than just one unit which has helped me get to know all of the residents better."

Throughout our inspection we observed the registered manager and deputy manager to be on hand and available to people, relatives and staff. It was clear from their interactions that they knew people well and were committed to ensure people received good quality care. One staff member told us that the management team occasionally worked with care staff on the floors, leading by example in showing them how they wanted people to be supported. The registered manager also worked across different shift patterns, including night shifts and at weekends so they were visible presence to all staff at different times.

Records confirmed that staff attended regular meetings to discuss the running of the service and to highlight and ensure good practice. Topics discussed at a recent staff meeting had included reminders for staff on upcoming training, any developments at the home, including any new equipment which had been purchased, discussions about staff shifts and staff member's understanding of the provider's whistle blowing policy. The registered manager had also recently introduced weekly clinical risk meetings for clinical staff in order to review the management of specific aspects of people's conditions, for example

wound management, to ensure they were receiving appropriate treatment.

Additionally daily handover meetings were held between shifts in order for staff to share information about people's current conditions and any information relevant to ensuring people's needs were met. We also sat in on a daily morning meeting held by senior staff where aspects of the day to day management of the service were discussed. These included any maintenance issues, plans for activities, expected visits from healthcare professionals, and whether any new admissions were expected. These meetings helped ensure that staff were aware of their responsibilities whilst working at the service.

People and relatives were able to express their views about the service and were involved in driving service improvements. The registered manager held regular meetings for people and relatives in order to seek their feedback on aspects of the management of the home. Minutes from a recent meeting showed areas for discussion had included the activities on offer, any maintenance concerns, the cleanliness of the home and a discussion about fire procedures. The provider had also recently sent out an annual survey for people and relatives to complete. The registered manager told us that the results of this would be analysed upon completion in order to identify any areas for improvement, although we were unable to check on this at the time of our inspection.

We found examples of people's views having been sought when making improvements to the service. For example records showed the registered manager had sought people's views when choosing a new mural which was being put up in one of the lounge areas during our inspection. People and relatives also told us they felt there been recent improvements made at the home. For example, one person commented positively about the installation of new carpets and a relative told us there had been improvements in communication with staff, and in the administration of the service following their feedback.

The provider had systems in place to monitor the quality and safety of the service. Staff told us, and records confirmed, that they regularly conducted checks and audits in a range of areas to help identity any potential issues which may need addressing. Audit areas included fire safety, the environment, infection control, care planning and medicines. We saw action had been taken to address issues where they had been identified. For example, emergency lighting within the service had been replaced where an issue had been identified. In another example, we noted that one person's mobility care plan had been updated in response to the findings of a care plan audit conducted by the registered manager. This showed that the provider's systems were effective in identifying issues resulting in improvements to the quality and safety of the service people received.