Mr & Mrs M Hopley

Georgian House Nursing Home

Inspection report

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Website: www.ghnh.co.uk

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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 01 March 2017 and was unannounced. The service was last inspected on 25 November 2014 and at the time was found to be meeting all the regulations we inspected.

Georgian House Nursing Home is a care home providing personal and nursing care to up to 26 older people. There were 22 people living at the service at the time of our visit. Some people were living with the experience of dementia and one person was being cared for at the end of their life. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

A range of activities were organised by staff. However there was a lack of person centred activities, and the environment had not been developed to meet the needs of people who were living with the experience of dementia.
The provider had taken some steps to protect people in the event of a fire and there was a policy and procedure in place. The provider carried out regular fire checks and fire drills. However, people using the service did not have personal emergency evacuation plans (PEEPs) in place. There was a fire risk assessment in place but this had not been reviewed and updated since March 2011.

The temperatures of fridges used to store medicines were not consistently recorded, and where temperatures were out of the safe range, there was no evidence of any actions taken. There was a procedure for the recording, storing and administering people's medicines and the staff were aware of this. Staff received regular training in the administration of medicines.

We have made recommendations in relation to the provision of person-centred activities, the environment, fire safety and medicines management.

The risks to people's safety were identified and managed appropriately. The provider had processes in place for the recording and investigation of incidents and accidents.

The provider had put systems in place to ensure people lived in a safe environment. We saw a variety of health and safety checks were conducted on a regular basis by staff and external agencies.

There were appropriate recruitment procedures and systems were in place to ensure that only suitable staff were appointed to work with people who used the service.

There were enough staff on duty to keep people safe and meet their needs, and there were contingency plans in place in the event of staff absence.

There were appropriate procedures in place for the safeguarding of vulnerable people and these were being followed.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People's capacity was assessed and they consented to their care and support.

People were cared for by staff who were suitably trained, supervised and appraised.

Staff treated people with kindness and dignity and took into account their human rights and diverse needs.

People's nutritional and healthcare needs had been assessed and were being met.

Assessments were carried out before people were admitted to the service to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

There was a complaints procedure in place and people and their relatives knew how to make a complaint. They felt confident that their concerns would be addressed. People and their relatives were sent questionnaires to gain their feedback on the quality of the care provided.

There were regular staff meetings, and these were recorded. Staff told us that communication was good and they had regular handover meetings.

People, relatives and professionals we spoke with thought the home was well-led and the staff and senior team were approachable and worked well as a team. The staff told us they felt supported by the provider and there was a culture of openness and transparency within the service.

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 always safe.

Medicine fridge temperatures were not consistently recorded, and where temperatures were out of the safe range, there was no evidence of any actions taken.

There was a fire procedure in place, however, the fire risk assessment was out of date and people did not have a personal emergency evacuation plan (PEEP) in place.

Recruitment procedures were in place to ensure that only suitable staff were appointed to work with people who used the service.

There were enough staff on duty to keep people safe and meet their needs, and there were contingency plans in place in the event of staff absence.

There were appropriate procedures in place for the safeguarding of vulnerable people and these were being followed.

The risks to people's safety were identified and managed appropriately. The provider had processes in place for the recording and investigation of incidents and accidents.

Is the service effective?

Good

The service was effective.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were cared for by staff who were suitably trained, supervised and appraised.

The environment was not developed to meet the needs of older people and those living with the experience of dementia.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a friendly and caring way. Relatives and professionals felt that people using the service were well cared for.

Care plans contained people's personal history, likes and dislikes. People were supported by caring staff who respected their dignity, human rights and diverse needs.

Where people were able to make choices, they told us that staff respected these.

Is the service responsive?

Good

The service was responsive.

A range of activities were organised by staff. However, there was a lack of specific activities to meet the needs of people living with the experience of dementia.

Assessments were carried out before people were admitted to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

People and their relatives were sent questionnaires to ask their views in relation to the quality of the care provided.

Is the service well-led?

Good

The service was well-led.

There were systems in place to assess and monitor the quality of the service.

There were regular meetings for staff and people who used the service which encouraged openness and the sharing of information.

People, relatives and professionals we spoke with thought the home was well-led and that the staff and senior team were approachable and worked well as a team.

The staff told us they felt supported by the provider and there was a culture of openness and transparency within the service.

Georgian House 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 checked 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 01 March 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist professional advisor (SPA) 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 for this inspection had experience of caring for older people. The SPA for this inspection was a qualified nurse.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 reviewed the information we held about the service including notifications of significant events, safeguarding alerts and the findings of previous inspections.

During the inspection, we spoke with eight people who used the service, seven relatives, seven staff members, including the registered manager, two nurses, three care workers and a chef. We also met with the owners who were visiting on the day of our inspection.

We looked at the environment and observed how people were being cared for. We looked at records, including the care records for four people, four staff recruitment records, staff supervision and training records, medicines records and other records relating to the management of the service.

Following our visit, we emailed eight external healthcare and social care professionals and received

feedback from five.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service and relatives we spoke with echoed this. Their comments included, "Yes I feel safe", "Yes she does [feel safe]", "He always seems happy. He's always smiling and does not show distress. The staff seem kind and calm", "The staff know them well and there's a good ratio", "I turn up at all hours as well as twice a week to take her out to her church group and there's never been anything untoward", "I've been here for over a year and I'm quite happy with the nice people to look after me" and "I've never had any worries about his safety." A healthcare professional told us, "Georgian House is a safe and happy place."

The provider had taken some steps to protect people in the event of a fire and there was a policy and procedure in place. We saw that a 'fire based risk assessment' was in place, however this was out of date and had last been reviewed in March 2011. We saw evidence that checks of all fire safety equipment was carried out regularly. These included the fire alarm system and fire extinguishers. The service carried out regular fire alarm tests and fire drills and staff were aware of the fire procedure. People did not have personal emergency evacuation plans (PEEPs) in place. We saw a 'patients' fire evacuation information' document. This included a list of people, their room numbers, and whether they could mobilise or not. However this was basic and did not take into consideration people's abilities and needs and there was no detailed guidance for staff to follow about how to evacuate people safely in the event of a fire.

We recommend that the provider seeks relevant guidance in relation to fire safety.

Medicines requiring refrigeration were appropriately stored in a medicines fridge. We saw that staff recorded the fridge temperatures, however this was not always consistent, and we saw several gaps in recording. We also noticed that where temperatures had been found to be outside the safe range, no action had been recorded on the monitoring chart. This meant that we could not be sure appropriate action had been taken and there was a risk that medicines stored in the fridge could be less effective.

We recommend that the provider seeks relevant guidance for the safe management of medicines.

All medicines were available for people and staff could describe how they obtained supplies in an emergency. Medicines were disposed of appropriately and records kept. The medicines administration records (MARs) were clear and completed correctly with signatures or, where appropriate, codes for refusals or omissions. These included records for creams and lotions.

Controlled drugs (CDs) were appropriately locked in a cupboard on the wall of the nurses' station. We saw that these were recorded in a CD recording book, and this was checked weekly to ensure accuracy. We saw that two staff had signed for each administration of CDs and the amount recorded corresponded to the stock we checked.

Audits were undertaken regularly to check that medicines were handled safely in the service and all staff who administered medicines received regular training and had their competencies assessed.

Where there were risks to people's safety and wellbeing, these had been assessed. Among the areas covered were risk from falls, pressure ulcers, malnutrition, infection and dehydration. Person-specific risk assessments and management plans were available and based on individual risks that had been identified. We saw detailed guidance was available for staff to follow on how to mitigate these risks. For example, we saw a moving and handling risk assessment for a person specifying the appropriate handling aid, how to use this and the number of staff required to support the person to move safely. It also included what additional measures were in place to reduce the risk, such as, 'Ensure environment is clutter free', 'Ensure left leg is not twisted' and 'Ensure [person]'s left hand is supported by a pillow'. However we saw in another person's care plan that they had a grade 2 pressure ulcer on their sacrum. We did not see this recorded on a body map and there was no clear plan or picture about how to manage this. We discussed this with the registered manager who informed us that the person's skin was intact and was being monitored. They also informed us that to protect the person's dignity, photographs were logged electronically rather than in folders. We were satisfied that all other risk assessments we checked were detailed and appropriate measures were in place to mitigate risk.

We noticed that the provider had installed a gate at the top of the stairs. They told us that this was a safety measure to prevent people falling. We saw that there was a detailed risk assessment in place which was regularly reviewed. The provider had consulted the fire officer to ensure that the gate did not present a risk in the event of a fire, and an appropriate lock had been installed which could easily be open in an emergency. People were able to use the lift to go upstairs and downstairs whenever they wanted.

The provider had a health and safety policy in place. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. Equipment was regularly serviced to ensure it was safe and we saw evidence of recent checks. This included fire safety equipment, bedrails and moving and handling equipment such as hoists. Environmental risk assessments were in place and included electrical appliances, lighting, smoke detectors, call bells, door guards and fire doors.

Recruitment practices ensured staff were suitable to support people. This included checks to ensure staff had the relevant experience and qualifications. Checks were carried out before staff started working for the service. These included obtaining two references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) check were completed.

Staff had completed training in safeguarding adults and records confirmed this. They were also aware of the provider's safeguarding policy and procedures. Staff we spoke with were able to give definitions of abuse/neglect. Staff told us they felt confident in challenging and would report anyone who abused a person using the service. They showed us a poster displayed in the service which had information about safeguarding vulnerable adults and included relevant contact details of agencies they could report concerns to. The registered manager had raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They had also notified the CQC, as required, of allegations of abuse or serious incidents.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required, and involving healthcare professionals when needed. All incidents and accidents were recorded and analysed by the provider and included action plans. We saw that incidents and accidents were responded to appropriately. For example, where a person using the service had several falls, we saw that the GP had been consulted and the person had been referred to the falls clinic and the optometrist to check if their vision had deteriorated thus causing the person to fall. We saw that a detailed plan was in place to prevent reoccurrence. This indicated that the provider had robust systems in

place to protect people from the risk of harm.

People and their representatives told us they were happy with the staffing levels, and we saw there were enough staff on duty on the day of our inspection. The registered manager told us they never required the need of agency staff and employed a pool of bank staff to cover staff shortages. They also informed us that regular staff were happy to work overtime. This showed that people were supported by regular staff who knew them well thus providing people with continuity of care.

All areas of the home were clean and free of any hazards. The bedrooms we saw were spacious and fresh smelling and people had personalised their own rooms with photographs and objects of their choice. All cupboards containing chemicals and cleaning materials were kept locked.

All staff we spoke with explained how they prevented the spread of infection. They explained about the use of hand gel and hand washing before and after attending to people. They changed linen daily and placed soiled bedding in appropriate bags. We saw that all staff wore appropriate personal protective equipment (PPE) such as aprons and gloves.

Good

Is the service effective?

Our findings

People and relatives we spoke with thought that the staff were well trained and met their needs. Their comments included, "Yes they are very good", "They really, really understand people here. Everyone is truly an individual", "It needs two people to hoist her and they respond immediately" and "10 out of 10. I've never felt worried about him. It's a homely place. The staff are wonderful and the food is good."

The environment was clean and appropriately maintained. However, we saw that the environment had not been developed to meet the needs of people living at the service. For example, people's bedroom doors were not identified with visual clues such as photographs or pictures of their choice. The walls were painted a similar colour throughout and there were no signage to help people find their way to different areas of the home. The colour schemes and textures of the environment did not reflect good practice guidance for environments for older people and those living with dementia.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, "Good practice regarding the design of environments for people with dementia includes incorporating features that support spatial orientation and minimise confusion, frustration and anxiety." The guidance also refers to the use of "tactile way finding cues." The government guidance on creating "Dementia friendly health and social care environments" recommends providers "enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do." These guidelines are also relevant for other older people who would benefit from these environments.

We recommend that the provider considers how they can implement good practice guidance to enhance the environment.

People were supported by staff who had relevant knowledge and experience. However the registered manager did not keep a training matrix. They showed us a basic document recording the training each staff had undertaken, but no date was entered, so it was not possible to ascertain when the training had taken place and when it was due to refresh. There were very few training certificates in the staff files we viewed. The registered manager told us that staff who attended training offered by the local authority were not issued with a certificate. They added that they were currently trying to obtain written evidence from the local authority's training department of all the training undertaken by staff, in order to update their records.

The registered manager told us that all new staff received an induction. This included training and working alongside other more experienced staff members. All new staff were expected to complete the Care Certificate as part of their induction. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

Staff told us they received regular training and refreshers. Subjects included safeguarding, health and safety, medicines management, food hygiene, moving and handling and infection control. There were also courses

specific to the needs of the people who used the service. These included dementia awareness, dignity in care and dysphagia. Most of the staff working at the service had been there for a long time and most had achieved recognised qualifications in Health and Social Care.

During the inspection we spoke with members of staff and looked at four staff files to assess how they were supported within their roles. Staff told us and we saw evidence that they were receiving formal supervision from their line manager. This provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. However records showed that this was not always regular. One staff record showed that their last supervision meeting had taken place in December 2015 and we could not find any evidence of supervision in another staff's file. Records showed that staff received an appraisal from their line manager. This provided an opportunity for staff and their manager to reflect on their performance and to identify any training needs or career aspirations. However the frequency of this varied. We saw that one member of staff had received an appraisal in October 2016, but another had not been appraised since July 2015.

We recommend that the provider seek relevant guidance in relation to the supervision and appraisal of staff.

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).

Assessments were undertaken to establish people's capacity to consent to aspects of their care and support as they arose. Staff told us that they encouraged people to be as independent as they could be. People confirmed that staff gave them the chance to make daily choices. Staff had training in the Mental Capacity Act (MCA) 2005, and showed a good understanding of its principles. The registered manager told us that some people using the service lacked the capacity to make decisions. We saw evidence in the care records we checked that people were consulted and consent was obtained. Where able, people had signed the records themselves indicating their consent to the care being provided.

Some people were using bedrails. Care records showed that there were appropriate assessments in place. These included the reasons for the use of bedrails, alternatives, discussion with the person or their representative or a best interest discussion.

The service recognised the importance of food, nutrition and a healthy diet for people's wellbeing and as an important aspect of their daily life. People's likes and dislikes were recorded in their care plans and menus were devised according to people's choices. Menus were displayed in the lounge and the food served on the day of our inspection corresponded to these. People and relatives told us that the food was good. Their comments included, "The food is fine", "[Person] likes the food. There is always a choice and she has lists of her food likes and dislikes", "I don't think he really gets a choice of food. He's vegetarian but it does vary from week to week. He did say that the food was 'first class' today" and "You get three different ones to choose. I like to have two slices of bread with marmalade in the mornings but you can have what you want."

All meals were freshly prepared by a chef. We saw that a list of people's likes and dislikes and their individual

dietary needs were available for the kitchen staff and the chef showed a good knowledge of people's dietary needs, including their cultural needs. People told us snacks and drinks were available anytime and we saw people being offered hot and cold drinks throughout our visit. Mealtime was unhurried and we saw that people were supported in a calm and kind manner. People's weight was monitored monthly, and more often where necessary. For example, where people's weight changed significantly, we saw that action had been taken and weekly checks had been undertaken until weight had stabilised.

People were supported to maintain good health and had access to healthcare services. People told us they were able to see their doctor and other healthcare professionals whenever they needed. One person told us, "A lady doctor comes around every now and then. I go to [a specialist hospital] for my eye appointments", and another said, "The chiropodist visits and that's very important to me." We saw evidence that the provider made a variety of referrals to external health professionals when needed. This included referrals to the Speech and Language Therapy (SALT) team and regular visits from the chiropodist. Records we checked confirmed this. The support plans we looked at contained individual health action plans. They contained details about people's health needs and included information about their medical conditions, mental health, dental, medicines, dietary requirements and general information.

The service worked closely with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff. Healthcare professionals spoke positively about the staff. Their comments included, "The staff are genuinely keen to help the residents and have always been helpful when I have contacted them about the residents I have seen and their requirements", "They always act on any advice I give them", "They communicate easily with people, families and healthcare professionals alike", "The staff's dedication to provide excellent patient care has been a treat to watch particularly owing to their vast ability to handle emergencies with warmth, sensitivity and professionalism" and "The staff are responsible and from my experience have never ignored the needs of their patients and their families."

Good

Is the service caring?

Our findings

People and relatives were complimentary about the care and support they received. Their comments included, "There's a low staff turnover and the staff have caring hearts. You can't buy that", "It's like a large family and it reminds me of those films of living in an old hotel. It's mixed which is good. She has no worries because the staff look after her", "I get on famously with them", "[Person] would always feel safer sleeping in the lounge and they used to make up a bed for him in the night if it was needed and then clear it up before breakfast. They were very person-centred", "I do think he's happy here. He's a smiley happy person", "[Person] does not like showers or baths. They're hugely respectful and preserve her dignity with everything" and "Yes they are very kind and respectful."

Throughout the visit we observed a relaxed and calm atmosphere in the service and a lot of interaction between people and staff. All staff displayed a gentle and patient approach to caring throughout the day. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people.

The staff and the provider spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. Staff were aware of people's needs, routines and behaviours and were able to explain how they supported different people. We saw evidence of kind and empathetic care. Staff told us that the way they respected people's dignity was to give them choice, to listen and to knock at the door before going in. Our observations confirmed this. However we noticed that one of the bathrooms did not have a lock and there was no way of knowing if it was occupied or not. We raised this with the registered manager who told us they would take action without delay. People look well kempt and had clean fingernails. One relative told us, "His hair looks immaculate and he's always clothed well and looks dignified."

We noticed that where people required their food to be pureed, pureed meat and vegetables were presented separately to ensure that it looked appetising and well presented. A notice in the kitchen reminded staff of this.

We observed interactions between people and staff during lunchtime. Staff supported people who needed assistance with eating. There was a relaxed and unrushed atmosphere and staff appeared to have a good rapport with all the people who used the service.

People's last wishes were recorded in their care plans and some people had been involved in devising advanced care plans. These were documents which took into consideration how people wanted their care to be provided at the end of their life and what they worried about. For example, 'I want to see a priest before passing' and 'I am worrying that my family is away'.

The home had subscribed to the Gold Standard Framework (GSF) but had not yet achieved accreditation. GSF is an approach to planning and preparing for end of life care. However the registered manager told us they had adopted the principles of the GSF and we saw a board with all the necessary information about it,

and evidence that the home had adopted GSF guidance to end of life care. We saw that the home had a good rapport with the local hospice staff who offered regular training and advice to staff.

Care plans included advice to staff about how to provide person-centred care and meet the individual needs and wishes of people. Instructions included, '[Person] prefers to choose her own clothes to wear for the day', '[Person] prefers female carers only for her personal care' and '[Person] prefers to be washed after breakfast at exactly 10.30am except Mondays'. We observed that staff respected these wishes on the day of our inspection.

All the rooms we looked at had been personalised to people's tastes and contained ornaments, pictures and photographs.

Good

Is the service responsive?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing the person's needs. People and relatives confirmed this.

Care plans were comprehensive and contained sufficient information to know what the care needs were for each person and how to meet them. Each person's care plan was based on the information collated during the initial assessment and was based on their needs, abilities, likes, dislikes and preferences. We saw that person centred guidance was available for staff to follow to ensure they knew the individual needs of each person. This included comments such as, 'Please ensure [person's] nails are trimmed regularly and refer to podiatrist for toe nails' and '[Person] can brush her own teeth when sitting on a chair by the sink'. We saw that this had been reviewed and updated in February 2017. This meant that people were cared for by staff who knew and met their individual needs.

Care records were completed by staff at the end of each shift and included a summary of the person's day or night. These were clearly written but mainly consisted of tasks undertaken and relevant information. We saw that each record included 'Safety and comfort maintained'. However, there were few records of social interactions or events people had taken part in, apart from family visits. We discussed this with the registered manager who told us that they had raised this with staff before and would discuss this again in their next staff meeting.

Keyworkers completed a monthly summary of each person. This included any changes in the person's health, any concerns and events that had taken place.

People's opinion about the activities offered at the home varied. One person told us, "They make you do exercises. I can walk a little with a frame. I've got a TV in my room but I prefer to be down here with everyone" and another said, "I like sitting out in the garden, weather permitting. You can have a coffee. It's a well-tended garden. They did the flower beds last week." Relatives' opinion also varied. Their comments included, "I don't think there are any activities here. Last week he asked me if I was the physio. I think they provide more of a comforting atmosphere with warmth, where people feel connected and they don't push. But they are not neglectful though. I'd say it's not a stimulating environment", "They have sing-a-longs and my [family member] joins in the bingo. Yes I do think she has enough stimulation within her means of ability" and "My [family member] is not an activity person, but she has started to do the exercises and she likes the musicians. She also likes the bingo. They also like watching films together."

Staff organised a number of group activities on a weekly basis and these were recorded and displayed on a weekly activity plan. The registered manager told us they were currently recruiting an activity coordinator. Activities on offer included bingo, arts and crafts, exercises, card games and movie day. There was also evidence that external entertainers and theatre companies had visited the service, and we saw photographs of these events. The registered manager told us that the mobile library visited regularly and people were

given the opportunity to borrow books. However people did not have their own activity plans based on their preferences and abilities. We saw a 'Leisure interest' checklist in a person's file. However, this was dated 12 January 2008 and had not been reviewed and updated. Staff encouraged people to take part in activities on offer and recorded their attendance.

We spent time in the lounge where the activities were taken place. On the day of our inspection, Eucharistic officers were visiting for Ash Wednesday. We saw that staff gathered with people who used the service to say a prayer, sing a short hymn and receive communion if they wished. In the afternoon we saw that every person enjoyed taking part in the exercise class. People with limited ability and poor mobility were supported by staff.

A number of people who used the service were living with the experience of dementia. There was information for staff entitled 'activities for people with dementia'. However, we saw that there was a lack of dementia-friendly activities for people.

We recommend that the provider seeks relevant guidance to improve the provision of activities and develop the environment for people living with the experience of dementia.

The service was responsive to people's healthcare needs. Staff told us they were aware of people's healthcare needs and would know if they were unwell. One relative was confident that staff would identify their family member's individual needs and said, "They've discussed [family member's] hearing aid. They picked up that his hearing is better on his left side and advised me to go up closer to that side to talk to him. I do think they understand his needs. He has sensory deprivation". Another relative echoed this and said, "The staff are always with residents doing things like painting their nails and chatting." The service had a good relationship with the GP and other healthcare professionals who visited regularly. The provider kept a record of the visits which included the reason for the visit, diagnosis and treatment. Healthcare professional were complimentary about the staff and thought people's healthcare needs were met. Their comments included, "The staff are friendly, committed and in my opinion amazing, compassionate with good communication skills and they are always attentive to the needs of the people under their care", "Working in a nursing home, the staff can accept suffering and death without letting it get personal and have in my opinion always been compassionate in their care delivery" and "Staff are self-assured and calm, professional and have all been a credit to Georgian nursing home where they have reliably provided patients with exceptional nursing care."

We observed throughout the day that staff interacted well with people and responded to their needs in a timely manner. Personal care needs were addressed in a calm and discreet manner showing respect and kindness to the person. Staff were patient and encouraging and supported people without rushing them. They were softly spoken and we saw that people received kindness and praise.

The service had a complaints procedure in place and this was available to people who used the service and their relatives. However this was not available in an easy-read format. People told us they knew how to make a complaint and were confident that their concerns would be taken seriously. However none of the people we spoke with had any complaints. On person told us, "I'd talk to the supervisor; I know what she looks like." A relative told us they were aware that all the information was displayed on the walls and they would go to [staff] if they had to. Another relative told us, "If I had to, it would be [staff]." However we saw that there had not been a complaint since 2012.

People and their representatives were encouraged to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and

support they received and whether people's needs were being met. It also included questions about the quality of the food, the environment and their social needs. We saw that the results showed an overall satisfaction. Some comments included, "Staff are very good", "The staff are delightful and deeply caring", "My relative is safe from harm. She is vulnerable and 24/7 security gives me peace of mind", "Can't think of anything nasty about this home", "It's clean" and "Staff are always there to attend my needs."

Good

Is the service well-led?

Our findings

People and relatives we spoke with were complimentary about the provider and the staff. They said they were approachable and provided a culture of openness. People thought that the home was well managed. Their comments included, "Yes, I remember [manager] being caring from all those years ago" and "[Owners] are in a lot and they visit the residents too."

The registered manager had been managing the service since 2010, and had started working at the service in 2001. They were supported by a team which included qualified nurses and care workers. The service was owned by a team of family members. We were told that they provided good support to the registered manager and often visited the service. The registered manager told us, "They are good and have always supported me."

The provider had put in place a number of different types of audits to review the quality of the care provided. These included environmental checks, health and safety checks and monthly care plan audits. Records were kept of safeguarding concerns and accidents and incidents, however some records were disorganised and untidy. We viewed a range of audits which indicated they were carried out regularly and action was taken to address any shortfalls identified. The registered manager had introduced a monthly nutritional audit tool. This enabled staff to identify any issues, for example, weight loss. We saw that this tool had been effectively used, and people had been referred to a dietician when necessary. The registered manager told us that the Clinical Commissioning Group (CCG) carried out monthly audits and their supplying pharmacist undertook twice yearly audits of all the medicines.

Staff commented that they felt supported by the registered manager and the owners and were confident that they could raise concerns or queries at any time. Staff were very positive about their jobs and told us the registered manager was hands on to ensure the home was running well and people's needs were being met. Healthcare and social care professionals also thought the service was well-led. Their comments included, "I feel that the management and staff are always on top of their game and they always make sure that they are clearly understood by people and their families and other healthcare professionals", "I have no concerns about resident care or safety or indeed any other concerns" and "I really could not fault Georgian House."

The provider kept a record of compliments received. Comments we saw included, "Thank you [staff's name] for being there so that my mum did not die alone" and "You are an amazing team." We saw other comments that included 'care and kindness', 'warm friendly capable hands' and 'care and compassion showed'.

Staff told us they had regular meetings and records confirmed this. However, the minutes of the meetings were sometimes disorganised, handwritten, and did not always reflect the agenda. Items discussed included safeguarding, health and safety and issues concerning people who used the service. We saw that regular handover meetings were organised where staff would share important information about people who used the service.

There were regular meetings organised for people who used the service. Items discussed included activities, residents' party, menus and an open discussion. Relatives told us the service communicated well with them. We saw a 'Relatives communication/meeting records' document which confirmed that staff involved relatives with upcoming reviews or any medical concerns.

There were boards in the home which displayed relevant information for people and visitors. This included the service's last report, information about advocacy services, a safeguarding referral process, health and safety information and the complaints procedure. We saw that some information was dated and no longer relevant and asked the registered manager to remove it.

The registered manager told us they attended provider forums organised by the local authority, and undertook relevant courses to keep abreast of developments within the social care sector.