Baytrees Homes Limited

Baytrees Nursing Home

Inspection report

Baytrees
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Worthing
West Sussex
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Tel: 01903693833

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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

The inspection took place on 6 January 2016 and was unannounced.

Baytrees Nursing Home is a large detached building in a built-up residential area in Worthing. The home is registered to provide care for up to 30 people with a range of physical and mental health needs. At the time of our inspection, 27 people were living at the home. Baytrees Nursing Home has communal areas comprising a large lounge/dining area, a quiet room where people can receive visitors, a further lounge and a conservatory leading to an accessible decking area. Rooms are all single occupancy.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported to be safe and were looked after by staff who knew what action to take if they suspected any kind of abuse was taking place. Risks to people were identified, assessed and managed appropriately and information and guidance was provided to staff on how to look after people. Emergency evacuation plans were in place should people need to be moved out of the home in the event of an emergency. There were sufficient numbers of staff on duty and staffing levels had been assessed based on people's individual care and support needs. Robust systems were in place to ensure new staff were recruited safely and all appropriate checks undertaken. Medicines were managed safely by trained staff.

New staff followed an induction programme and all staff received training in a wide range of areas appropriate to the needs of people they were looking after. Staff had regular supervision meetings with their supervisors and staff meetings took place. Staff did not have a thorough understanding of their responsibilities under the Mental Capacity Act 2005, although they had received training on this topic. We have made a recommendation to the provider that they put measures in place to resolve this. People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services. People's rooms were personalised to reflect their tastes.

People were looked after by kind and caring staff and positive relationships had been developed. People and their relatives spoke highly of the staff. Staff knew about people's personal histories and backgrounds and used this information to help build relationships. People were involved in planning their care and in making decisions about how they wished to be supported by staff. They were treated with dignity and respect. At the end of their lives, people were supported to have a dignified, comfortable and pain free death.

Care plans contained comprehensive, detailed information and guidance to staff about people's needs. Care and treatment was delivered in line with the requirements of care plans and in a person-centred way. A range of activities was on offer to people on a daily basis with trips out into the community for meals out or

theatre trips. Complaints were listened to and managed by the provider in line with the complaints policy and to the satisfaction of the complainant.

The service was well led. People were involved in developing the service and residents' meetings were held so they could feed back their views. The culture of the home was person-centred and people's choices were taken account of in the way they were cared for. Staff felt the home was managed well and that the registered manager was accessible and would listen to any issues they wished to discuss. Robust quality assurance systems were in place to audit a range of areas at the home and to drive continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from avoidable abuse and harm and staff were appropriately trained; they knew what action to take if they suspected abuse was taking place.

People's risks were identified, assessed and managed appropriately by staff. Emergency plans were in place in case the building needed to be evacuated.

There were sufficient numbers of staff on duty and safe recruitment practices were in place.

Medicines were managed safely.

Is the service effective?

Requires Improvement

One aspect of the service was not effective.

Staff did not have a thorough understanding of the requirements of the Mental Capacity Act 2005 or their responsibilities to people under this legislation.

People received effective care from staff who had been trained in a wide range of areas.

Staff received regular supervisions with their supervisors and staff meetings took place.

People were supported to have sufficient to eat and drink and had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

Positive, warm, friendly relationships had been developed between people and staff. People were treated with dignity and respect and encouraged to be involved in decisions relating to their care.

At the end of their lives, people were supported to have a comfortable and pain free death.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed appropriately and care plans provided comprehensive information and guidance to staff about how people wished to be cared for.

There was a range of activities available to people on a daily basis with trips out into the community.

Complaints were responded to in a timely fashion and to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well led.

People were involved in developing the service and regular residents' meetings were held.

Staff felt supported by the registered manager and that any issues they wanted to raise would be listened to.

There were effective, robust quality assurance systems in place to audit the quality of the service overall.

Baytrees Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 6 January 2016 and was unannounced. Two inspectors undertook this inspection.

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 any improvements they plan to make. We examined the previous inspection reports and notifications we had received. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also examined the action plan that the provider had returned after the last inspection. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including eight care records, seven staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with four people living at the service and one relative. We spoke with the provider, the registered manager, a registered nurse, a team leader, three care staff and the chef.

The service was last inspected on 29 October 2014 and achieved a rating of 'Requires Improvement' overall. No breaches of regulations were found at that inspection.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and staff had been trained to recognise the signs of potential abuse. Staff had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let my manager know if I suspected abuse. I'd let Social Services know if I had to". Another staff member said, "I know that abuse can be a lot of things and not just harming someone". Staff confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they might have in confidence.

Risks to people were managed so that they were protected. People's risks were identified, assessed and guidance for staff was recorded in people's care plans to help mitigate the risks. Risk assessments covered a wide range of areas such as mobility, falls, general health, personal care, catheter care, recreation and activities and last wishes. Assessments included action plans and risks were assessed as high, medium or low. People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for this purpose. Registered nurses monitored and dressed people's pressure ulcers and involved other specialists such as tissue viability nurses or consultants for advice. Wound management plans were in place for people which provided clear tracking of the wound, including what dressings were applied and recorded the involvement of healthcare professionals. Where assessed as needed, people also had pain management plans in place. Some people had been assessed as requiring bed rails to prevent falls and risk assessments were in place as needed. One person's care record showed that they had consented to bed rails being in place and for a lap belt to be used on their wheelchair.

We asked staff about their understanding of risk management and keeping people safe whilst not restricting their freedom. One staff member said, "These are young people living here, not older people. They don't need tea and sympathy. They need to get on with their lives and that means risk sometimes". Another staff member told us, "We have one person who likes to go out on their own. That's fine, but we need to know where they are as we do have responsibility to keep them safe. That's difficult sometimes". In one care plan, it showed that a person with full mental capacity had difficulty in swallowing and they had been recommended a pureed diet by a visiting healthcare professional. However, the person did not wish to comply with this request and continued to eat a normal diet. The risks of choking as a result had been properly assessed and measures put in place to minimise the risk.

There were plans in place in the event of an emergency, for example, evacuation of the premises because of fire, power failure or flood. The provider had made arrangements with another home to house people overnight should this be required. People also had Personal Emergency Evacuation Plans in place so that staff and the emergency services had information about people's individual support needs.

In general, there were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. Two people required 1:1 support from care staff, one continuously and the other during the daytime. In addition, there were usually seven or eight care staff on duty with two registered nurses. At night, there were

three care staff on duty and one registered nurse. Occasionally, over weekends, agency staff were utilised. The registered manager told us that there had been an increase in the level of staffing recently because of new admissions. They had used a dependency tool to assess people's needs and calculated the number of staff required accordingly. We were told this tool had calculated that, on average, each person required over two hours of care per day, but staffing levels had been calculated to ensure that over four hours per day were available for staff to care for people. When asked whether they thought there were sufficient staff to meet their needs, one person told us, "Sometimes we have to wait a little while [referring to how long they had to wait after ringing their call bell], it all depends". They added, "At the moment, they're all right. Sometimes they're a bit down, if someone calls in sick. Sometimes they get the agency in if there's not enough staff". Another person referred to the agency staff and said, "You get new ones. I get on mostly with the staff". A relative thought that staffing levels were mostly sufficient. They told us, "Over Christmas there were fewer staff, but still enough. I never feel that anyone is at risk because staffing levels are too low".

We asked staff about staffing levels at the home. All the staff we spoke with felt the home did not have enough staff to consistently care for people effectively. One staff member said, "There aren't enough staff sometimes. We can't do extra things for people. I have mentioned it in supervision. Things were better earlier on, but we have more residents now". Another staff member told us, "We do struggle to give good care sometimes with the numbers. A lot of the people we have taken on recently have a lot of need, for example, we have two who need one to one care. It's putting a strain on things". A third member of staff said, "We are very busy and sometimes there aren't enough staff if someone goes off sick. The manager always tries to get cover though, I mean other staff or agency". During our inspection, we did note call bells were ringing for extended periods of time in the morning. One person's call bell rang for seven minutes and another for 15 minutes before being switched off.

We looked at the staff duty rota for the period 16 November 2015 to 10 January 2016. The rota revealed staffing levels were consistent across the time examined, with two registered nurses and seven to eight care staff in the daytime plus two care staff for 1:1 support and the registered manager. At night there was one registered nurse and three care staff. Kitchen and domestic staff were also on duty during the day.

Appropriate checks were undertaken before staff commenced employment. Staff files contained recruitment information for staff and criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including character references, job descriptions and Nursing and Midwifery Council registration documentation in staff files. Staff files were regularly audited to ensure the information they contained was relevant and up to date.

Medicines were managed safely. We observed a registered nurse administering medicines to people during the lunch period. The registered nurse checked the Medication Administration Record (MAR) to identify the correct medicine to be dispensed for each person. They extracted the tablet(s) from the monitored dosage system and put the medicine into a dosset pot which they then took to the person. The trolley was locked whilst the registered nurse administered each person's medicine. We observed the registered nurse explained to each person what their medicine was for and stayed with them whilst they took their medicine. We overheard them say to one person, "If you have problems with that pain let me know" as they offered pain relief medicine. The registered manager undertook competency checks with the registered nurses. One nurse told us that the registered manager asked them questions during the checks, like what a particular drug was for. Medicines that were required to be kept at a certain temperature were stored in a refrigerator. Controlled drugs were managed safely. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated regulations. Medicines were

ordered and stocked over a 28 day cycle and two members of staff checked these in when they were delivered by the pharmacy. The medicines were cleared every 28 days from the medicines trolley when stock levels and expiry dates on medicines were checked. Some people had been risk assessed and administered their own medicines.

Requires Improvement

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. We spoke with staff about their experiences of induction following commencement of employment. One staff member told us, "I hadn't done this kind of work before and so I did a lot of shadowing. It was fine".

We asked staff about the training opportunities on offer. One staff member said, "There is training around, that's for sure". Another staff member told us, "The manager makes sure we get all the basic training done". A registered nurse talked about the training they had received and that several training sessions were coming up; they added, "We get quite a lot of support". We looked at the 2015 training matrix and at staff files. All staff were able to access training in subjects relevant to the care needs of the people they were supporting. The provider had made training and updates mandatory for all care staff in the following areas: Infection control, health and safety, moving and handling, fire awareness, safeguarding vulnerable adults, first aid and food hygiene. Other training undertaken by staff included: Medicines management, understanding Human Rights, equality and diversity, Mental Capacity Act 2005 and challenging behaviours. Staff were also undertaking, or had completed, training in National Vocational Qualifications (NVQ) at various levels. NVQs are work based awards. An NVQ assessor was meeting with a staff member during our inspection.

We asked how staff were formally supervised and appraised by the provider. All staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member said, "Supervision is open and honest". Another staff member told us, "I always say what's on my mind anyway, but the manager does listen". A registered nurse told us they felt supported and there was good teamwork. They explained, "I enjoy working in my team. There is a good rapport with management and we support them" and added, "The staff here are so good and so hardworking". Supervision and appraisal records and an appraisal planner showed that supervision sessions and yearly staff appraisals for all staff had been undertaken or was planned in line with the provider's policy.

Minutes of the latest team meetings, including the management team and other meetings open to all staff, showed that staff were able to discuss matters of importance to them and the people they were looking after. However, the minutes did not contain a review of the minutes of the previous meeting or an action plan for the current one. This meant it was not possible to ascertain whether issues raised previously had been resolved. We discussed this with the registered manager who stated they would ensure actions were followed up at team meetings and recorded.

We attended a staff handover meeting held during the afternoon. According to the duty rota, some staff worked either in the mornings and afternoons or in the afternoons and evenings. The purpose of the meeting was to share information about people's care and support needs to ensure continuity of care. The discussions during the handover meeting were relevant and focused on the care needs of people. They involved the exchange of up to date information, such as changes in people's care and visits from health and social care professionals. It was evident from the discussions held that staff possessed a high level of

knowledge about the care needs of the people they were supporting.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 discussed the requirements of DoLS with the registered manager and they had a good understanding of MCA and DoLS. They told us that they had applied for authorisation to the local authority for some people living at the home. The local authority was in the process of considering these applications.

We asked staff about issues of consent and about their understanding of the MCA. Some of the staff had undertaken recent training in this area. None had a thorough understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. No staff members could tell us the implications of DoLS for the people they were supporting. One staff member told us, "This isn't a psychiatric home so we don't need to know much about that". Another staff member referred to DoLS and said, "It's about keeping people safe".

We recommend that the provider puts measures in place to ensure that staff have a good understanding of their responsibilities of the requirements of the MCA and are able to put this into practice.

Where people had been assessed as lacking capacity, care records contained documentary evidence of this. Where people had capacity to make particular decisions, consent forms were signed by them and placed within their care records. We saw consent forms had been completed for people to have invasive procedures carried out, for example, the administration of an enema and consent to have their medicines administered by trained staff.

People were supported to have sufficient to eat, drink and maintain a balanced diet. One person confirmed that the meals were good, that they had their main meal at lunchtime and a sandwich at about 5pm. They told us that they helped to plan the menus. Another person said that the food was better than it had been and that they had a choice. They told us, "If there's something we like, we can tell them and they sort it out. I absolutely adore Spaghetti Carbonara, so we have it now. The food is good". People also had sufficient drinks available to them, either in their rooms or in communal areas. One person said, "I've got bottled water and I love coffee" and they were enjoying their coffee when we visited them in their room. Another person said, "Food's pretty good. Today was a choice of corned beef or cheese salad. I don't like corned beef, so chose cheese salad instead". The chef showed us the menus which spanned a four-weekly cycle. They told us they had included some classic recipes and some foreign foods on the menu. Roasts were cooked on a Sunday and fish was served on a Friday, in line with people's preferences and other options were available. People helped to plan the menu at residents' meetings. They chose what they wanted to eat for their main meal at breakfast time on the same day. The chef confirmed this and added, "We can always accommodate people's choices". Some people had been assessed as requiring special diets, for example, pureed food and food for people living with diabetes. When people celebrated a birthday, the chef baked them a cake.

People had been assessed, using a combination of height, weight and body mass index, to identify whether

they were at risk of malnourishment. The provider had completed these assessments using the Malnutrition Universal Screening Tool, a tool designed specifically for this purpose.

People were supported to maintain good health and had access to healthcare professionals and services. People's care plans showed that the provider involved a wide range of external health and social care professionals in the care of people. These included speech and language therapists, consultant neurologists and the Huntingdon's Disease Clinic at University College Hospital, London. Advice and guidance given by these professionals was followed and documented. One person told us that their GP would be called, "Even if I don't realise there's something wrong with me, they'll get a doctor in to check on me".

People's rooms were personalised to reflect their tastes. One person's room had pictures of Bob Marley and Mohammad Ali on the walls and equipment that enabled them to listen to music. In another room, the person liked animals and had pictures of puppies and kittens on their walls, as well as an array of soft toys. A relative said their family member enjoyed going out into the garden and said, "It's lovely in the summer, we spend a lot of time on the deck".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. One person referred to the staff and said, "The majority of them are lovely. They have a chat and make me laugh and I make them laugh". They added, "Yes, we are well looked after and I like it here". Another person was joking about staff with us and said, "They're all right. I haven't had an argument or falling out with anyone!" A relative made several positive comments about the staff, "They were very good to me here when I was struggling, with help and advice and that" and, "The atmosphere is friendly and caring, as well as the care itself. It's not like some of the homes I've been to. [Named family member] likes all the staff, they're all nice". The relative said that they visited their family member on most days of the week and commented, "I'm never made to feel, 'Oh she's here again!'" (by staff).

We observed care in communal areas throughout the day and particularly at lunchtime. The care was safe and appropriate, with adequate numbers of staff present. We observed excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting people. There was a high level of engagement between people and staff and a convivial and informal atmosphere. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistently high standard.

Care plans contained life histories and social assessments for people. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships, for example, people's previous occupations and hobbies.

Care plans showed the level of people's involvement in their care and people confirmed to us that they were involved in decisions about their care. People and their representatives could have regular and formal involvement in care planning and risk assessment if they wished. A relative told us, "Oh yes, they will consult me. They've kept me informed, when he wasn't eating, and we worked together" (to find solutions). People's views were sought on care plans and risk assessments, so there were opportunities to amend the care plans if the person did not feel they reflected their care needs accurately.

People told us they were treated with dignity and respect. One person referred to this and staff saying, "They're all fair, they're all helpful". We asked staff how they supported people to maintain their dignity and privacy. One staff member told us, "We know where the line is. Of course, we have a laugh and a joke with people as they tend to be younger here and they like that. But it's never at their expense. We're here to support them". At lunchtime, we observed that people only wore clothes protection if they wanted to and staff checked this with them. In one care plan, a person with a physical disability did not wish to use a conventional beaker to drink from as they thought it was "babyish". A suitable alternative was used. Staff understood how to respect people's human rights and were offered training in equality and diversity and the Human Rights Act.

People were supported at the end of their lives to have a private, comfortable, dignified and pain free death.

Some care plans contained advance directives from people and/or their relatives about how they wished to be cared for. One care plan stated, 'I do not wish to record any advance decisions at this time'. A registered nurse said they would talk with people about their end of life wishes and they had received training from a local hospice on this topic. They also talked about the importance of communicating with the person's GP and about working alongside other healthcare professionals and the person's family. They referred to whether people wanted to be admitted to hospital or wished to stay at the home and said, "We would ask people whether they wanted to stay. It's what families want". Relatives could stay with their family member as they reached the end of their life and a registered nurse described how they would be made comfortable, perhaps with the use of a reclining chair in the room, so they could be near their loved one.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans and daily records for people were kept on a computerised system and the records were relevant and up to date. They contained detailed information about people's care needs and personal histories, their likes and dislikes. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care or support, for example, in their choices of food and drink. Care plans and risk assessments were reviewed monthly and signed by staff and people and/or their representatives were involved in this.

People's needs were assessed appropriately and care and treatment was planned and delivered to reflect their individual care plan. Care records provided comprehensive information and guidance to staff on a variety of areas. For example, one care plan contained information on the person's mental health needs, eating, smoking, cognition, memory and behaviour and an action plan was in place which was followed by staff. In addition, people had summaries of their health and support needs printed off as hard copies; these were useful if the person needed to be admitted to hospital urgently and hospital staff had all the relevant information. Daily records were kept in people's rooms and the registered nurse said they would check these had been completed appropriately by care staff when they administered people's medicines. Daily records charted people's activities, hydration, positioning and output.. The provider explained how they encouraged staff to always have a quick chat with people when they came on shift. For example, staff might ask, "Is there anything I can do for you quickly because I may be busy for a few minutes". This helped to reassure people that staff were on hand to support them, even though they might not be able to respond to call bells as quickly as they might like between shifts. The call bell system also allowed people to summon staff if their needs were urgent and in an emergency situation.

We asked staff what they understood by the term 'person-centred care'. One staff member told us, "We occupy a niche in the market. There are a lot of younger people here and we try to stay aware of that. For example, in what people choose to eat, like Chinese food. You don't find that in most nursing homes".

A range of activities was on offer to people and an activities co-ordinator was in post (although they were on annual leave at the time of our inspection). We were given a programme of events that were planned throughout November and December and activities were organised on two or three days each week. Activities available to people in November included outings to the theatre, lunch in Newhaven, a visit to an animal sanctuary, Christmas shopping in Worthing and Shoreham, as well as some 'indoor' activities. In December, people could go out Christmas shopping or have lunch at a garden centre or visit the theatre to see Cinderella. A range of other Christmas activities and a party had been organised. One person told us that they enjoyed going out on trips to Portsmouth and Bognor Regis and had meals out. Another person said, "I don't go out, but I could if I wanted to". A relative said, "They go out and I can go as his carer. I can go out with him. It's quality time with him. He enjoys it and so do I". Daily activities were organised in the communal sitting/dining area if people chose to participate. One person said, "We've got a woman coming in at 11 o'clock for exercises". A registered nurse told us, "We do promote independence, we try and get people to do as much as they can".

Complaints were listened to and learned from. We asked one person who they would go to if they wished to make a complaint. They told us that they would go to the registered nurse or registered manager and added, "But I've not really had to make a complaint so far". Another person said they would try and talk with the registered manager if they had a problem. We looked at the provider's complaints policy and procedures which were displayed in communal areas. We also looked at the complaints log. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the local government ombudsman and the Care Quality Commission.

There had been nine informal complaints made within the year and four formal compliments. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent further issues from occurring. In addition, complaints were audited by the provider in order to ensure consistent and effective management of complaints. Each person's care plan contained information about resident's rights with their own copy of the complaints procedure.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service. One person felt the home was good and said, "The conditions and food are good. I can have a shower every day" and added that they had no concerns and there was nothing about the home or their care that they would change. Residents' meetings were held usually on a monthly basis and minutes recorded that people were able to discuss matters of importance to them, such as menus and the provision of activities. We asked the provider whether people or their relatives were asked for their views in a formal way, for example, through the circulation of a survey or questionnaire. The provider told us that surveys had been completed in the past, but none recently. A relative said they had not received any formal request for feedback, but added that they had no concerns and were very happy with the home.

We asked the registered manager about the culture of the home. They told us, "I am very hot on person-centred care because people need to have choice. For example, young people don't necessarily want to go to bed at 6 o'clock in the evening". They added, "We try and give people an independent life and we try and be as 'homely' as possible". We asked staff about the vision and values of the home. We asked the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "We offer safety I think to a very vulnerable group of people". Another staff member told us, "We provide as good a life for people as we can".

Good leadership and management was visible at all levels. A relative said that their family member had initially come to the home for a short break and then had moved in permanently. They told us, "I'm very impressed. I come in whenever I like. I'm here virtually every day. I've been to quite a few rest homes. We were recommended here and we didn't look anywhere else. The outside may need some 'tlc', but it's what inside that matters".

We asked the staff if they thought the home was well led. One staff member told us, "It's well led and I can speak to the manager if I need to". However, another staff member said, "I think sometimes the owners don't really understand what we do here. I've said to them 'work a shift and see what we achieve every day' but it hasn't happened". The registered manager said, "I personally think most of the staff get on very well with my management and nurses, we feel like a big family".

There were robust quality assurance and governance systems in place to drive continuous improvement. We looked at a range of monthly audits regularly undertaken by the provider. These included monthly auditing of maintenance issues and environment, infection control, care plans to identify any errors and discrepancies and medicines management. The provider also conducted an evaluation of the effectiveness of activities, with proposals for improvement. Issues arising from these audits were discussed and managed at monthly management meetings. The minutes of the latest meeting showed that action was taken where appropriate. An analysis of accidents and incidents was undertaken and the registered manager sent us copies of these reports by email following the inspection.

A copy of the previous inspection report was on display in the reception area of the home, together with the

rating applied at that time. Evidence we saw and observed at this inspection corroborated that the provider and registered manager had implemented changes and made improvements since the last inspection. The registered manager said, "We've been working so hard in the past year" and referred to the challenges of funding and staff pay rises. They added, "We're trying our best".