Victoria Lodge Care Home Limited

Victoria Lodge

Inspection report

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Worthing
West Sussex
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19 May 2016

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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 17 and 19 May 2016 and was unannounced.

Victoria Lodge is registered to provide care for up to 23 people older people who are living with dementia. At the time of our inspection, 17 people were living at the home. Victoria Lodge is situated close to the town centre of Worthing and within walking distance of the seafront. Accommodation is provided over three floors and all rooms are of single occupancy; some have en-suite facilities. There is a large sitting room and adjacent conservatory, the latter also used as a dining area. People have access to an attractive rear garden with seating areas.

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.

Staff had not received specific training on the requirements of the Mental Capacity Act 2005 and did not understand their responsibilities under this legislation. Some staff had not completed or updated their training in all essential areas. Staff had supervision meetings, but formal meetings or annual appraisals were not planned on a regular basis.

Staff understood how to gain people's consent before delivering their care and involved people in day-today decisions. Coded keypads around the home prevented people from leaving the building or accessing some parts of the home without staff support, which was for their safety. People had sufficient to eat and drink and were encouraged to maintain a balanced diet. They had access to a range of healthcare services and professionals. The home was undergoing refurbishment.

People and their relatives felt the home was a safe place. Staff understood how to protect people from the risk of abuse and knew what action to take if they suspected abuse was happening. People's risks had been identified and assessed and were managed appropriately. There were sufficient numbers of staff on duty to keep people safe and meet their needs. Safe recruitment practices were followed. The home was clean and there were no unpleasant odours.

People were looked after by kind and caring staff who knew them well. People were encouraged to be involved in all aspects of their care and they were treated with dignity and respect.

Care plans were person-centred and provided detailed information and guidance to staff about people's care needs, including their personal histories, likes and dislikes. A range of activities were available to people and the provider was planning to increase the number of organised activities delivered by an external activities co-ordinator. Complaints were managed appropriately in line with the provider's policy.

People were asked for their views about the service and the registered manager had individual meetings with people to obtain their feedback. Staff felt supported by the management team and the registered manager spoke highly of the provider. A range of audit systems was in place to monitor the quality of care delivered and the service overall.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

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 felt safe living at the home and their risks were identified, assessed and managed appropriately. Staff had been trained to recognise the signs of potential abuse and knew how to address these.

Staffing levels were sufficient and robust recruit systems were in place.

Medicines were managed safely.

The home was clean with no unpleasant odours.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not understand the requirements of the Mental Capacity Act 2005 and had not received specific training on this topic. Some staff were not up to date with their training in other areas. Staff did not always have supervision meetings on a regular basis.

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.

People were supported by kind and caring staff and encouraged to express their views in relation to decisions about their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans contained detailed information and guidance to staff about people and their care needs.

An activities co-ordinator visited the home twice a week to deliver a range of activities for people. Other activities were also available.

Complaints were managed appropriately in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their views about the service and their feedback was used to drive improvement.

Staff felt supported by the management team.

Audits were undertaken to measure and monitor the quality of care.

Victoria Lodge

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 17 and 19 May 2016 and was unannounced.

An inspector and an expert by experience undertook this 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. The expert by experience at this inspection had expertise in older people and dementia care.

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 checked the information that we held about the service and the service provider. 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 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 five 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. 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.

On the day of our inspection, we met with five people living at the service and spoke with two relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider, the registered manager, two senior care assistants, two domestic staff, the chef and a kitchen assistant. We spoke briefly with a visitor who was organising an activity for people.

The service was last inspected on 10 June 2014 and there were no concerns.

Good

Is the service safe?

Our findings

Without exception, people we spoke with felt the home was a safe place. Comments included, "Yes I feel safe", "I certainly feel safe here" and "I feel safe. I have no problem with the staff. I've not come across anything nasty". A staff member told us, "I've not seen anything or heard any harsh words from staff with the residents". We observed there was always a staff member available to support residents in the sitting room and conservatory.

Staff understood how to recognise the signs of potential abuse and had been trained in safeguarding adults at risk. They knew what action to take if they suspected people had been the subject of abuse. One staff member explained how they would support the person and complete an incident form. They added, "I would go to my manager. I would report it". They told us they would, if necessary, report allegations of abuse to the local safeguarding authority.

Risks to people were managed so they were protected and their freedom was supported and respected. One person told us, "I am free to move around here as I wish". Risks to people had been identified and assessed and were reviewed, alongside their care plans, every three to six months as needed; records confirmed this. People's risks had been identified in a range of areas such as skin integrity, falls and moving and handling. People's risk of developing a pressure ulcer had been assessed using Waterlow, a tool specially developed for the purpose. Sensor mats were placed beside people's beds, so that if they got out of bed, for example at night, then staff would be alerted when an alarm sounded. Risk assessments we looked at identified the area of concern or risk, who was likely to be affected, the control measures in place and were rated as 'low', 'medium' or 'high'.

Accidents and incidents were reported appropriately and risk assessments were reviewed. For example, some people had sustained falls or slipped from their armchairs. In one case, the furniture in one person's room had been rearranged to alleviate the risk of falls. We were told that staff regularly monitored people at night and that hourly checks were undertaken. The registered manager said, "If someone becomes more frail, then half-hourly checks are done". Premises were managed to keep people safe and exits and stair gates were operated by key coded pads. Sensor lights were fitted in corridors and automatically switched on when people were moving around the home.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. People felt there were enough staff on duty during lunchtime, as well as being available to support people as needed. One person told us, "The staff are very patient and there are enough staff around usually". Another person said, "Generally there are enough staff and they are good at handling the awkward residents" [referring to people who displayed challenging behaviour].. We checked the staffing rotas which showed that there were normally four care staff on duty during the day and three waking night staff. In addition to the care staff, the deputy manager and registered manager were also available to provide support to people if required. The registered manager told us, "When the home's full, there is one senior and four care staff. At the moment there is one senior and three care staff all day and three waking night. Between 8pm and 11pm it's busy and sometimes we do activities at night".

Safe recruitment practices were in place. New staff completed an application form, two references were obtained and checks made with the Disclosure and Barring Service to ensure staff were safe to work in the home.

Medicines were managed safely. People we spoke with said they received their medicines as prescribed and that staff watched to ensure they took their medicine as required. One person said, "I have tablets and they check you taking them" and another person said, "Yes, I get my tablets when I should". We observed people being given their medicines at 1.30pm by a senior member of care staff. The staff member checked the relevant Medication Administration Record (MAR) to ascertain the medicine prescribed and the dosage. They then dispensed the medicine from the blister pack, if in tablet form, and handed it to the person to take. One person received soluble aspirin and the member of staff said, "[Named person], it's your lunchtime aspirin. You just need to drink it". When people had received their medicine, the MAR was then signed by the staff member to confirm this. We asked a member of staff what action they would take if people refused to take their medicine. They told us, "We document they've refused and destroy the medicine" adding that they would refer the issue to the person's GP for advice. For example, one person had refused to take their medicine in tablet form, so the GP had arranged for the same medicine to be available in liquid form, which had solved the problem. Staff had been trained in the administration of medicines and the registered manager and deputy manager undertook competency checks to monitor staff's capability. A medicines audit had been completed by the dispensing pharmacy in July 2015 which was satisfactory. Medicines were ordered, stored, administered and disposed of safely.

We observed the home was clean and there were no unpleasant odours. One person said, "They keep it absolutely clean here and my room is kept spotless". Another person told us, "They do clean my room, but I make my own bed". A third person said, "Yes, it's a clean place. They do my room every day". A relative told us, "They are very good at keeping the place clean. When there is a spillage, they deal with it very quickly". Cleaning schedules were completed on a daily and weekly basis. Schedules we looked at confirmed when each part of the home had been cleaned including areas such as the main kitchen, bedrooms, communal areas, dining room and sitting room. Night staff had cleaning responsibilities and ensured that communal areas were vacuumed and clean ready for when people got up in the morning.

Requires Improvement

Is the service effective?

Our findings

People did not always receive care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Training was delivered to staff by an external company who delivered training on a different topic every month. Training was offered in two different time slots, one during the day and one in the evening so staff could easily access what was offer. In the year to date, training had been delivered for new staff on induction, nutrition and health, infection control, first aid awareness and safeguarding. Other areas covered by staff included health and safety, moving and handling, Control of Substances Hazardous to Health (CoSHH), dementia matters, challenging behaviour, diabetes and stroke awareness. The training plan indicated that 17 staff had not completed safeguarding training within the last year, 13 staff had not completed dementia awareness training and 15 staff had not received moving and handling training either in 2015 or in 2016. No staff had received training on the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS), although this was planned for August 2016.

According to the registered manager, staff should have meetings with their supervisors at least four times a year. Staff records showed that staff had not always received formal supervisions with such regularity. For example, records showed that three staff members had one supervision meeting in 2016 and two in 2015. Some staff, who had worked at the home for over a year, had not received annual appraisals. The registered manager told us that they regularly met with staff and kept notes of meetings on their computer. They told us, "Some staff are up here every day talking about things". The registered manager concurred that not all staff had received annual appraisals and that they were, "Always chasing people [staff] for training".

The above evidence shows that staff did not always receive appropriate support, training, supervision and appraisals necessary to enable them to carry out their duties. People were at risk of receiving inappropriate or unsafe care because staff training was not up to date. The lack of supervision for some staff meant that their competence in their role was not formally discussed and could not be assured. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said, "They are well trained and you can discuss things with staff if you need to". A relative told us, "The staff seem very well trained". All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, which had been introduced. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Where staff supervision meetings had taken place, records showed that a range of topics was discussed including care plans, holidays, dress code and reporting abuse. A member of staff told us that discussions were about, "Staffing levels, anything I feel would benefit people here, training, any issues or problems in the home" and added, "Yes, I feel listened to". Staff were encouraged to study for additional qualifications, such as a national vocational qualification in health and social care. Some staff had already achieved a National Vocational Qualification at Level 2 or Level 3. One member of staff said they would be supported if they wanted to take additional qualifications and told us, "If I wanted to. I'm sure I could get their backing and support".

Staff meetings were held regularly and minutes confirmed that four meetings had taken place during 2016. Minutes of a meeting held in April 2016 showed that the staffing rota, people's care needs, documentation, cleaning schedules and the completion of MAR had been discussed. Handover meetings took place between shifts at 7.45am, 1.45pm and 7.45pm each day. We sat in on a lunchtime staff handover meeting where staff shared information with the incoming shift. Information for staff was compiled on a handover sheet which included updates about people, their food and fluid intakes, personal care and people's moods. Staff were reminded to keep an eye on temperatures in people's rooms, as they might be at risk of overheating during the hot weather.

People felt that staff asked them for their consent before delivering care. One person referred to staff and said, "They always have time for people and they always explain what they are going to do". Another person told us, "They discuss my care". 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. Records showed that a best interest meeting had been organised for one person in June 2015 and had been attended by health and social care professionals, staff from the home and the person's relatives. A decision had been taken relating to this person's future care and accommodation needs. Whilst staff had not received training about the MCA, all the staff we spoke with had a good understanding of the importance of gaining people's consent on a day-to-day basis. One staff member thought the MCA was about, "Rules you have to treat people with regard to their capacity".

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had completed capacity assessments and applications for DoLS for everyone living at the home and was awaiting responses from the local authority. People were unable to leave the home independently as there was a coded keypad next to the front door. In addition, people's movement on the stairs was limited by similar keypads which prevented them from accessing the stairs without staff support.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. One person said, "The food's good usually". Another person said, "The food's wonderful, meals are good. This drink [referring to fruit squash] is great!" A third person said, "The meals are very good. There is a good choice of meals and portions are okay and if you want more, you can have it. You can have a drink at any time. People who are diabetic get what they should". A fourth person told us, "The meals are excellent and you can have an alternative if you want". Menus were planned over a four weekly cycle. People could have a cooked breakfast on three days each week, instead of the usual cereals or toast. Lunch consisted of a meat or vegetarian choice and a hot dessert or cold pudding. Supper included choices of soup, sandwiches, pasta, jacket potatoes or cheese and biscuits. Roasts were popular with people on Sundays, as was a fish option on Fridays.

We observed lunch being served from 12.30pm to 11 residents by four members of staff. The meal consisted of two courses, with two choices for each course. Cold drinks were on offer of either water or juice. The main course meals looked appetising and were served hot. Staff took time to describe the choices on offer to people and second helpings were available. We observed one person left the room and their lunch was removed to be kept warm. Where needed, staff assisted people to eat their meals and we observed staff encouraging people to eat their food. Staff were also seen taking meals on trays to people who chose to eat in their rooms. The menu of the day was displayed on a board in the dining room. Drinks were freely available to people throughout the day, as well as biscuits or cakes during the morning and afternoon.

People at risk of malnourishment had been assessed and their weights monitored closely to ensure they were eating and drinking enough. One person had been assessed by the dietician and had a nutritional plan in place that included fortified drinks.

People were supported to maintain good health and had access to a range of healthcare services and professionals. One person said, "They keep an eye on you and if I'm not well, they will get the doctor in", adding, "A person comes in to cut my toenails". Another person said, "I go out to the dentists and I also go out to the chiropodist. We get a visit from the district nurse". A third person said, "They organise visits from the chiropodist and the dentist and they take me in a taxi to the doctors". Care records confirmed that people had access to their GP, chiropodist, dentist and optician. Where necessary, people were also supported by a community psychiatric nurse.

The home was in the process of being refurbished and updated. Redecoration and maintenance in communal areas of the home was undertaken between 10pm and 4am with minimal disruption to residents.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People could choose whether they wanted to be looked after by male or female care staff and one person received visits from a member of the clergy, in line with their wishes. People felt the care delivered was good and that the staff were friendly, kind, caring, attentive and respectful. We observed that staff were kind when supporting people and addressed them in a caring way. For example, staff were patient and reassuring with one person who was walking aimlessly around the home and seemed unsure where they wanted to go. One person told us, "Yes, the staff are okay. It's nice here". Another person told us, "The staff are very kind and very good with all of us". A third person confirmed that staff were, "Kind and caring and they take care of us all very well". A relative said, "The care [named family member] gets here is very good. I am pleased they are here". Some people said they had to wait a little while before staff responded to their needs. One person said, "Sometimes you have to wait for help, but they are busy". Another person said, "When I need help, they could come more quickly".

On the day(s) of our inspection, staff attended to people's needs promptly and had time to sit with people. One member of staff said, "We spend time with people. We try and sit with people. Some people come down for meals and others prefer to stay in their rooms". A member of the domestic team said, "I always have a chat with residents". A cat and small dog also lived at the home and the dog named Sugar, was very popular with people. A member of staff told us, "The residents love him". We saw people stroking Sugar and one person had encouraged him to sit on their knee, to the amusement of staff. A risk assessment was in place which assessed the risk of either pet causing harm to people; this had been assessed as 'minimal'.

Staff supported people to express their views as much as they were able and to be actively involved in making decisions about their care. We asked people whether they were involved in reviewing their care plans. One person said, "I am aware of my care plan, but I don't know if I've had a review". Another person confirmed they knew about their care plan and that it was reviewed every six months. We saw that some care plans had been signed by people and showed they had been involved in their review. People's capacity to make decisions had been assessed. Where people had been assessed as lacking capacity, then their relatives were consulted in the reviewing of their care. We asked a member of staff how they involved people in decisions about their care and obtaining their consent and they said, "Just asking them and getting them involved". The majority of people were supported to make day to day decisions such as when they wanted to have a bath or shower, what clothes they wanted to wear or when they wanted to get up or go to bed. A member of staff gave an example of one person who always refused personal care and said, "We always explain what's happening when we deliver care". They went on to say, "We do a lot of encouragement. I take the time to spend with people, to wash, choose their clothes and tidy their room a bit". They told us about one resident who liked to help fold laundry and to do some washing-up. People told us there were no restrictions to visiting times and visitors were made to feel welcome. A relative said, "There are no restrictions at all for my visits".

We observed that people were treated with dignity and respect. One person said, "They certainly treat me with respect". Another person told us, "When they are dealing with me, they deal with me privately. They

are very good at confidentiality". A third person said, "They are respectful when dealing with me". A relative said, "They deal with private matters very well". A member of staff said, "I'm very caring and very understanding; I'm very patient. You've got to understand these people are here not through their own fault".

Some care records contained 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms which had been completed by healthcare professionals. People had been assessed regarding their health and mental conditions and whether staff should attempt to resuscitate them, should they stop breathing. The forms had been completed appropriately and copies were kept with people's medication records for easy access, in the event of an emergency. We asked staff about end of life care and one member of staff said, "Make sure people are comfortable at the end, dealing with and supporting the family". Another member of staff told us they had not done any specific end of life training, "But I've dealt with it quite a bit".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People felt that the care they received focused on their individual needs. One person told us that their health had improved since coming to the home. Another person said, "I definitely get the care I need. I had a stomach problem and they sorted me out very quickly. I don't mind who looks after me". A third person said, "When I'm here I feel quite comfortable and well looked after".

Care plans provided information about people in a person-centred way that focused on the person's personal needs, wants, desires and goals so they were central to the process. For example, one care plan informed staff about, 'People who are part of my life' and, 'My Needs – When I get dressed I need some help'. The plan provided information about the person being able to dress independently, but that they could dress in dirty clothes or put on several layers of clothing at once. The short term goal had been identified as, 'Continue to supervise [named person] and give her support and encouragement. Ensure she has choice as to what she wears'. Information was also provided on this person's bathing, a nutritional assessment and a mobility assessment and how staff were to support this person, whilst encouraging their independence. There was guidance for staff on managing this person's emotions and the plan stated, 'I want you to help me with my mood, my emotions and feelings, independently or with appropriate help and some medication. I would like to be on the least possible amount of medication to help me control my mood'. Further information was provided to staff about this person's sleep and rest, personal care, physical health, medicines, skin integrity, sight and hearing and help with money. The care plan had been reviewed every couple of months and changes incorporated as needed. We saw that another person's care plan which had been reviewed in March 2016 now required that two members of staff supported the person, 'To help dress due to her level of confusion and agitation. Can be rude and hit out at staff'. It advised staff to, 'Support [named person] with lots of reassurance. Try to regain positive mood'.

People's personal histories and lives they led before they entered the home had been recorded in their care records. Information was provided about people's friends and family, their working life, religion, holidays, travels, music, TV and films, for example. Before people were admitted to the home, the registered manager completed an assessment and also consulted with relatives about people's care and support needs, as well as their likes and dislikes and personal preferences. This information then provided the basis of the care plan. Where no detailed personal history had been recorded in people's care plans, the registered manager had written to family members requesting for help with this.

A range of activities was organised for people and these usually took place during the afternoon. One person said, "Oh yes, there is enough to do" and another person told us, "There is plenty to do here and I am amazed at what choice there is". A third person said, "They don't do much until the afternoon. I am happy just sitting here and watching the TV". We observed an activity that had been organised by an external activities co-ordinator who visited the home twice a week and how they interacted with people. Eight people joined in the activity which was based on a quiz about London. People were engaged and interested in the quiz and the activities co-ordinator supported people to be involved. For example, people were asked to name as many London underground stations as they could think of. When people supplied the answers

they were encouraged to talk about their experiences of London, where some people had lived and worked, whilst others had visited. The activities co-ordinator knelt down to talk with people at their own level and they were enjoying the discussion about London. Where people chose not to be actively involved, we observed they were looking on with interest. Some people chose not to join in with group activities and the activities co-ordinator provided 1:1 sessions with people in their rooms. For example, they were helping one person to put together a scrap book of photos and pictures about their life. Other activities were organised for people that included gardening, flower arranging, gentle exercises and arts and crafts. People could also receive a massage every fortnight. The registered manager told us they would like to do more, for example, involve the chef in baking sessions with people. The provider told us they hoped to increase the visits from the activities co-ordinator, so they could organise activities for people on at least one additional day per week. Staff also engaged in activities with people.

Complaints received from people and their relatives were managed appropriately. One person told us, "No, I've not had a grumble" and another person said, "I've never needed to complain about anything". A third person said, "I've never needed to make a serious complaint. If I did, I'd go to the manager". The provider had a complaints policy in place that stated complaints would be acknowledged within 24 hours of receipt and resolved within 28 days. Contact details were provided of the Care Quality Commission and the Local Government Ombudsman.

Good

Is the service well-led?

Our findings

As much as they were able, people were actively involved in developing the service. Residents' meetings had been tried in the past, but were not appropriate, as most people had difficulty in participating in a formal meeting. Instead, the registered manager met with people on a day-to-day basis to obtain their feedback on areas such as menus, activities and laundry. One person said, "I feel they listen to residents and try to sort problems out". People were complimentary about the registered manager and the management of the home, saying that the registered manager and staff were approachable. One person said, "The manager is a nice person". Another person told us, "All the staff are very good. They are all very open with me and others. The manager is lovely". A third person said, "The manager is nice and friendly. She is very good. I feel she is approachable". A member of staff told us that people had been asked for their views when a new chef had been employed. People and their relatives were asked for their feedback about the home and the last survey had been sent out in May 2015. Eighteen surveys were sent out and nine were completed and returned. Overall people and their relatives felt the home provided a good service, but that more activities could be provided. As a result, a programme of activities had been implemented.

We asked staff whether they felt supported by the management team and all staff confirmed this to be the case. One member of staff said, "The staff and the residents are good. It's like a family". Another member of staff told us, "You're supported by the management. You can always ask management to help". A third member of staff felt the home was well managed and that they felt supported. They explained, "It works as a good team. Most people are willing to do that little bit extra to get the job done". The registered manager told us, "The door's always open here and staff can come in at any time". We observed that staff were happy to go to any member of the management team, including the provider, and that they were responded to in a positive manner. The registered manager felt supported by the provider and said, "I can phone her any time of day or night and she will come down". They added, "Everything I've asked for, if it's for a resident, she's got it for me". The provider had responded positively to the registered manager's request for the activities co-ordinator to provide additional sessions at the home. The chef told us, "The owners have been totally supportive. I was allowed to order replacement equipment. The process of ordering and delivery of food is good. The management have been very supportive and they have a four week menu. We are currently on the winter one and I've been encouraged to make improvements". Staff were asked for their feedback about the home through a satisfaction survey. The last survey, undertaken in May 2015, included questions for staff about their induction, the running of the home and management, training needs, their employment and any health and safety issues. Twenty-four surveys had been sent to staff and results showed that overall staff were satisfied.

We asked staff about the culture of the service. One member of staff thought this was, "Just to encourage the residents to continue doing what they're able to do, that's the ultimate aim". The registered manager told us, "We aim to give the resident the same home life as much as we can before they came here. We promote their independence and their choices. I want people to be treated the same as I would want my family treated".

Monthly audits were undertaken to monitor the service delivery and where improvements were identified,

actions were taken. Audits were undertaken to monitor the administration of medicines, reviews of care records, any trends with accidents and incidents and safeguarding. The registered manager said, "There's been no safeguarding since I've been here and very few deaths. We've managed to keep people safe". Quality was integral to the home's approach and staff were pro-active in providing high quality care. One staff member said it was about, "Making sure people are comfortable and safe and that people get the care that is right for them". The provider said, "Everyone deserves good quality care". The registered manager talked about driving up the standards of care and said, "I'm proud of turning the home around and getting all the standards met. I'm hoping to maintain that". They added, "I've got a good staff team here and I try and support them well. The home is definitely moving forward in all aspects".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Staff did not receive appropriate support, training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)