Ranc Care Homes Limited

Romford Nursing Care Centre

Inspection report

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Date of inspection visit:
07 August 2018
08 August 2018
09 August 2018

Date of publication:
19 September 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place took place on 7,8 and 9 August 2018. At our last comprehensive inspection on 10 August 2016, we rated the service 'Good'.

We brought forward our inspection to look into concerns we received in relation to the safety and the management of the home, including how the service operated at night times.

We carried out an unannounced inspection of the home on one night and on the two following days. We did not find evidence to substantiate the concerns we received and we have found the home remains 'Good'.

Romford Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Romford Care Centre accommodates up to 114 people across five units, each of which have separate adapted facilities. The units specialise in providing nursing and residential care to older people living with dementia. At the time of our inspection, 95 people were living in the home.

The home did not have a registered manager in post as the person who held this position, left their role a month before our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider has since appointed a new manager who will register with the CQC.

Each unit in the home was managed by a registered nurse or a team leader, who were supported by a deputy manager and an operations manager. We met with both these managers during our inspection.

Risk to some people had been assessed and identified. However, we noted that risks to some people were not always identified in their risk assessments and there was a lack of overall consistency, to ensure all risks were being managed. We have made a recommendation for the provider to ensure risk assessments are clear and contain relevant and consistent information.

People were involved in the planning of their care and received care and support to ensure their individual needs were met. Care plans contained information on people's backgrounds and preferences. However, we have made a recommendation for care plans to take a more person-centred approach towards people's end of life care wishes and for staff to receive further training in this area.

The provider had safe recruitment procedures in place and carried out checks on new employees.

There were enough staff on duty to ensure people's needs were met. Staff rotas were not always completed to show that staff cover had been arranged when required.

The management team was committed to developing the service and this was done through quality assurance systems that were in place. Some further improvements were required to ensure people received a responsive service because some people and relatives did not always feel listened to.

Medicines were stored, managed and administered by staff who were trained. We saw that medicines on all units were managed and used safely.

Staff ensured people had access to appropriate healthcare when needed and their nutritional needs were met. People were provided with a choice of meals and were able to make specific requests.

Feedback was received from people and relatives in the form of questionnaires and surveys to help drive quality improvements.
Records of accidents and serious incidents showed that the provider learned from mistakes to prevent reoccurrence.

People and relatives were able to make complaints, which were investigated by the management team. Complaints were planned to be used to also learn lessons and make improvements in the service.

The premises were clean and regularly maintained. The environment was suitable for people who had specific needs such as dementia.

Infection control procedures were followed by staff to ensure the home remained safe and clean.

Staff knew how to keep people safe and protect them from abuse. They were able to describe the actions they would take if they had any concerns about people's safety. The provider also had a whistleblowing policy, which staff were aware of and they knew how to report concerns both internally and to external organisations.

Staff were supported with regular training, meetings and supervision. Staff performance was reviewed on a yearly basis and they were encouraged to develop their skills.

The provider had systems in place to support people who lacked capacity to make decisions for themselves. Staff had received training on the Mental Capacity Act 2005. They were knowledgeable of the processes involved in assessing people's capacity.

Staff were aware of people's preferences, likes and dislikes. They also had an awareness of equality and diversity and challenged any discrimination they encountered.

People were encouraged to participate in activities and remain as independent as possible. Their choices were respected.

Staff were able to communicate with people in order to understand their needs.

Staff felt supported by the management team, who reminded staff of their responsibilities and requirements when providing care.

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.

Risks to people were assessed and identified. However, risk assessments were not always consistent and we have made a further recommendation around risk assessments.

Medicines were managed, stored and administered safely. People received their medicines on time by staff who were trained.

The provider had a safe recruitment procedure. There were enough staff to meet people's needs.

Staff were aware of the steps to take to report any allegations of abuse.

Is the service effective?

Good

The service was effective.

Staff had good knowledge and understanding of the Mental Capacity Act (2005). Staff were supported with training and received regular supervision and guidance.

People were supported to eat a balanced diet and their nutritional needs were met.

People could see healthcare professionals when required and their health care needs were monitored.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Changes in people's care needs were updated in their care plans.

Is the service caring?

Good

The service was caring.

Staff knew people well and provided care with dignity and kindness.

People were able to express their views about how they wished to be cared for. Their relatives had involvement in the decisions made about their care.

People were supported to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans contained information about their preferences. However, their end of life care needs were not effectively monitored and we have made a recommendation about this.

The provider ensured information was accessible to people in a way they could understand.

People were encouraged to participate in activities of their choice.

Complaints were investigated and responded to and the provider was committed to learning from lessons to help improve the home.

Is the service well-led?

Good

The service was well led.

Quality assurance audits took place regularly to ensure the home was safe and people's needs were being met.

Staff felt supported by the management team and told us there was a positive culture in the home.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

Romford Nursing Care Centre

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.

We carried out an unannounced inspection of the home at night on 7 August 2018, which was carried out by two inspectors. Our night inspection was prompted by information we had received, which indicated potential concerns about the management of risk in the home during night time hours.

We continued our inspection over the next two days on 8 and 9 August 2018, which were both announced and was carried out by three inspectors.

Before the inspection, we reviewed all the information we held on the service such as previous inspection reports and notifications. A notification is information about events that by law the registered persons should tell us about such as safeguarding alerts and serious incidents. We also received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We also obtained feedback from the local authority for their views on the service.

During our inspection we spoke with six people and 14 relatives. We also spoke with four nursing staff, six care staff, the deputy manager, the operations manager, a training administrator, a facilities manager and a chef.

We looked at 12 people's care plans and other records relating to people's care, such as turn charts and medicine administration records. We also looked at accidents and incidents records, 10 staff files, training records, quality assurance audits, health and safety information and other records kept in the service.

Good

Is the service safe?

Our findings

Prior to our inspection, we received concerns that people were not being looked after well at night and they were not always safe. We visited the home on 7 August 2018 at 11.00pm to check how the home ensured people were safe at night. We observed all five units and found that people were safe. One person told us, "The night staff make sure I am OK."

People we spoke with throughout our inspection told us they felt safe. One person said, "Yes I do feel safe." Another person told us, "I am safe yes." A relative said, "My [family member] is definitely safe and well looked after." Another relative commented, "Extremely safe for [family member]" and a third relative told us, "If [family member] felt unsafe, she would let us know."

Most people's care plans contained specific sections on their health care needs that included any risks. Risk management plans were in place for each person, which covered risks around falls, mobility, challenging behaviour and any risks relating to the home environment. However, not all risk assessments were consistent or thorough in taking into account all possible risks. A staff member told us one person, who received half hour checks on their safety, may put themselves at risk by tying a call bell around themselves. There was no reference to this in their care plan, other than that "[person] is at risk of harm if he pulls the call bell out of the wall as they do not understand what it is for." It did not state how they could use the call bell unsafely and whether they did tie it around themselves. Another person's records contained reference to them possibly having an 'allergy to eggs.' There was no information found in their care plan as to the severity of the allergy or the planned response of staff, should the person have an allergic reaction. We spoke with care staff who told us the person was not provided food that contained eggs. However, they were unsure whether the person had an allergy or simply did not like eggs.

We discussed these concerns with the management team because there was not enough attention to detail in some of the care plans to make it clear what the actual risks were. This would avoid contradictory information being given either verbally or in a written format. The management team assured us they would carry out further assessments, if required, to ensure all identified risks were clearly set out.

We recommend the provider looks at best practice guidance on completing and reviewing risk assessments.

Dependency assessments had been completed to calculate staffing numbers in accordance to the needs of the people. We found staffing levels were adequate and the required number of staff were present. Agency staff were called when needed to cover any staffing shortfalls. One relative told us, "There is enough staff but they use agency staff a lot, who don't always know the people here." Another relative said, "The staff are too busy. Especially in the laundry where it takes ages for clothes to be returned. It is too much for them." Most staff told us that they were not rushed in their duties and had time to spend with people. A night staff member said, "I have no concerns with staffing. We have enough at nights here." However, some staff did feel there was not always enough staff cover. Comments included, "Not always enough as we have to wait for agency staff to come in" and "We have a lot of work to do because there is only a few of us."

We checked the rotas for the home across all units. We found some inconsistencies with the night rota as for some units, there were gaps on the rota. This made it appear that there was a shortage of staff during those shifts. Records showed that agency staff had been used on some of the days where the rota showed gaps. This meant there was a risk the management would not have oversight of the staffing arrangement for each unit because the rotas were not completed in full. The deputy manager told us they would ensure they would complete the rota in future, before or after each shift was completed.

The provider had systems to ensure only suitable staff were recruited to work with people who used the service. We looked at 10 staff files which detailed their employment history, qualifications and previous experience. Pre-employment checks were undertaken before staff started working at the service. This included, obtaining references, checking if they had any criminal records and proof of their identity.

The provider had safeguarding policies and procedures in place for staff to refer to if they had any concerns about people's safety. Staff demonstrated an understanding of how to recognise different types of abuse and what actions to take to prevent or report it. They told us they would report abuse if they were concerned about a person. Whistle blowing procedures were in place. A whistle-blower is a person who raises a concern about the practice of an organisation to external organisations, such as the local authority, police or the CQC. The provider attended safeguarding strategy meetings with the local authority to help investigate any concerns about people's safety.

There was a procedure in place to review any accidents or incidents that occurred in the service. We noted from accident and incident reports, that the management team had ensured necessary actions were taken following incidents. Lessons were learned from serious incidents and safeguarding investigations to help prevent reoccurrence. For example, action was taken to reduce conflicts between people in the service by deploying staff with different skills to work with them and help to reduce behaviour that challenged.

The premises were maintained daily. Equipment, such as hoists and wheelchairs were maintained and serviced as per the manufacturer's recommendations. People had individual evacuation plans for staff to follow in the event of a fire and practice drills took place regularly. Gas, water and electrical systems were serviced annually or when they were due.

We observed how medicines to people were administered. Medicines were stored securely in medicine trolleys and cupboards within a secured room. Temperatures of the rooms were recorded daily and were stored at the correct temperature. Arrangements were in place for the collection and disposal of unused medicines. We checked 30 Medicine Administration Record Charts (MAR) across four units. We found that the MAR charts we reviewed had been accurately completed. Some people were administered medicines covertly and records showed that authorisation had been obtained from GP and pharmacists. Staff had been trained on medicine management and were confident with managing medicines. Records showed that staff competence had been assessed to ensure they were competent with managing medicines.

We saw that appropriate records were being maintained for controlled drugs (CDs) and people received their CD's when required. CDs are subject to legal requirements for recording and storage and were at a higher risk of diversion and abuse. Protocols were in place to support staff when administering PRN medicines. These are medicines that were given when needed, for example pain killers and relief inhalers.

Staff were knowledgeable about their role in preventing the spread of infection and confirmed there was plenty of personal protective equipment (PPE). We observed that people's rooms were clean, free of odour and staff wore appropriate clothing when supporting them such as gloves, aprons and uniform. Anti-bacterial lotion was available throughout the building for hand hygiene and we saw staff used these to clean

their hands.

Good

Is the service effective?

Our findings

People and relatives told us staff were helpful and provided them with the care that met their needs. One person told us "Yes, it is very good. I get the care I need." Another person said, "The staff are very nice and they know what to do." A relative said, "The staff are brilliant. So helpful and professional."

At our last inspection in August 2016, we found the home did not always have an effective training, supervision and appraisal programme in place for staff. For example, some staff did not receive regular supervisions, which are meetings with their line managers to discuss any concerns, issues and work performance. Some staff had not received refresher training in the Mental Capacity Act 2005 (MCA). We made a recommendation for the provider to ensure that all staff have regular formal supervision, annual appraisals and training including for staff to attend refresher courses in the MCA.

At this inspection, we saw that this issue had been addressed. Staff felt supported by the management team. One staff member said, "The managers are good, they are supportive and helpful." Staff received supervision every three months and we saw records of supervision meetings and annual appraisals between staff and their line managers. A supervision schedule detailed dates of when each member of staff's next meeting was due. Staff were able to discuss topics such as their performance, any concerns they had and areas for their development. This meant people were supported by staff who had received guidance and support to carry out their roles effectively.

Staff were knowledgeable of what the different needs of people were and received relevant training to help them meet their needs. Some staff had achieved diplomas in Health and Social Care to become qualified in certain skills. Care Certificate standards were tailored into the training, which are nationally recognised learning standards and assessments for health and social care workers. This meant that staff were provided with relevant and up to date training. Most staff had been trained in mandatory areas to perform their roles effectively. Staff had been trained in the MCA, Deprivation of Liberty Safeguards (DoLS), safeguarding adults, health and safety, basic life support, infection control, fire safety, food safety, dementia and medicines management. A training matrix detailed the areas staff had completed training and where training was due.

Refresher training was provided to staff, which included the MCA and we noted that this training was also scheduled for October 2018. Staff and the management team had received training and demonstrated a good understanding of the MCA and DoLS. We found that moving and handling refresher training was overdue for staff. A training administrator, who was qualified in delivering moving and handling training, told us they would be delivering this training later in the month. Staff felt the training provided them with the necessary skills to carry out their role. One member of staff said, "The training is really good and helped me to perform in my job."

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the management team had made applications for people where there were indications they may be deprived of their liberty for their own safety. This meant people were not being restricted without the required authorisation.

Staff respected people's ability to make their own decisions and sought their consent before providing care to them. We saw records of capacity assessments for day to day decisions, such as for washing, dressing and feeding and when decisions were taken in people's best interest. People and relatives were involved as far as they were able to with decisions about their care and support needs. Where people had capacity to consent to their use, bed rails were in place to keep them safe, we saw that they had provided their signed consent to their use.

People's nutritional needs were monitored. If people were at risk of malnutrition, staff sought advice from relevant health professionals, such as dieticians. People's food and fluid intake was recorded to show how much people ate and drank, so it could be monitored. We noted that staff supported people with risks around swallowing or choking on food. Information was included in people's care plans so that all staff were aware of any guidance they needed to follow to mitigate risks.

Staff supported people to have sufficient amounts to eat and drink in order to maintain a balanced diet. People's weights were monitored and any risk of malnutrition or dehydration was assessed to make sure they maintained their health. Menus were available for all meals each day and were located on each table within dining rooms. We observed a lunchtime service during our inspection. Food was served at a relaxed pace with staff supporting people in a discreet, patient and helpful manner. We spoke with the chef in the home, who told us they were able to cater for people with specific dietary requirements, such as soft or pureed food or meals that were suitable for people with diabetes. We saw that this information was on display in the kitchen. This ensured people were provided the correct type of meal. Two people commented favourably after eating their meal, "It was nice" and "I enjoyed my lunch." We observed that people who were not eating in the dining room, were served hot food in their own room.

People's needs were assessed before they started to use the service. Information was obtained from other care professionals and relatives in order for staff to fully assess whether the home would be able to meet their needs. Assessments of need contained details such as the person's mobility requirements, skin care, health needs such as diabetes, dementia or wound care, communication, nutritional needs and personal care requirements. Changes to people's needs were communicated to staff at team meetings and handovers to enable them to respond to people's current needs. Staff worked together and shared important information so that all staff were aware of any issues and what actions needed to be taken. One staff member said, "We all work well as a team in our unit. There is good communication."

The environment was suitable for people with complex care needs, such as dementia or physical disabilities. There was appropriate signage, a range of colour schemes and adaptations around the premises, which was a large building with three levels, with two units on each level and one unit on the ground floor. People with mobility difficulties had enough space to get around and were supported by staff.

Records showed people were supported to maintain good health. Observation charts were in place and they were up to date, such as for people who required turning to avoid pressure sores. Their health care needs were checked daily and referrals were made to healthcare professionals, such as GPs and speech and

language therapists (SALT) when required. One relative said, "Yes, the doctor comes to see [family member] every week." Staff had good knowledge of people's health conditions and communicated with health professionals. Outcomes of appointments or treatments was recorded.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One person said, "Yes, the carers are caring and friendly." A relative told us, "The carers and staff are good. They do their job well in what can be difficult situations They are friendly and polite."

Our observations of staff during our inspection included looking at the manner in which people were supported, to check privacy, dignity and respect was shown to them. We observed that staff knocked on people's doors before entering their rooms and spoke to them politely, addressing them by their preferred names. Staff sought the consent of people privately in their rooms, before providing them with personal care. Staff told us they ensured doors and curtains were shut when providing people with personal care, to ensure people were given privacy and their dignity was maintained.
Staff communicated with people clearly. This assisted in creating a calm and relaxed environment in all the areas of the home, throughout the day.

We found that staff were attentive and did not wait too long before checking to see what help a person required. For example, one person in the dining room asked a staff member for a drink of water and was given a bottle from the person's own refrigerator, immediately. Staff were respectful when communicating with people and told us they knew people and what their needs were. Staff were patient and considerate when supporting people, such as when assisting them to eat their meals.

During our night inspection, we saw that people were asleep and comfortable in their rooms. Some people were awake in their rooms and were watching television, chatting to staff or reading. Where people required one to one support we saw that staff sat outside their rooms, while the person was asleep, to ensure they remained safe and well. People were provided with hot and cold drinks if they requested them.

One relative told us, "We can't fault the staff they are really nice"; "The nurses are really good and caring." Another relative said, "The staff work really hard. They do care and they are gentle." We observed staff comforting people and relatives when they became upset and provided them with reassurance.

Staff had received training in equality and diversity. This helped them understand how to treat people as individuals and respect their human rights. They understood how to treat people equally regardless of their race, sexual orientation or religion and were respectful of people's cultures, beliefs and backgrounds. A staff member told us, "We treat people of all backgrounds the same. No one is considered different to others."

We saw that people were appropriately dressed during the day and they were free to spend time in their rooms or in the communal areas. People and staff engaged in positive and respectful interaction. Staff also encouraged people to remain as independent as possible. One staff member said, "I encourage people to maybe wash their face or behind the ears so they can do things for themselves. We don't want to take away their independence."

People and relatives told us they were involved in developing and reviewing the care plans for people. A

relative told us, "Yes, the home always involve us and keep us updated." Relatives told us they could visit the service at any time and were made to feel welcome. We saw they provided feedback to staff and managers about their family member's care.

People's personal information and care plans were stored securely in locked cabinets. This showed that the provider recognised the importance of people's personal details being protected. Staff said they were aware of confidentiality and not sharing people's personal information. They adhered to the provider's data protection policies.

Requires Improvement

Is the service responsive?

Our findings

During our inspection, we viewed 12 care plans and found most to be personalised, detailed and up to date. The care plans were structured in a way that was clear and comprehensive. They contained details about the person's needs, their background and any preferences. For example, one person's plan stated, "Staff to help [person] by showing objects or picture cards prompting them to do some small things like eating and drink by himself and walking independently."

However, we found some areas within care planning that did not fully meet a person-centred approach with regard to decision making and support, particularly around end of life care. People's wishes for end of life care were expressed in their care plans and staff ensured people were comfortable and any pain was managed sensitively and carefully. When required, advice and support was provided to people, relatives and staff on pain management for those on end of life care. Records showed that support was received from health professionals, who provided advice to staff on managing people's end of life care sensitively.

Some people had DNACPR (Do Not Attempt Cardiac Pulmonary Resuscitation) forms where applicable, which meant that they did not wish to be resuscitated should they fall into cardiopulmonary arrest. For one person, a DNACPR form was included at the beginning of their care plan but later in their care plan, we found a document reviewed in July 2018, that stated that 'CPR must be used' if necessary. This contradicted the requirement in the same person's DNACPR. The monthly care plan review document, indicated that the plan was checked monthly by staff and as being correct at the time of the review. This meant that staff had 'signed off' the review without referring to the DNACPR document. We discussed with the senior nurse on duty who confirmed that the documentation was conflicting and inconsistent. Some people had an 'Advanced Care Plan' (ACP) document, which contained further information on people's wishes for their end of life care. The ACP documents that we viewed, were signed by a relative but they did not indicate that the person had been involved in reviewing the document and they were not dated. This meant that not all care plans followed a person-centred approach. Training records showed that some staff had received death and bereavement training, however we did not see that further end of life or palliative care training was included within the training schedule for the coming year.

We recommend the provider seeks best practice guidance and training for staff on end of life care to ensure care plans are consistent, person-centred and respectful of people's wishes.

People and relatives provided mixed feedback about the responsiveness of staff. One person said, "They listen to me and get me what I need." Another person told us, "The staff are really good, very friendly. We have things to do if we want and we do go out." However, a relative said, "The staff don't always listen and they ignore what we tell them. I don't think that is acceptable." Another relative said, "Most of the staff are nice but one or two are rude. They don't always provide my [family member] with enough drinks even though they need it." We viewed a fluid chart for the relative's family member and saw that staff had not fully completed it and some entries were blank. The operations manager told us they would investigate the concern and carry out any disciplinary action, if required.

The provider had a complaints procedure in place for people and relatives to make formal complaints if they wished. An easy to read complaints procedure was available. There was a system in place for receiving, logging and responding to complaints. We saw that the management team investigated all formal complaints that were received. They were acknowledged and responded to appropriately, with explanations of actions they were taking to resolve the complaint.

However, we were concerned that the complaints were commonly from relatives about their family member's personal care and about staff not complying with people's care plans and requirements. We asked the operations manager how they intended to improve and learn from complaints and ensure there was more effective communication with people and relatives following complaints. They said, "As a provider we are committed to learning from lessons. In future complaints, as well as incidents would be analysed. We have revised our form for this. We will make sure we talk to families more to ease their worries." We viewed the revised 'lessons learned' feedback form which included complaints and concerns and how they would be communicated to staff in future.

Care plans provided information on people's communication needs and how staff could communicate with them. Staff told us they communicated with people and relatives well and used gestures or signs for people who were less able to communicate, so that they could understand each other. We saw staff using a helpful, attentive and respectful tone of communication for people who were hard of hearing or had difficulties in understanding them.

A key worker system was in place for each unit in the home, where people were allocated a member of staff, who took responsibility for arranging their care needs and preferences. Each person had their own room and had the required adaptations in place according to their needs. People's rooms were clean and had been personalised with their pictures and belongings.

People were able to call for assistance by pressing a call bell that was attached to their beds or placed next to them. Some people that were unable to use their call bell, received half hourly checks from staff. However, during our night inspection we found that three people in one unit, did not have their call bell within accessible reach. This meant that staff may not be able respond in a timely manner if people needed assistance. We addressed this with the unit manager and the deputy manager who told us they would ensure people's call bells would be more conveniently placed. We tested call bells to check staff response times during the day on two units and found they responded quickly, within one minute of the alert. We observed people were supervised in the communal areas and when support was required, this was provided.

There was an activity programme in place and notices of activities were on display in the home. People had the opportunity to take part in activities, such as coffee mornings, arts and crafts, flower arranging, film showings, book clubs, day trips and bingo. An activity coordinator worked in the home and devised activities based on people's interests and preferences. On the third day of our inspection, we saw a small group of people attended an outing to the local greyhound track and they were transported by a minibus arranged by the provider.

Good

Is the service well-led?

Our findings

People and relatives told us the home was well led. One relative said, "It is a very nice home. The managers are nice and approachable. The senior nurse works really hard." Another relative told us, "We had some concerns previously but it was sorted out." Another comment from a person was, "I like it here. If something is not good, I will tell them. They will listen and sort it out."

The previous registered manager had left their role a few weeks prior to our inspection. The home was being managed by the operations manager, who worked in the home on some days during the week and a deputy manager who worked in the home daily. They told us that the provider had recruited a new manager who would start within the next few weeks and would register with the CQC.

We found that the management team were knowledgeable of all the people staying in the home. They regularly met with people and relatives to listen to their concerns. The management team monitored the service, during the day and at night, through observations and discussions with people, staff and relatives. At our night inspection, staff asked us to show them our identification and sign in. This showed that staff took the necessary safety precautions when visitors arrived in the home at all times of the day. The operations manager and deputy manager arrived later in the night to assist us, which demonstrated their commitment to support staff during the night. The deputy manager said, "I have a responsibility. People need looking after and I try to keep an eye on everything. My office is always open for staff and I am usually here 'til late."

There were quality assurance systems to monitor and improve the quality of the home. Senior staff carried out daily, weekly and monthly audits to ensure the home was safe and improvements were made where necessary. For example, we saw audits on care plans, medicines and health and safety of the premises and staff training. However, we found some shortfalls during our inspection relating to people's risk assessments and end of life care plans, communicating with relatives and staff rota records. The management team assured us that these areas would be addressed to make further improvements.

The home was also complying with any recommendation and actions set by the local authority. Records showed that staff on each unit met daily to discuss concerns and notify staff coming on to the shift of any important information. A communications book was used by staff to record information that could be shared.

Staff told us they knew how to ensure that people were safe and received the necessary care. They told us they felt supported by the managers and felt confident they had the skills to meet the day to day challenges of their work. We asked if the registered manager leaving had affected their work and most staff told us that it had not had a significant impact. One staff member told us, "The deputy manager is very supportive and approachable. We have had to adjust and just get on with our jobs to look after people." Another member of staff said, "It's OK at the moment. The managers are both very nice. [Registered manager] was really good and it was a shame she left. It does get very demanding and stressful but that is the job. With a new manager, hopefully there will be more calm in the home." The deputy manager told us, "We want to develop

the home and invest more in technology to improve what we do."

Staff felt they worked well with their colleagues. Each unit contained a photographic display showing who the staff were that worked on the unit so that people and relatives became familiar with them. Meetings took place between the night staff and topics of discussion included hourly checks, care plans, training and staff allocations. Care staff and nurse meetings also took place and agenda items included similar topics.

The home also held 'resident' meetings where participants were able to express their views about the service and provide feedback about activities and meals. We noted that people's requests or suggestions were responded to. For example, people had requested 'more salads' and 'good quality fish' which kitchen staff were able to provide. This meant that the provider took action to ensure people were satisfied with the service to make further improvements. Annual questionnaire surveys were sent to people, relatives and staff. We looked at the results from the most recent survey and noted comments were mainly positive. Compliments received from people and relatives included, "Thank you very much for all the care you gave [family member]. Making her smile meant a lot." Another person had written, "We are satisfied with the service and the care." Feedback from people and staff was analysed to drive further improvements in the home.