HC-One Limited

Washington Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this unannounced inspection over two days, on 16 and 22 December 2014. Washington Lodge is a purpose built two storey home set in its own grounds. Accommodation is provided over two floors with parking areas to the front and side. It provides care for up to 65 people who live with dementia and who require nursing and personal care. There is an enclosed internal courtyard on the ground floor of the home for people to access and utilise. At the time of our inspection 38 beds were occupied.

The home had a registered manager who had been in post since November 2014. 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.

Summary of findings

Care records contained risk assessments, which identified risks and described the measures in place to ensure people were protected from the risk of harm. Staff we spoke with told us, and we saw that there were procedures in place to instruct staff in the action to take if they were concerned that someone was at risk of harm and abuse. The care records we viewed also showed us that people's health was monitored and referrals were made to other health professionals as appropriate.

Our observations during the inspection showed us that people were supported by sufficient numbers of staff. We saw staff were responsive to people's needs and wishes and we viewed documentation that showed us staff were enabled to maintain and develop their skills through training and development opportunities. The staff we spoke with confirmed they attended training and development courses to maintain their skills. We also viewed documentation that showed us there were safe recruitment processes in place and staff confirmed these had been carried out when they had been employed.

The presence of unpleasant odours in some sections of the home, the potential of cross contamination between clean and soiled linen, and the need to refurbish some bedroom and communal areas meant some aspects of this service were not always safe. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

We spoke with relatives during our visit to the home. Comments we received included; "My dad can't make any decisions now, but I know they do their best". Others told us "The staff here all do a good job, they just know when dad is becoming agitated and anxious". Another relative told us "I asked the manager to move my dad downstairs so we could go outside and they sorted it the next day".

We spoke with two visiting health professionals who told us they found the home to be responsive to people's needs and they had no concerns.

During the inspection we saw staff were attentive and patient when supporting people. We saw people were encouraged to eat and drink sufficient amounts to meet their needs. We observed people being offered a choice of food and if people required assistance to eat their meal, this was done in a dignified manner. We did observe some people being given their lunchtime meal and were sitting with the food in front of them. Staff members came back five minutes later and sat down beside them and encouraged people to eat.

We saw a complaints procedure was displayed in the main reception of the home. This provided information on the action to take if someone wished to make a complaint and included contact details of the company's headquarters.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The presence of unpleasant odours in some sections of the home, the potential of cross contamination between clean and soiled lined, and the need to refurbish some bedroom and communal areas meant some aspects of this service were not always safe.

We have made a recommendation that the service considers recording and monitoring room temperatures in the clinical store room. This is to ensure medicines are stored in accordance with the manufacturer's instructions.

Relatives told us that their family members were cared for safely at Washington Lodge.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. Appropriate checks had been carried out before staff were employed to make sure they were fit to work with vulnerable adults.

Is the service effective?

Good

The service was effective. Although at lunchtime some people waited five minutes before staff began assisting them with their meal, records confirmed and relatives told us their families nutritional needs were being met .

Staff told us they were well supported to carry out their role and that they received the training they needed. We saw that staff training was up to date.

Staff followed the requirements of MCA and DoLS and people were asked for their consent before receiving any care.

Is the service caring?

Good

The service was caring. Relatives and health professionals we spoke to were confident staff cared for people well. Their comments and our observations provided clear evidence that people were treated with respect and dignity.

Staff interactions with people were kind, considerate and caring.

Staff gave us examples of how they adapted their practice to ensure people maintained their dignity.

Is the service responsive?

Good

The service was responsive. People had their needs assessed and the assessments had been used to develop individual care plans.

People received individualised care that met their needs and wishes. They could participate in a range of social activities.

The service referred people onto other health and care professionals when specific expertise was needed and worked well with them.

Summary of findings

People and their relatives had no complaints about the service, and felt confident about raising concerns if they had any, and felt any issues would be dealt with appropriately.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post. Staff told us the registered manager was supportive.

Relatives were confident the service was interested in their views and took action to make improvements in the care of people where they could.

The local authority commissioner and health professionals who visited the service confirmed that the service had made improvements in the quality of care since the registered manager took up her post and that she was supported to do this by the provider.

Washington Lodge 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.

This inspection took place on the 16 and 22 December 2014 and was unannounced. We last visited the home in July 2013 and found there were no breaches in the regulations on that occasion.

Before this inspection we reviewed previous inspection reports and notifications that we had received from the service. We also spoke with a member of the local commissioning team and used the information we gained to plan our inspection.

On the first day of the inspection, two adult social care inspectors were present and we were accompanied by a specialist advisor who had knowledge of dementia care. On the second day of the inspection, one adult social care inspector was present.

People who lived at the home could not always tell us their experiences of living at Washington Lodge. Due to this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We spoke with eight relatives and two external health professionals who visit the home on a regular basis. We spoke with nine members of staff. These included six care staff, and the activities co-ordinator. We also spoke with the operational manager, the registered manager and the deputy manager. We did this to gain their views of the service provided.

We looked at eight care records and also looked at five personnel files. We looked at all areas of the home including the lounges, people's rooms and communal bathrooms.

Good

Is the service safe?

Our findings

Unfortunately due to the extent of cognitive impairment of people on both floors of the home it was difficult to engage with them in direct questioning about aspects of their care and treatment. Relatives told us "At the other place they didn't have time for my dad". "My dad now always gets seen to straight away". Another relative told us "My dad can't make any decisions now, but I know they do their best, it's very difficult". Other relatives told us "Sometimes my dad can misread certain situations". "The staff here all do a good job, they just know when dad is becoming agitated and anxious". Another relative told us "I asked the manager to move my dad downstairs so we could go outside and they sorted it the next day".

We viewed a sample from the most recent medication administration records (MARs) for the 38 people who used the service. Individual resident photographs were held with medicine prescription sheets to aid identification. The locked clinical store room on the first floor had no obvious means of keeping the room cool for the safe storage of medicines, some of which required to be stored at below 25 degrees centigrade. Considering the size and under floor heating, temperatures above 25 degrees could be exceeded on some occasions, particularly during the summer months. We recommend that the service consider recording and monitoring room temperatures in the clinical store rooms, and take remedial action to ensure medicines are stored in accordance with the manufacturer's instructions.

The drug fridge temperatures were within the prescribed temperature range. The clinical room on the ground floor is more spacious with a range of storage cupboards for dressings and other nursing aids. Individually named nutritional supplements were kept in storage baskets in this room. We saw there were no obvious overstocking of medicines or supplements.

Individual resident medicine was dispensed using a blister-pack system which had individual blisters for each medicine. The 'lunchtime' drug round was observed, and took place after most residents had finished their meals. Arrangements were in place for people who required their medicine to be administered before mealtimes. People were observed taking their medicine or provided with assistance. No one was left unobserved without taking medicine. The process of identification and administration was carried out safely. Individual photographs were held with the medicine prescription sheets to aid identification.

We were informed by the nurse administering the lunch time medicines that the morning drug round took the longest time on each floor. The nurse told us "Any medication requiring pain relief is given first unless the person is asleep". We looked at two sets of records for people who were prescribed controlled drugs'. These were checked and found to be in date and corresponded in number to those received and administered. No covert medicine was being administered at the time of this inspection. During our walkabout we did notice thickening powder prescribed for one person, in another person's bedroom. We brought this to the attention of the registered manager. She immediately asked staff to check that all thickening powder was assigned only to those people for who it was prescribed for.

The majority of the 14 people on the first floor had a primary diagnosis of dementia and a range of chronic physical health issues, which included respiratory disorders, diabetes, mobility problems associated with a stroke and associated with incontinence issues. The nursing/care assistant ratio during the day, was one registered nurse, supported by two care staff. The nursing/care assistant ratio on the ground floor for 24 people was one registered nurse, supported by four care staff. The registered manager told us they did not use a formal assessment tool to assess the number of staff required, however they monitored accidents and incidents, carried out observations and assessed people's individual needs to ensure sufficient staff were available.

Care staff worked a variety of shifts based around their hours of employment, including early and late shifts. There was also a 'twilight shift' available although at the time of inspection although not all days were covered by this shift. Staff members we spoke with told us "Things have improved since the new manager took over, especially around staffing". "Yes it can be tough, particularly when you are working on the ground floor". "I love working here, much better than in domiciliary care, you get time to do things". Others told us "Some days can be heavy going, non-stop, and we could do with more staff". Visiting relatives we spoke with told us "Staffing numbers had been

Good

Is the service safe?

an issue especially at the week-end". "You just cannot find the staff on some days". One relative told us, "A whiteboard near reception would be helpful letting relatives know which members of staff are on duty".

The environment on both floors required a high level of domestic attention and cleaning. On the day of our inspection, there was no cleaner available for the first floor due to staff sickness. The operational manager told us how two of the three full time domestic staff were on long term sickness leave. She also told us "If she is notified she would request domestic cover from other homes owned by the provider to provide domestic backup cover on those occasions". This was the case on the day of the inspection, where a staff member from another home had arrived to provide domestic cover. We discussed the numbers of nurses and care staff on duty with the registered manger and the operational manager. The operational manager confirmed that there were staff vacancies following recent staff resignations and how the registered manager is currently using agency staff to provide qualified nurse cover on night duty.

During the inspection we noted that some of the walls in the corridor areas showed signs of scuffing and doors had been damaged revealing different layers of paint. Relatives we spoke with told us about the state of the kitchen / pantry on the first floor. They told us "We have stopped using it because of the state it is in". "The sink could do with replacing and the place cleaned and decorated". We noted that the home had an underlying unpleasant odour of urine in certain areas (noted on both floors). The corridor areas and rooms were carpeted, and had under floor heating which exacerbated the problem. Domestic cleaning on the first floor was not of a good standard, on the day of inspection. The 'heavy traffic' areas of the home were worse for wear in some areas (carpet stains, gouges to bedroom doors, sticky floor coverings and unpleasant odours). The sluice room in particular smelt strongly of urine. This was a breach of Regulation 15 (Suitability of premises) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The actions we have asked the provider to take can be found at the back of this report.

A check of the mechanical ventilation in some of the bedrooms and communal areas indicated a poor circulation of fresh air throughout in those areas of the home. We discussed this with the registered manager, who said she would bring this to the attention of the person responsible for maintenance at the home. On our second visit a week later she informed us the maintenance engineer had checked the system and increased the main setting control. We noted an improvement in the circulation of fresh air throughout the home on our second visit. The operational manager gave a verbal undertaking, that there would be financial investment in the fabric of the building to improve the facilities.

The home had recently undergone a change of management in November 2014. At the present time they did not have a specific identified 'champion' for dementia care although the registered manager told us she is currently undergoing training to lead on this. We discussed with the registered manager and the operational manager how care staff moved people from their bedroom to one of the lounges. This was mainly transfer using a wheelchair. On one of those observations we saw staff moving someone in a wheel chair without footrests fitted, which we considered to be unsafe. This was because there was a danger someone's feet could be trapped under the wheelchair. All other transfers were undertaken in a safe manner, with clear explanations made by the staff concerned.

During the inspection we looked at a selection of the first floor bedrooms, bathrooms and toilets and some of the ground floor bedrooms. Inspectors noted that on the first floor sluice commode pots were being stored next to washing bowls used for people. We also noted how combined linen skips were being used, where clean bedding was placed next to the skip containing soiled/foul bedding. This meant potential clean linen could be contaminated with the close proximity of the soiled linen skip. The operational manager acknowledged this represented an infection risk. The fibreboard shelving in the sluice had suffered water damage meaning this was difficult to keep clean. The flooring in the bathrooms and toilet areas were "sticky" to walk on and therefore difficult to clean effectively in its current state.

The home did not have a portable suction machine, for staff to use. Whilst this is not obligatory, this equipment would prove useful in cases of people choking, particularly for those people who had swallowing difficulties. We also discussed with the lead nurse on the first floor how there was only one 'Ambu Bag' located on the ground floor. This meant in the event of sudden collapse on the first floor a

Good

Is the service safe?

member of staff had go through two sets of 'digital lock' doors and go down and up a flight of stairs to obtain one. We discussed this with the registered manager who agreed to risk assess the current arrangements to ensure it met the required needs of people at the home.

We asked staff what systems were in place to ensure people were protected from the risk of harm and abuse. Staff we spoke with had a good understanding of safeguarding and how to report any concerns they had. We spoke to four staff who told us they had received training in safeguarding vulnerable adults and records confirmed this. They were able to tell us how they would respond to any allegations or incidents of abuse and were aware of the lines of reporting in the organisation. Some of the relatives we spoke with told us "I know they do their best to keep my dad safe, it's very difficult". Others told us "The staff here all do a good job". "I would speak to the staff if I had any concerns".

One staff member told us "I am satisfied any concerns would be taken seriously". Other staff told us they were aware of the whistle blowing policy and procedure. They were able to describe how they would report any concerns. Staff told us, and records confirmed that they had completed safeguarding training. We received feedback from the local authority about how staff had responded to keep a particular person safe following a recent safeguarding strategy meeting.

There were systems in place to ensure that new staff were suitable to care for and support vulnerable adults. We viewed the recruitment records for five members of staff. We found the provider had requested and received references in respect of prospective new staff, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments. We saw documentation that showed us a process was in place to ensure safe recruitment checks were carried out before a person started to work at the home and we asked three staff to describe the recruitment process to us. All the staff we asked told us that prior to being employed by the service they had attended an interview and satisfactory references and disclosure and barring checks had been obtained.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with told us "They tell me all the time if things have happened or contact me if my dad has been poorly". Another said "They ask me if I have any worries about his care and I keep the family updated of any issues and we decide as a family". There were effective communication between the home and relatives. One relative told us that whenever anything happened at the home the staff were quick in ringing and letting them know. Other family members we spoke with said, "The staff are good at keeping you up to date". If anything is wrong they will ring me." Another said, "If anything is wrong they will either speak to me when I visit or ring me" "I know if I need to talk to them I know I can".

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. At the time of this inspection we were informed by the registered manager that one DoLS application had been made and authorisation for this had been received. The registered manager was aware of the Supreme Court judgment and told us they were working with the local authorities to arrange DoLS assessments for the people who lived at the home. Information on the MCA and DOLS was available for families and visitors, in commercially produced leaflets. Copies were available at the home's reception. We saw documentation within the care records that we viewed that showed us the correct processes were followed to ensure people who did not have the capacity to make significant decisions had their rights upheld.

There had been some changes in the workforce recently, with some staff resigning, and a new registered manager recently being appointed. On the first floor there were three care assistants, one of whom had worked in the home for 14 years as well as a newly employed care assistant. The registered nurse on duty was employed through a nursing agency, and had received update training specifically on MCA and DOLS through the agency. The registered nurse and the deputy manager told us that DOLS applications were being made for the majority of residents over an agreed period of time (agreed with the local authority) based on who presented the greatest risk.

Staff told us they had induction training provided when they first started work. One staff member told us, "I feel well supported by the manager and her deputy and they are very approachable." Another staff member said, "I did not get supervision regularly, but I do now. The new manager had made a difference."

We asked staff to describe the training activities they had completed at Washington Lodge. They told us they had received "Lots of training going on online and the challenging behaviour team are really good at providing hands on training". One new member of staff had recently completed a three day induction programme, which comprised of 'shadowing' other staff. This was discussed with the registered manager who was able to confirm that the member of staff had a full organisation induction programme booked within the next few weeks.

The general design of the building on both floors posed challenges for purposes of providing observation and care. On the first floor we saw staff were attending to people in bed, leaving other people unobserved in either of the two smaller lounges, or the 'sitting area' off the main corridor.

We saw some characteristics of good practice in caring for people with dementia. For example the small café room on the first floor where people and their families could sit and chat in a less formal environment. Although staff had no clear knowledge of an overall 'vision' for dementia care in the home, the registered manager and her deputy were undertaking further training to become 'Dementia Champions'. A dementia champion is someone who encourages others to make a positive difference for people living with dementia.

We observed lunch being served in the ground floor dinning area. Most of the people required some level of assistance with their meals. 10 people were in the dining room and six people in their own rooms required assistance from staff to eat their food and others needed prompting and occasional assistance. Staff were very seen to be busy and all of them were involved in the serving of the lunchtime meal. We saw five people were asleep in their chairs in the dining room and while some did wake up others were gently wakened. We observed staff were attentive when assisting people with their food.

As most people needed assistance some people we saw sat for over five minutes without their meal. We saw how one person became distressed and started banging on the table. When the deputy manager came into the dining room she began coordinating the meal time service. We

Requires Improvement

Is the service effective?

found thereafter staff responded promptly and kindly to requests for help. Staff who were assisting people to eat were pleasant and sat with them chatting at the table. We saw people were offered a choice of meals and alternatives were provided where people did not like the food on offer. Drinks were provided and we saw some people had food and fluid charts. We saw these were kept updated and reflected that people received the intake required. Staff were able to explain that one person's chart was not always completed as they were able to drink unaided and sometimes they could not say how much had been taken. We saw the person had drinks available within reach in their room.

Good

Is the service caring?

Our findings

Interactions between nursing/care staff were discreetly observed, and were seen to be 'friendly and professional' in approach. In many cases the conversation between staff and residents was related to the Christmas carol service and the pending Christmas festivities. Visiting relatives told us "My dad can't make decisions now but I know they do their best". "The staff are great with him, so much better than other places he has been in". "He is looked after well". During the period of inspection the staff were observed to be attentive, focussed, and respectful of people they were caring for. Explanations were given of what was being done on the day of the inspection, and the staff on duty were seen to give time to people, and interventions were unhurried.

Resident's rooms were personalised, some with 'memory boxes' outside their rooms with small mementos, photographs of family. People had their names on the bedroom door; however it may be useful to consider to have a photographs of people on the bedroom door.

We spoke with relatives who told us they were involved in the care and support their family member received and we saw documentation in the care records. The records confirmed the involvement of relatives in care planning. This helped to ensure that important information was being communicated effectively and care planned to meet people's needs and preferences. One relative told us "The family had a meeting with the manager to discuss our concerns". "I am certain our mam's care plan was discussed then". We asked about what their concerns and they were told us "Mainly issues with her clothes not being laundered correctly".

We spoke with the registered manager regarding whether anyone was currently using any advocacy services. An advocacy service ensures that vulnerable people have their views and wishes considered when decisions were being made about their lives. We were told only person was currently using the services of an advocate, and how this had been arranged while the person was in hospital.

During our visit the staff regularly checked people who were in their own rooms and spent time in the sitting room to make sure people had the assistance they needed and spent time talking to them. We observed throughout the day of our inspection that staff were regularly sitting chatting with people. One staff member said, "People have one to one time every day." Staff told us they would spend this time sitting and chatting with people, having a cup of tea or going for a walk". Family members confirmed that staff understood people's needs. One family member said, "If I need to ask staff for something they act upon it."

Staff treated people with dignity and respect. For example one person on the ground floor required gentle prompting with her lunchtime meal as she fell asleep. This was seen to be done in a sensitive manner by one of the carers. We saw how the carer spent a considerable time helping a resident in her room, telling her exactly what was on each spoonful and also telling her about the Christmas carol service which had taken place in the home that morning. Relatives said, "Staff were great and chatty" confirming that staff treated their relative with respect. Another relative said staff were, "Very caring and kind towards my relative".

Good

Is the service responsive?

Our findings

Relatives we spoke with confirmed that staff knew their relative well and understood their needs. One person said, "My dad is now settled here". "Staff have time for my dad". Another told us "This is the fourth home my dad has been in and the staff here have just been great with him".

The people accommodated on the first floor were assessed as being 'high dependency' although in discussion with the registered nurses on both floors it was not clear as to how these criteria had been met. We saw no evidence in the care file documents of a dependency rating scale being used to determine this classification.

A local church' lay minister' attended to offer communion and carried out singing Christmas carols in the communal sitting area with those people in attendance. People were seen to respond positively, and staff members told us "People enjoyed the social get together". The lay minister later told us "I like coming here, and staff make an effort in helping people attend ".

We looked at a sample of care plans and saw these contained information about people's likes and dislikes such as preferred time of rising, going to bed and interests. A detailed nursing assessment of care needs was in place and was evidenced in all domains including, communication, behaviour, respiration/circulation, eating and drinking, hygiene and dressing, and mobility. These showed that monthly assessments were carried out. A daily statement of wellbeing was completed for each person. Although these daily statements were up to date, they had a tendency to be repetitive in entries written. For example statements such as 'unsettled' and 'slept well' resulting in brief entries only being made. This meant the daily statement lacked detail of the person's day reflecting the key assessment areas.

We saw records had been updated to reflect any changes. For example from the care files we looked at, each person had complex care needs. The care plans for each were found to be person centred, including a 'This is Me' profile located at the beginning of the care records. This provided an overview of specific care needs, and personal likes and dislikes, and a photograph of the person. We also saw a personalised 'Routine on Waking' document which assisted new staff, as well as promoting individual care needs.

Individual assessments were in place for identified needs including falls and nutrition. One person's nutritional care plan did not reflect the person had lost weight, however there was evidence of a referral to the speech and language team (SALT). Appropriate information was recorded for a person who was displaying challenging behaviour. Their care plan contained information about how staff assisted them to manage their behaviour and interventions to minimise any risks to themselves and others. For example, what actions to take when they may infringe other people's space, or made suggestive remarks.

We spoke with the recently appointed activities co-ordinator who told us how the recent Christmas party had gone well with people and relatives in attendance. She told us how the care files regarding the type of activities people had taken part in needed to be updated. The staff we spoke with told us "Activities are better now we have someone in post, and people were always asked if they would like to join in.", "We're doing painting in the dining room this morning and a carol service is happening on the first floor.

There was evidence of multi-disciplinary meetings, notifications forwarded to the CQC and safeguarding as and when appropriate. We saw evidence in the people's care files of referrals being made to other healthcare professionals and consultants when required. Any subsequent advice and actions were seen to be held on file and the information incorporated into the care plans. Staff told us the records were much better now and the new registered manager was really supportive. They said communication was much better and they felt this meant people got a better service.

We saw how some people were being nursed in bed. They had a bedside folder which provided a record of personal hygiene tasks carried out, positional change record, and a daily care record. There was a 'Record of Family Involvement in Care Planning 'document in place, which had been signed and dated. There was also a 'Relatives Communication Record' which is useful in preventing any misunderstanding. The relatives we spoke with told us they found the registered manager approachable and would discuss any concerns with them. One relative told us, "The family have had a meeting with the manager to discuss our mothers care plan." Another relative told us "We have met

Good

Is the service responsive?

the new manager and she gets thing done". "If we had any concerns we would raise them and felt confident they would be dealt with appropriately. One person said, "I haven't had to raise any concerns".

People and relatives told us they were aware of the complaints procedure and knew how to complain. We spoke with the operational manager of the service who told us they would meet with people, or their relatives to discuss concerns or complaints if this was appropriate. The registered manager also told us residents' and relatives' meetings were held four times a year or more often if required. We saw minutes from the last three meetings and in one meeting we saw the registered manager had discussed the complaints procedure with people who had attended.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post since July 2014. Her application to be the registered manager was approved by the Care Quality Commission in November 2014. The provider had been pro-active in submitting statutory notifications to the Care Quality Commission. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns.

The care professionals we spoke with were positive about the management of the home and felt that the new registered manager was ensuring the home's standards were being maintained. A healthcare professional we spoke with told us, "The manager is very helpful and approachable." The local authority commissioner who visited the service confirmed that the service had made improvements in the quality of care since the registered manager took up her post and that she was supported to do this by the provider.

The home kept records of any accidents and incidents. The registered manager said she acted upon analysis of accidents and incidents. For example two people who had been assessed as at risk of falling had bed and chair sensors fitted linked to the nurse call system. This alerted staff when they tried to walk unaided. Some staff members took responsibility for checking specific areas of health and safety such water temperatures and infection control. We saw recent audits had been undertaken in these areas.

There was a broad quality assurance programme in place which consisted of a range of monthly and quarterly checks to keep people safe and ensure they received good quality care. Monthly audits included checks of people's weight loss and weight gain, record keeping and support plans, risk assessments, accidents, health and safety related checks. Quarterly audits included checks of recent complaints and significant events, and checks on equipment used in the home. The operational manager also carried out quarterly audit checks. We saw there were regular audits of the operation of the service and these included areas such as, infection control, medication, kitchen and falls.

Relatives told us there was a good atmosphere in the home. Their comments included, "The manager and the staff were welcoming and open. One relative we spoke with said, "From day one I knew it was going to be the right place." Another told us "There was good communication between the home and families". "The staff are really good at ringing and letting me know how my dad is". "If anything is wrong they ring straight away", and, "Staff would tell me anything that was happening with [my relative]." Family members told us "The manager is lovely", and, she listens to you". "Her door is always open". Staff also confirmed that there was an open door policy. One said, "If I am unsure about anything I know I could go to the office at any time".

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 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not take proper steps to ensure adequate maintenance and the proper operation of the premises. Regulation 15 (1) (b & c)**