Tamhealth Limited

Flowerdown Care Home

Inspection report

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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?	Good
Is the service well-led?	Good

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the home.

The inspection was unannounced. Flowerdown Care home provides accommodation for up to 48 people who require nursing, respite or end of life care and some people who were living with dementia. At the time of our inspection there were 46 people living at the home. The home is located in a residential area of Winchester. There is a car park located at the front and there are gardens to the rear and side of the property. The accommodation is arranged over two floors and there is a lift available for accessing the first floor.

A registered manager was in post who is responsible for the day to day running of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home and has the legal responsibility for meeting the requirements of the law; as does the provider.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

Summary of findings

which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People told us that they felt safe and there were systems and processes in place to protect them from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team. Staff were aware of the importance of disclosing concerns about poor practice or abuse and were informed about the organisations whistleblowing policy.

There were sufficient numbers of suitably qualified staff. We saw that the registered manager was taking action to monitor response times to call bells to inform judgements about on-going staffing levels. Safe recruitment practices were followed which made sure that only suitable staff were employed to care for people in the home.

People were supported to take informed risks to ensure that their choices and freedom were not restricted. People were involved where able in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

There was a programme of repair and on-going improvement being planned to ensure that people continued to be cared for within a comfortable and pleasant environment.

People told us that their care workers provided them with the support they needed. Staff told us that the registered manager supported them to develop their skills and knowledge by providing a programme of training which helped them to carry out their roles and responsibilities effectively. Staff received regular supervision which considered their development and training needs. Volunteers working within the home were enabled to access relevant training and were regarded as valued members of the care team.

The home worked effectively with healthcare professionals. A healthcare professional told us that Flowerdown worked were proactive with wound care and very receptive to their advice and recommendations. Staff also consulted with healthcare professionals to inform nutrition care plans and to ensure people received a healthy balanced diet.

People we spoke with were positive about their care and the support they received from staff. We observed interactions between staff and people which were kind and respectful. There were a clear set of values in place to support staff to respect people's dignity and privacy.

People's preferences, likes and dislikes had been recorded and we saw that support was provided in accordance with people's wishes. People were encouraged to take part in meetings where they could express their views about the home and the care they received. People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

People knew how to make a complaint and information about the complaints procedure was included in the home user guide, including how to raise concerns with the Care Quality Commission. People were confident that any complaints would be taken seriously and action taken by the registered manager.

There were a range of activities for people to access in line with their personal interests and hobbies. Plans were in place to increase the activities provision to enable activities to be provided seven days a week and enhance this aspect of the home.

The home was well managed and we found that there was an open and transparent culture within the home which was encouraged by the registered manager who actively sought feedback from people and staff in order that improvements could be made to the home.

There were effective systems in place to monitor and improve the quality of the home. Action plans were drafted where audits or incident review indicated that improvements could be made to the safety and quality of the home.

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?

Good

The home was safe. People told us that they felt safe. Staff had a good understanding about the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

There were policies and procedures in relation to the Mental Capacity Act (2005). All staff had received training in the Mental Capacity Act (2005).

There were staff available in sufficient numbers to meet people's needs and provide person centred care.

Recruitment practices were safe and relevant checks had been completed before staff worked with vulnerable people.

Is the service effective?

Good

The home was effective. People were supported by staff that had the necessary skills and knowledge to effectively meet their assessed needs. Staff received an appropriate induction to the home and training relevant to their role.

There was a strong emphasis on nutrition in maintaining people's wellbeing. People told us the food was tasty and was provided in sufficient quantities.

The home was effective in assessing and planning people's care needs and people told us they were pleased with the care, treatment and support they received and

The home maintained effective working relationship with a number of health care professionals which helped to ensure people received co-ordinated care, treatment and support.

Is the service caring?

Good

The home was caring. People were supported by kind and attentive staff. Staff treated people with dignity and respect and we saw that care was delivered in an unhurried and sensitive manner. Staff were courteous and people were relaxed and comfortable in the presence of their carers. We observed that staff knew people well and spoke with them about the things that were meaningful to them.

People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

Is the service responsive?

Good

The home was responsive. People's preferences, likes and dislikes had been recorded and we saw that support was provided in accordance with people's wishes and in a manner that was responsive to their needs.

People were provided with the opportunity to take part in a range of activities in line with their preferences. There was an attractive garden which had recently been redeveloped in response to feedback from people living at Flowerdown.

Where necessary action was taken in response to changes in people's needs and plans were put in place to guide the interventions of nursing and care staff.

Summary of findings

People knew how to make a complaint and information about the complaints procedure was included in the service user guide. People were confident that any complaints would be taken seriously and action taken by the registered manager.

Is the service well-led?

Good

The home was well led. The registered manager actively encouraged feedback from people and staff which was used this to make improvements to the service.

The home was well managed by a registered manager who maintained a strong and visible presence within the home.

There was an open and transparent culture within the home and the engagement and involvement of staff in planning and developing the service was promoted. There were effective quality assurance systems in place to monitor and review the quality of the home and the registered manager had a clear vision for the future of the home which was underpinned by their intention to achieve continuous improvement and good quality care.

Flowerdown Care Home

Detailed findings

Background to this inspection

We inspected Flowerdown Care Home on the 8 July 2014. The inspection team consisted of an inspector, a specialist advisor, who is a nurse, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, this includes dementia.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the provider tells us about important issues and events which happened at the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with 15 people who use the service. We also spoke with four relatives, a volunteer, two nurses, five care workers, two catering staff, the housekeeper and the registered manager.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observing the care and support they received. We looked at all areas of the building, including people's bedrooms, and the communal areas. We reviewed ten people's care records and other records relating to the management of the home.

Following the inspection we spoke with one community health professional and four commissioners of the service to find out their views of the home and the quality of care people received.

The last inspection of this service was in August 2013 where no concerns were identified in the areas that we looked at.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read relation to these topics, however, can be read in the 'Is the service safe' sections of this report

Good

Is the service safe?

Our findings

People told us they felt safe living at Flowerdown Care Home. A person who was visually impaired said, "Yes I feel safe here. They hold my hand, that is so important." A relative told us, "My wife is safe here. She is taken care of and I can't speak too highly of the staff." Another relative said, "It was very hard when mum was brought here from hospital but I know she is safe and loved by staff."

Staff had received training via e-learning in safeguarding adults and were required to repeat this on an annual basis. Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place. Safeguarding Adults Multi-agency Policies, Procedures and Guidance were available within the home and contained relevant information about how to raise safeguarding alerts including contact details. All of the commissioners we received feedback from said that they agreed or strongly agreed that the home kept people safe from abuse or harm.

Following a recent television documentary highlighting concerns about care in residential homes, the registered manager had held a group supervision to discuss and reflect upon the issues the programme had raised. This helped to ensure people's welfare was safeguarded because staff had received training and were supported to develop their awareness about factors that could affect the safety of people living within the home.

Staff were informed about the organisation's whistleblowing policy and we found that information about how to raise concerns about poor practice confidentially was displayed in the staff room. All of the staff we spoke to were clear that they could raise any concerns with the manager of the home, but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Policies and procedures were in place in relation to the Mental Capacity Act (MCA) (2005) and we saw the home had a copy of the MCA 2005 Code of Practice. All staff had received training in the Mental Capacity Act (2005) and were able to describe some of the key principles of the Act.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Whilst no-one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. A small number of people who might now require aspects of their care to be authorised by a DoLS had been identified and that work was in progress to make the required referrals to the Local Authority.

Our observations indicated that some of the people would have difficulties giving valid consent to complex or significant decisions about their care, treatment and support. The registered manager told us that they had taken steps to identify which people required a mental capacity assessment and we saw that the need to progress with these was identified in the home's recent improvement plan.

People's records contained appropriate risk assessments which covered a range of areas. For example, we saw assessments had been undertaken to identify whether people were at risk of choking when eating. Where people were at risk of pressure ulcers, care plans contained information about how this risk was to be managed and a completed pressure ulcer risk assessment.

Where appropriate, staff supported positive risk taking. For example, one person had experienced two recent falls. In response staff had consulted with the person and identified that, whilst undesirable, the risk of falls was acceptable in order that the person could retain their wish of mobilising independently. The person's care plan had been reviewed and updated to help ensure that any risk of injury was minimised.

We observed that daily handovers were undertaken which summarised people's key needs and any changes or concerns about their wellbeing. This helped to ensure continuity of care and effective communication between staff. We were able to sit in on the home's quarterly health and safety meeting. Discussions included the maintenance of equipment to ensure safe moving and handling and falls prevention for people using the home.

There was an effective system to ensure that staffing levels were monitored, reviewed and adjusted in light of changes in people's needs and the layout of the building. Each

Good

Is the service safe?

month the amount of support each person needed was monitored to ensure that staffing levels remained adequate. At the time of the inspection, the target staffing levels for day shifts were two registered nurses, two senior care workers and six care workers in the morning. In the afternoon, the number of care workers reduced to five. At night there were two registered nurses on duty supported by three care workers. The registered manager explained that the home was currently fully staffed and therefore there had been no need to use agency nurses for some time.

Staff rotas for the week of the inspection and the previous three weeks showed that the home was staffed at the target levels. The registered manager explained that she was able to increase staffing levels if this was required for particular reasons. For example, we saw that approval had been given for a member of staff to start their shift earlier so that they would be available to support a person who was leaving the home the following day for a specialist care centre.

The majority of people told us that there were sufficient staff on each shift to make sure that their needs were met and to ensure they were protected from the risk of harm, although a small number of people also told us that at times there was a delay in their call bells being answered. We fed back to the registered manager who was aware of some concerns raised by people. We saw that in response they had completed an audit of response time to call bells in April, May and June 2014. This had not shown that people were experiencing any significant delays in response times to the call bells. The registered manager told us that plans were in place to install a system which would electronically record response times to assist in the on-going auditing of this area of care delivery. In the interim, staffing levels would continue to be reviewed to ensure that people's needs were met in a person centred and timely manner. During our visit staff responded quickly and appropriately to people who needed support although over the lunch-time period some people experienced a delay in their needs being met as staff were engaged with supporting people to eat their meals. A staff member told us, "Most of the time, the staffing levels are very good, we cover for each other and work well as a team".

Recruitment and induction practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks (DBS). We found that the registration details of nursing staff had been checked with the body responsible for the regulation of health care professionals and that these checks were repeated on a monthly basis. The registered manager was aware of the process to follow to ensure that staff that were no longer fit to work in health and social care were referred to the appropriate bodies.

Good

Is the service effective?

Our findings

People told us that they were pleased with the care, treatment and support they received and we found that the home was effective in assessing and planning people's care needs. One person told us, "The staff are marvellous, they really care for us." Another person said, "The staff are very in tune with my wife's needs. Since she has been so poorly, they are in and out all of the time."

People were supported by staff that had the necessary skills and knowledge to effectively meet their assessed needs. Staff received a two day induction which covered their familiarisation with the environment, the people living at the home and the policies and procedures of the organisation. The registered manager told us that if a new staff member did not have prior experience of working in health and social care, then they would be supported to complete a wider induction in line with Skills for Care Common Induction Standards. The majority of staff had been employed for some time which meant the staff team was stable and supported the delivery of consistent care by staff who were familiar with the needs of people.

There were arrangements in place to ensure that staff received appropriate training. Within the first six weeks new staff were required to complete a range of essential training which included; safeguarding vulnerable adults, infection control, fire safety and Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were opportunities for staff to undertake training in other subjects related to the needs of people. For example, the registered nurses had been trained in the use of equipment that managed people's pain during their end of life care. Registered nurses also undertook additional training such as life support and medicines management. Systems were in place to alert the registered manager if staff needed to update aspects of their mandatory training. One care worker told us, "If you identify a gap in your training, you only have to ask [the registered manager]."

There were nominated champions to lead and provide advice to colleagues on dignity, infection prevention and control, moving and handling, tissue viability and nutrition. The registered manager explained that they were arranging for the champions to undertake an eight week distance learning course in their specialist areas so that they were then in a position to share good practice and learning with the wider staff team. Training was shortly to take place in maintaining tissue viability which would further support the development of the skills and knowledge of the nursing staff. Volunteers working within the home were enabled to access relevant training and were regarded as valued members of the care team. Commissioners feedback was that they agreed or strongly agreed that the staff were competent to provide the care and support required by people.

Staff were given appropriate supervision and support which helped to ensure they were able to provide effective care. Staff told us they felt well supported in their role. We saw records which showed that staff were receiving regular supervision in line with the organisation's supervision policy. Staff told us that discussions in supervision covered their goals, performance, whether they were happy in their job. Formal clinical supervision was not taking place for the nursing staff. However we saw that the registered manager held daily meetings with her nursing staff during which they discussed the needs of people, but was also an opportunity to reflect on practice issues to support on-going professional development.

There was a strong emphasis on nutrition in maintaining people's wellbeing. Appropriate steps had been taken to identify those people who could be nutritionally at risk by using tools such as the Malnutrition Universal Scoring Tool (MUST). Nutrition care plans were in place which described the assistance people needed to eat their meals, the consistency of food required, whether they needed specialist equipment and any risks associated with eating and drinking. We found that recommended best practice was being followed in relation to cleaning and storage of the equipment needed for supporting those who were fed via artificial feeding regimes.

Where people were at risk of dehydration or weight loss, daily nutritional checks identified target food and fluid intake and recorded actual intake so that senior staff could appropriately monitor people's nutritional status. These records were reviewed by the registered manager on a weekly basis. Information about which people required fortified meals was regularly available and staff were knowledgeable about which people required special diets. Staff had liaised with professionals such as speech and language therapists (SALT) to inform nutrition plans and manage identified risks such as swallowing difficulties. We saw that information provided by the SALT was displayed in the bedroom of one person who ate their meals in their

Good

Is the service effective?

bedroom. We observed that one person who liked to eat their meal in their bedroom, was struggling to eat his meal as he had not been positioned correctly. When we commented on this, the person was helped to sit up and was able to eat his meal in a safer and more comfortable position.

People told us that the food was tasty and was provided in sufficient quantities. Options were offered at breakfast, lunch and supper and we saw that drinks were available throughout the day including fortified milkshakes. Fresh fruit was available on the dining room tables and we saw people being supported to eat this. One person said, "The food is appetising and we have plenty of choice." Another person said, "We have a glass of sherry if we want it." Although one person said, "Sometimes my breakfast is cold when I get it."

If people wanted to eat in their rooms, then risk assessments had considered whether this was safe. Staff had encouraged a small number of people who seldom left their rooms to have lunch together in the small upstairs lounge with positive effect. One person told us, "I love our lunchtime chats, we meet every day you know."

Care plans provided information about the care and support people needed and how this should be provided.

For example, there was a comprehensive care plan for the management of one person's pressure ulcer which was evidence based and in line with relevant quality standards such as those provided by the National Institute for Health and Care Excellence (NICE). This included, regular photographs, measurements and documented treatments in line with guidance from the tissue viability nurse. A tissue viability nurse offers specialist clinical advice and support in complex wound management to people living in the community. This person had been supported to understand where they could assist in relation to supporting the healing of their pressure ulcer to prevent further problems with the integrity of their skin.

There was an effective working relationship with a number of health care professionals to ensure that people received co-ordinated care, treatment and support including memory nurses supporting those living with dementia and respiratory nurses working alongside those with breathing difficulties. We spoke with the tissue viability nurse that supported the home. They told us that they felt the home managed people's wound care well and that the nursing team were receptive to advice and guidance. They told us that the home had effectively managed a complex wound and that this was now healing well.

Good

Is the service caring?

Our findings

People told us that they were well cared for. One person told us, "I feel they take good care of us. They [staff] are so kind and careful." Another said, "It's much better than being at home. I had a nasty fall at home and had to go to hospital. I came here and everyone helps me. It is a lovely place here." A third person said, "All the [carers] are so kind and helpful. Nothing is too much trouble for them." A relative told us that staff had, "Gone out of their way to know [their father]."

People were supported by kind and attentive staff. Staff treated people with dignity and respect and we saw that care was delivered in an unhurried and sensitive manner. Staff were courteous and people were relaxed and comfortable in the presence of their carers. We observed that staff clearly knew people well and spoke with them about the things that were meaningful to them. We observed friendly and light hearted discussions which seemed to be enjoyed by the people. One person told us, "I am so pleased to see the [carers]. They smile a lot and are wonderful."

Staff had time to deliver personalised. For example, one care worker supporting a person who was becoming increasingly agitated. The care worker spoke to the person in a calm and reassuring manner which prevented the behaviour from escalating. We observed staff supporting a person to transfer using a hoist. They provided constant reassurance and communication throughout the process. The person told us, "They are very gentle with me."

Staff encouraged and enabled people to complete tasks for themselves, even if this took a long time. For example, we observed one person being encouraged by a care worker to take a short walk instead of using a wheelchair. When we spoke with the person, they told us how pleased they had been that they had been able to manage this independently. Staff told us that where possible, they encouraged people to care for themselves, even if this was by completing a small task. A care worker told us, "Whilst It is tempting to intervene, it's important that people think and do for themselves.

The home was enrolled in the Dignity in Care Scheme which is a campaign that aims to share good practice and encourage improvements in the quality of care people receive. Throughout the home there were posters encouraging dignity in care and actively promoting the values and actions that care homes should aim to demonstrate. Commissioners feedback was that they agreed or strongly agreed that people were treated with respect and dignity by the staff.

People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered. Where people were unable to express their views and wishes, relatives were involved in decisions about the care of people. One said, "They talk to me in great depth, everything is handed over." Another relative told us, "They always update me about my mother's care and I have attended a care review meeting to discuss her long term needs." We saw evidence in peoples care records that family members were promptly informed when their relative was unwell. Relatives told us that they were always welcomed by staff and were able to make themselves refreshments.

Is the service responsive?

Our findings

People's needs were regularly assessed and reviewed and they were involved in the assessment of their needs. One person told us, "They [staff] always tell me what is going on and ask what I would like to do."

Care plans were based on people's choices and preferences. Each person had a part of their care plan called, 'My choices, and My preferences'. This gave details of their personal history and their spiritual and cultural needs. Information was also provided about what was important to the person and what a good and bad day might look like. This helped to ensure that staff knew the preferences of the people they were caring for and enabled them to be responsive to their needs.

People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered. New care planning documentation was being introduced that encouraged people to express what was important to them in relation to their care. In addition, each day one person was identified as the 'Resident of the Day'. This meant that the staff team comprehensively reviewed with the person, every aspect of their care and support, including, their care plans, their dietary preferences, their environment and social activity.

People had a care plan in relation to their 'Rights, Consent and Capacity". These plans considered how people could be involved in making decisions about their care and who they might like to support them with this process. For example, one person's plan stated that they should be given time to discuss options so that staff could find out their wishes and choices.

People were involved in reaching decisions about how risks to their health and welfare might be managed. For example, we saw that one person had requested the use of bed rails to manage the risk that they might fall from their bed. However, they had then decided that they preferred other measures to be used to manage this risk. This person's wishes were respected. The bed rails were removed and crash mats and a hi-lo bed were put in place instead.

Where necessary action was taken in response to changes in people's needs. For example, we saw a number of examples where staff had identified that people were unwell and had arranged for the person to be seen by their GP. When people developed an acute illness or an infection, a short term care plan was put in place to guide the interventions of nursing and care staff. For example, staff had observed that one person had a skin tear to their leg. A wound management plan was put in place the same day which included the use of body maps, observations of the wound and a treatment plan.

A relative told us that staff had identified that their relative had been presenting as more tired than usual and had arranged a GP review. This resulted in the person being admitted to hospital. They also told us that when they had been concerned about their relative's swallowing staff had immediately referred the person for an assessment by the speech and language therapist. The relative told us, "You never have to ask twice." This ensured that people were enabled to have access to care, treatment and support when they needed it.

Additional training for staff had been provided in response to people's specific needs. For example, training had been arranged to ensure that staff were informed about the condition Myalgic Encephalopathy or ME, sometimes known as Chronic Fatigue syndrome. This was to enable staff to deliver effective care to a person with this condition.

People were offered a range of social activities overseen by a activities co-ordinator who was supported by an activities volunteer. The home benefitted from having its own mini-bus and so activities included trips out to local garden centres, quizzes and sing songs. The home was also supported by a voluntary group called the 'Friends of Flowerdown' who were made up of past and present relatives. This group actively raised funds for the home and organised the summer fete and other projects with the aim of enhancing the care experience of people living at the home.

There was an attractive garden which had recently been redeveloped in response to feedback from people. People had been directly involved in the design of the garden which now included a gazebo and raised beds A volunteer told us that people enjoyed the use of the garden and that flowers and plants were positioned carefully so that people who were very frail could enjoy them from their rooms. One person told us, "The garden is a peaceful place. I love the birdsong and I love the flowers." Another said, "When I want to go outside, I can."

Is the service responsive?

The volunteer also explained how they provided 1:1 support to people who were more frail and spent more time in their rooms. This helped to reduce the risk that these people might become socially isolated. We were told that there were plans to install Wi-Fi within the home which would enable people to readily access a software package that allowed them to make instant voice and video calls to family or friends supporting them to remain in contact even if they lived some distance apart. There were plans to increase its activities provision to enable activities to be provided seven days a week.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide, including how to raise concerns with the Care Quality Commission. People were confident that any complaints would be taken seriously and action taken by the registered manager. One person told us, "I've got [the registered managers] number on my phone and I would phone her up." We looked at the complaints records and found that one written complaint had been recorded since our last visit. This had been fully responded to in writing by the registered manager in a timely manner.

The registered manager told us that regular resident's and relatives meetings were held. People told us that their concerns were noted and acted upon. One person said, "I always go to the residents meeting and have my say."

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the manager. Comments included, "They gave me time to talk and never once looked at their watch and that is so important." Another person said, "We know all about [registered manager] she comes to see us you know." A third person told us, "Her door is always open."

Staff were also positive about the leadership of the home. One member of staff told us, "You are able to raise concerns, she listens to you, she is a very caring person, she spends time out on the floor and helps, she knows the residents personally." Another staff member said, "Her soul is here, it is her second home."

The registered manager is a registered nurse and holds a recognised qualification in the management of care homes and has had over twenty years' experience of working within the care home sector. The registered manager maintained a strong and visible presence within the home and actively encouraged feedback from people and staff and used this to make improvements to the home. Meetings were held with people on a regular basis where their concerns or comments were noted and acted upon. For example, concerns had been expressed regarding the lack of call bells in the communal lounge area. The registered manager had made arrangements for quotes to be obtained for the additional equipment needed and this was awaiting approval. In the interim, a number of hand bells had been made available for people to be able to call for assistance, which was proving successful. The last satisfaction survey undertaken with people was in 2012. The registered manager told us that they had already identified that action was needed to ensure the next survey was facilitated.

We observed a number of meetings. For example, handover meetings took place daily at which all staff were present. The registered nurses and the registered manager also held a daily meeting which was an opportunity to review people's health and wellbeing, plan interventions and discuss how best to meet their clinical needs in line with best practice. For example, discussions included a review of those people who had fallen and the aftercare they had received; a review of people who had current wounds that required dressing and those that were perhaps more lethargic than usual. This helped to ensure that there was effective monitoring of clinical risks within the home.

In addition there were daily meetings for the heads of department which the housekeeper, the laundry manager, the chef and the maintenance man attended. These meetings ensured that the registered manager remained informed about day to day issues within the home. The atmosphere in these meetings was relaxed, communication was focused and effective. Staff were encouraged to ask questions or offer comments or suggestions and individuals were listened to. This helped to ensure that there was an open and transparent culture within the home and meant that the engagement and involvement of staff was promoted within the home.

We observed that the registered manager was supportive of all of the staff and was readily available if staff needed any guidance or support. The registered manager ensured that staff had opportunities to continuously learn and develop, for example, one of the care workers we spoke with told us they were undertaking a competency based leadership qualification. We saw that when gaps in skills or knowledge were identified, arrangements would be made for staff to complete the necessary training. The registered manager told us that they reviewed the training records of staff on a weekly basis to identify if training was out of date and needed to be repeated. This helped to ensure that staff were able to carry out their duties effectively so that people received good care and treatment.

A range of systems were in place to monitor and improve quality and safety within the home. The provider used an electronic system to report incidents and manage adverse events or near misses. For example if a complex wound dressing became dislodged, a report was made which triggered an investigation and analysis of the situation so that remedial action could be planned. This helped to ensure that the registered manager was able to effectively manage clinical risks within the home.

Audits were undertaken to monitor the effectiveness of aspects of the home, including care documentation, nutrition, medication and infection control. A tracking system was used to monitor the progress of pressure ulcers so that remedial actions could be taken if these were not healing. Admissions were also tracked to ensure that all the relevant information had been gathered about the new

Good

Is the service well-led?

person so that they could deliver effective care. Health and safety audits were undertaken to identify any risks or concerns in relation to fire safety and the effective control of legionella. Hoists, slings and other equipment used for safe moving and handling were also checked monthly to reassure that they remain fit for purpose.

A service improvement action plan was in place which detailed how it aimed to improve the quality of the service provided. This currently included; improving the activities available within the home, improvements to the flooring in the reception area and improving the dining experience for the people.

Systems were in place to identify and manage foreseeable risks. The organisation had a business continuity plan which set out the alternative arrangements that would be put in place if for example there was a loss of power or the need for evacuation of the building. Each person had a personal emergency evacuation plan (PEEP) which identified the assistance and equipment they would need for safe evacuation. An emergency grab bag and folder was in place readily accessible and contained torches and blankets and important contact numbers.

The registered manager explained that the home faced some challenges which at present were continuing the transition from task orientated care to person centred care and encouraging the on-going involvement of people and their relatives in the care planning. From a nursing perspective, the registered manager explained that the challenge was achieving a good balance between the need to complete care documentation and care delivery. The registered manager had a clear vision for the future of the home which was underpinned by the aim to achieve continuous improvement and good quality care. The registered manager told us that they were proud of the care provided and of the staff team who she explained had worked so hard to make improvements and remained committed to achieving the on-going development of the home.