Orton Manor Ltd

Orton Manor Nursing Home

Inspection report

64-70 Birmingham Road
Water Orton
Birmingham
West Midlands
B46 1TH

Tel: 01217494209

Date of inspection visit:
15 August 2017

Date of publication:
31 October 2017

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

Summary of findings

Overall summary

This inspection took place on 15 August 2017 and was unannounced.

Orton Manor is one of three homes owned by a small provider and provides accommodation, personal and nursing care for up to 40 older people living with physical health conditions or dementia. The home has two floors, each with a communal lounge and dining area. At the time of the inspection 36 people lived at the home. Orton Manor was last inspected by us in September 2016, and we awarded the home a rating of Requires Improvement.

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

People's medicines were not always administered as prescribed, and medicines records did not always demonstrate that medicines were administered consistently. Some prescribed creams were being administered by care staff who had not been trained to do so. Audits designed to check medicines practice was safe and in line with best practice had not identified some of the issues we found.

Risk assessments were not always in place where risk had been identified. Risk assessments did not always give staff the information they needed to manage risks safely and consistently.

People told us they felt safe with the staff who supported them, and we saw people were comfortable with staff. Staff received training in how to safeguard people and understood what action they should take in order to protect people from abuse. The provider ensured staff followed safeguarding policies and procedures.

There were enough staff to meet people's needs effectively. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people. Staff told us they had not been able to work until these checks had been completed.

People were asked for their consent before staff supported them. Where people lacked capacity to make particular decisions, this had been assessed to ensure people were protected. Where people lacked capacity and had been deprived of their liberty to keep them safe, the provider ensured they applied to the relevant authority to ensure this was done lawfully.

People and relatives told us staff were respectful and treated people with dignity. We observed this in interactions between people, and records confirmed how people's privacy and dignity was maintained. People were supported to make choices about their day to day lives. For example, they were supported to maintain any activities, interests and relationships that were important to them.

People had access to health professionals when needed and care records showed support provided was in line with what had been recommended. People's care records were written in a way which helped staff to deliver personalised care and gave staff information about people's communication needs, their likes, dislikes and preferences. People were involved in how their care and support was delivered.

People and relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. People and staff told us the management team were approachable and responsive to their ideas and suggestions. There were systems in place to monitor the quality of the support provided, and the provider was developing ways to ensure people were at the centre of helping the service to develop.

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 consistently safe.

Medicines were not always administered by trained staff and in line with prescribing instructions. Audits designed to check medicines management were not effective and had not identified the concerns we found. Risk assessments were not always in place where required, and did not always give staff the information they needed to support people safely. Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures in place to ensure they recruited people who were suitable to work in the home. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported by staff that were competent and trained to meet their needs effectively. People were offered a choice of meals and drinks that met their dietary needs, and where they were at risk, their food and fluid intake was recorded and action taken where required. People received timely support from appropriate health care professionals. Where people lacked capacity to make day to day decisions, this was assessed and documented. Staff understood the need to obtain consent from people in relation to how their needs should be met. DoLS applications had been made as required.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and showed respect for people's privacy. People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which had been planned with their involvement and which was regularly reviewed. Staff responded to people quickly and effectively on a day to day basis, and as people's needs changed. People were supported to maintain hobbies, activities and interests. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Good

The service was well led.

People and staff felt able to approach the management team and felt they were listened to when they did so. Staff felt well supported in their roles and there was a culture of openness. There were systems in place for the provider to assure themselves of the quality of service being provided, and the provider was exploring ways to ensure people and their relatives gave feedback so the service could improve.

Orton Manor Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 August 2017 and was unannounced. The inspection was conducted by two inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection visit, we spent time observing interactions between people and staff. We spoke with eight people who lived in the home, and with nine relatives. We also spoke with the registered manager, the clinical lead nurse, and four care staff.

We reviewed eight people's care records, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. Comments included; "They will come and check on me and they'll say 'you haven't pressed the buzzer are you alright?'.", and, "I feel safe. I can stop in bed if I want. I could go into the room (lounge). I do what I want." Relatives told us they were confident people were safely looked after and this gave them confidence and reassurance.

At our inspection in September 2016, we found some risks had not been assessed and actions were not in place to minimise those risks. At this inspection, we found steps had been taken to address this, but risk management still required further improvement.

The registered manager had identified some potential risks relating to people living in the home, and some plans had been devised to protect people from harm. The risk assessments we reviewed were up to date and had been reviewed monthly, or when peoples' health changed. Most of the risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing.

For example, where people had developed pressure wounds or damage to their skin, risk assessments and wound management plans were in place. This ensured any damage to people's skin was regularly assessed. Records showed nursing staff altered people's treatment plans when their skin changed and people's skin was healing. This meant wound care was being managed safely and effectively.

Where people were at increased risk of developing pressure sores or damage to their skin, risk assessments detailed the steps staff should take to minimise this happening. This included regular re-positioning of the person, especially when they were cared for in bed.

However, we found one person we were told had a catheter in place, did not have a care plan, risk assessment or risk management plan in place for their catheter care... Despite these omissions staff told us, and daily records confirmed, the person was receiving appropriate care and treatment for their catheter. When we asked the registered manager about this, they explained this was an oversight, and assured us this would be fully assessed and a care plan put in place to ensure consistency.

Another person placed themselves and others at risk of harm when they became agitated. Their records showed they often tried to leave the home, or could be physically aggressive towards other people and staff. Although their care records documented these incidents, we found the risk assessment and risk management plan for the person's behaviour could have been more detailed, to ensure staff knew how to distract and calm the person when they became anxious.

Detailed risk assessments and care plans were necessary, to ensure people received consistent and safe care from staff, as the home used agency staff at times to support people.

We raised this with the registered manager, who said they would update the person's records immediately. Following our inspection visit, the registered manager sent us information on how they had addressed what

we had found, and ensured all risk assessments were in place.

Other risks, such as those linked to the premises, or activities that took place at the home were assessed and actions agreed to minimise those risks were in place. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. The provider ensured equipment was safe for people to use. For example, we checked records of maintenance of hoisting equipment, and found this was up to date.

The provider ensured a plan was in place so they could continue to support people in the event of a fire or other emergency situation. Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. One staff member explained they were familiar with evacuation procedures, but added they would be guided by specially trained staff. They commented, "There is a fire marshall on every shift." Care records showed people had personal fire evacuation plans in place which took account of their needs and guided staff on how best to support people in the event of a fire.

People told us staff supported them to take their medicines safely and when they needed them. One person commented, "I am happy with them giving me the medications. I get them on time. They don't put on any creams on me. I have asked for paracetamol when I have needed it. I have had it."

However, we found some concerns in the safe management of medicines that had not been identified by the registered manager, although we were told they completed regular audits to check safe practice in medicines. For example, where people required pain relief in the form of patches on their skin, we found staff had not completed body maps or patch position records. These are needed to ensure patches had been applied in the right places. However, staff were able to describe how and when these patches should be applied to different sites on the body to reduce the risk of skin irritation to people.

Some people were prescribed creams and lotions [topical medicines] to be applied to their body. We found some care staff who had not received medicines training or had their competency assessed, were applying prescribed creams. The registered manager explained care staff who applied creams would inform the medicines trained staff that treatment had been applied, and then trained staff would record on the MAR (Medicines administration records) to confirm the medicine had been applied. The registered manager acknowledged this was not the most effective way to manage the application of prescribed creams. Following our inspection visit, they told us only nursing staff now administered and signed for any prescribed creams, to ensure this was done by staff with the correct training, skills and experience.

Records for most of the topical medicines we looked at did not inform staff where on the body they should be applied and the frequency. For example, one person had been prescribed gel to be applied to their skin three times a day. Medicines records for August 2017 showed the gel had been applied twice daily. This meant we could not be assured topical medicines were being applied as intended by the prescriber. Some creams did not record 'opened dates'. This meant staff could not be confident the creams remained effective and used within the specified time period.

There were plans in place to instruct staff on how to administer medicines prescribed on an 'as required' basis to protect people from receiving too little, or too much medicine. Where people required specialist medicine to manage their health, for example their diabetes, procedures were followed to monitor people's blood sugar levels before they received their medicine. This ensured people's health was maintained.

Medicines were stored safely in a locked room, at the recommended temperatures.

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to try and ensure new staff were of 'good character.' Staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. They understood how to look for signs that might be cause for concern, and were aware of their responsibilities to report any concerns to the management team.

People and their relatives had mixed views on whether there were enough staff to meet their needs. Some told us the home sometimes used agency staff which they felt meant there were not enough staff, while others told us they felt there were 'usually' enough staff. One relative commented, "There always seems to be enough staff." One person told us, "Sometimes they are a bit short (staffed). Sometimes you have to wait (for the toilet) if they are dealing with somebody."

We observed the support offered to people in communal areas of the home, and saw there were adequate numbers of staff available at all times to care for people safely, and meet people's care needs promptly. Staff confirmed there were enough staff on each shift, including at night, to care for people safely. One staff member told us, "There are enough staff. We are flexible team players, so we can move around according to where the need is." The registered manager acknowledged agency staff were used to cover unexpected circumstances such as sickness, but explained they tried to use consistent agency staff so people knew who was supporting them.

Good

Is the service effective?

Our findings

At our inspection in September 2016, we found the provider had not given consideration to how consent was sought from people when they were filmed by the home's closed circuit television. At this inspection, we found evidence that people and, where appropriate, their relatives or representatives had been consulted on this, and their consent had been recorded.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Assessments were completed when people did not have capacity to make decisions for themselves. Staff demonstrated they understood the principles of the MCA and DoLS. For example, one staff member commented, "For people's best interests, sometimes they might think they can walk safely but don't understand the risks. If someone wants to go outside, you go with them, you don't tell them they can't." Another staff member said, "We try to enable everyone to make their own choices and decisions, but sometimes we might do things in people's best interests. Some people have a DoLS in place for that, refusing important medication for example. There is a difference between someone saying they don't want to wear trousers when it's cold as opposed to saying they don't want to take their medicines."

Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with people who were important to them and health professionals. The registered manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Where people required a DoLS application to be made, the registered manager had made the appropriate applications to the local authority in accordance with the legislation.

Where there was a delay in DoLS assessments being undertaken by the local authority, records showed the provider had contacted them to ensure the authorities were aware of people's current needs and situation. This helped to ensure information was shared which would help the local authority prioritise their assessments for those most in need, and meant the provider could ensure they took advice on any restrictions in place while they waited for assessments to take place.

At our inspection in September 2016, we found people's weight was not always monitored as planned. At this inspection, we found improvements had been made.

Staff knew people well and could describe people's individual dietary needs. For example, some people were on a soft food diet, were vegetarian or required a reduced sugar diet. Information on people's dietary needs was up to date in their care records, and included people's likes and dislikes. In the kitchen area on

each floor, where care staff prepared regular drinks and snacks for people, there was a chart showing people's nutritional and dietary needs.

Where people were at risk of not receiving enough fluids or food to maintain their weight and health, nursing staff monitored the amount of food or fluid the person consumed each day. Fluids and food charts were checked daily by nursing staff, to ensure people had received the nutrition they required. Weights monitoring was completed consistently, and records showed where people had lost weight, the nursing staff referred the person to the doctor for referrals to nutrition specialists.

We saw staff supporting people who were at risk of malnutrition. For example, one person did not want to eat their sandwich. A member of staff spent time with the person, explaining it was important for them to eat something as their lunch time medicines needed to be taken after food. The person agreed they would eat half their sandwich, which they proceeded to do.

People told us they had a choice of food and drink, and spoke positively about what was on offer. One person commented, "I have porridge, toast and tea for breakfast. I have got a choice; everything I would want is available. I drink coke, water and squash." We observed one person asking for eggs, beans and a slice of toast as a late breakfast. Shortly after the request, a member of staff returned with the above breakfast, freshly prepared. Another person was given a choice of several different sandwiches. The person said, "Oh, I quite like corned beef." A staff member told the person they would get the kitchen to make a corned beef sandwich, which they did.

People, relatives and staff told us the provider worked in partnership with other health and social care professionals to support people. One person commented, "They [health professionals] have all been in. I had my feet done a couple of weeks ago. I am weighed every month." Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people had seen their GP, dietician, chiropodist and dentist when required. Staff made referrals to health professionals in a timely way.

The registered manager told us the doctor visited the home when they were required, and we found changes were made to people's care following advice from medical professionals.

People and relatives told us staff were skilled and experienced, and met their needs effectively, One relative commented, "I would say [name's] needs are 100% met. They certainly seem to know [name] well. Sometimes she will say she has got this or that [illness]. They were red hot about her chest infection. They knew the difference. I can't fault them."

The provider ensured staff had the training they needed to support them in providing effective care for people. New staff completed an induction to ensure they understood their role and responsibilities. The induction included training in all areas the provider considered essential and a period of working alongside more experienced staff. The provider's induction was also linked to the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff told us in addition to completing the induction programme, they had a probationary period to check they had the right skills and attitudes to support people effectively. Staff told us the registered manager encouraged them to keep their training and skills up to date. One nurse told us, "I am supported to keep my professional skills up to date. I recently attended tissue viability training to ensure wound management practices are up to date." The registered manager maintained a record of staff training, so they could

identify when staff needed to refresh their skills.

Staff told us they were supported in their role through regular supervision meetings, [individual meetings between care staff and a member of the management team] and observed practice. Regular supervision meetings provided an opportunity for staff to discuss personal development and training requirements. They also enabled the registered manager to monitor the performance of staff, and discuss any areas for improvement.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with kindness, dignity and respect. Comments from people included, "They do care, they are very caring all of them.", "They care, it is automatic, it is in everything they do. They treat me like you have treated me, with respect.", and, "The girls are so kind to you." We also observed a number of interactions between people and staff that demonstrated this. Throughout the day we saw examples of staff altering their approach, voice and position to effectively engage with people. This demonstrated staff had a good knowledge and understanding of people and their individual needs.

People and their relatives talked with us about things staff did to enhance their well-being and improve their quality of life. One relative explained, "They [staff] have got to know the residents. They have a laugh with them and they love them." Relatives also told us how staff supported and encouraged people's choices, which further enhanced their well-being. Comments included, "It's up to you to do what you want. If you want to lie down you can go. I think I wouldn't like to be told what to do.", "You have told them you don't like red meat. You like fish or chicken. They asked her all her likes and dislikes.", and, "They [staff] brought her smile back." Staff understood the important part they could play in enhancing people's lives. One staff member explained, "It is about being considerate of others feelings and making sure people are looked after properly. We try to make people's lives as happy as possible."

People made choices about who visited them at the home which helped people maintain links with family and friends. We saw visitors being offered drinks and snacks throughout our visit, which helped them feel welcomed into the home environment and more likely to share their thoughts with staff. One relative told us, "They [staff] involve the families in what is going on, be it the table top or the activities. [Another person] teaches me to dance. He loves to dance. They love the singer as well." Another relative spoke very positively about the approach staff took to include families. They explained, "They put up banners for their birthdays and include the families. They do what you would do at home."

The provider ensured people's cultural and religious preferences were met. The home had a noticeboard in place, entitled 'Our Community'. This contained information on what was in place in the home to help people be part of their local community. For example, there were photographs of three religious leaders who came into the home to help those of Methodist, Roman Catholic and Church of England faiths worship. The registered manager told us there was no-one living in the home who followed another faith, but if there were staff would contact people in the local community to help support people.

Staff promoted people's independence and only offered support when people needed it. For example, people were encouraged to eat their meals without the assistance of staff. However, where people required assistance staff stepped in and asked them if they would like support. Staff also encouraged people to try new experiences and join in with what was happening in the home because they recognised how this could enhance people's lives. One relative commented, "The Methodist church comes in and they [staff] encouraged her to sing. She was singing hymns here, something she hadn't done for years. For 4 years she was sat at home doing nothing and here she was singing."

People told us their dignity and privacy was respected by staff. For example, one person spoke about how they were supported with their personal care. They explained, "There is [staff member] who is very nice. I feel quite safe with them. I have a wash in bed. They cover my parts and I wash myself. They turn away and look at the pictures and when I have finished I tell them. They take me to the shower. I don't feel shy with them [staff]." We saw staff knocked on people's doors before entering, and announced themselves when they entered people's rooms.

To help ensure people's privacy and dignity was maintained, people's care plans were kept securely and were only accessed by those who needed to access them.. However, there were some areas where privacy and confidentiality could be improved. For example, we observed one occasion where a medicines trolley was locked but left unattended for a short time, with medical records left on top. We also observed screens in communal areas where staff can enter daily notes about people onto an electronic recording system. These screens could potentially be seen by people and visitors sitting in communal areas. We were concerned this could mean people who were not authorised to do so, could see potentially sensitive and personal information about people. We raised our concerns with the registered manager, who told us this was not standard practice in the home, and that medical records should not have been left out. They told us this would be raised at an upcoming staff meeting. They also told us they would contact the company who provide and maintain the electronic recording system, to see if there were screen protectors that could be used to shield information from people's view. The registered manager sent us evidence following our inspection, that they had contacted the company as above to explore options to ensure privacy and confidentiality.

Good

Is the service responsive?

Our findings

People and their relatives were involved in planning their own care, which meant people's personal backgrounds, their preferences and interests were discussed with them and recorded on their care records. For example, people's preferences for male or female care staff were recorded. One staff member told us how they got to know people's needs. They said, "We like to meet with families when people first come to us. So, if there are any little tips they can give us that is great. You get to know people's quirks."

People and their relatives explained how staff responded to people's needs and involved them, where appropriate, in changing support so people were well cared for. One relative said, "They had a talk with us when [name] began getting worse. They said it would be better for her to be in bed rather than transferring her to the chair because she was spending more and more time asleep. They wanted her to be more comfortable. They were looking after her welfare; they were looking after her needs."

Staff had a good understanding of people's needs and choices, from reading care records and also interacting with people. We saw numerous examples of staff responding quickly and appropriately to people throughout our visit. For example, one person signalled to staff. The staff member responded straight away saying, "When I get a minute I'll be back and I'll do your eyelashes." Another person told a staff member they were still hungry, having eaten some toast. The staff member responded, telling the person, "[Another staff member] is just buttering you some more toast, but here, why don't you have a slice of my toast while you wait?" They proceeded to give the person their toast.

Staff told us they were confident they delivered the right care and support to people because they were kept up to date on changes in people's care needs daily. Staff explained how they handed over key information to staff coming on the next shift. We saw this was conducted verbally, and also a daily handover sheet was prepared. During the 'handover', Information was shared about changes in people's health or care needs, or any special arrangements for the day. We were able to view the daily handover file and saw this was kept up to date so staff who missed the meeting could review the information.

People were supported to maintain activities, interests or hobbies, and were encouraged to try new experiences and were offered a range of activities the registered manager hoped would stimulate them. One relative commented, "I love it here. I visit regularly. Nothing is too much trouble for the staff, honestly. They added, "I love it when the activities are on. A singer comes in regularly and we get up and dance with people. The church come in as well – that is really lovely."
Another relative told us, "A group came in recently and brought a selection of sports equipment. They helped people decide which sport the equipment was used for. They also showed people photos of sports people from the past to see if people remembered them. I think that's good. People aren't just sat."

We observed some activities which took place in a communal lounge area of the home. People who chose to take part were animated and engaged in what was happening. They were singing, dancing, smiling and clapping.

People and relatives told us where they had raised any concerns, these had been dealt with well. One person said, "I have complained but it's been everyday sort of things, it's been sorted out immediately. It's not anything special just everyday things. There have been no major problems."

The provider had a system in place to monitor complaints and to identify any trends and patterns, so that action could be taken to improve the service provided. There was information about how to make a complaint or provide feedback about the service available in the reception area of the home. This information was also contained in the service user guide that each person received when they moved to the home. People and their relatives told us they knew how to raise concerns with staff members or the registered manager if they needed to.

There was no signage in place to help people living with dementia orientate themselves around the home. We raised this with the registered manager who told us this was something they would discuss with the provider. The registered manager also told us they had visited other homes supporting people who were living with dementia, and had plans in place to improve people's experience based on what they had seen. For example, they told us they had ordered some 'memory boxes' (these are display boxes placed by people's bedroom door, which people can fill with photographs or objects which are personal to them to help them locate their room), which they planned to trial in the home.

Good

Is the service well-led?

Our findings

At our inspection in September 2016, we found systems were in place to monitor the quality of the service provided but actions in relation to identified areas for improvement had not always been implemented. Some audits had missed opportunities to identify where action was required to implement improvement.

At this inspection, we found the management team now comprised of a clinical lead nurse who was the deputy manager, and a team leader who supervised care staff on a daily basis. The deputy manager worked at the home five days per week, and spent two of those days in the office. The registered manager told us this had allowed them to focus on and improve quality checks, and to help ensure actions recommended were taken.

For example, we reviewed a care plan audit which had been completed in June 2017. This had identified three care plans were not as up to date and accurate as they should have been. The audit helped to identify who was responsible for updating these, and we saw evidence of how this had been addressed and rectified. Records also showed the registered manager audited incidents and accidents that took place in the home on a regular basis. Analysis from June 2017 showed how action was taken in response to keep people safe. For example, some people were referred to the 'falls clinic' for extra support, while some people were ordered new chairs better suited to their needs.

A range of other audits were completed such as infection control, health and safety and medicines audits to help the service improve. However, the medicines audit had not proved effective in identifying some of the issues we found. The registered manager acknowledged this, and assured us they would change the way they audited medicines to make this more effective. After our inspection visit they sent us an action plan showing actions already taken, along with those actions planned, to improve how medicines were administered, as well improvements to the medicines audit to ensure it gave them the information they needed to keep people safe.

People and relatives were very positive about the home, and told us they felt this was down to how well it was managed. They also felt comfortable to raise anything with the registered manager, and were confident they would be listened to. One person said, "I would speak to [registered manager] in the office if I was concerned. I haven't been worried about anything." A relative commented, "It's a beautiful home. It's the best one I've been to. I've visited a few with various relatives being in one or another." I can't fault it." They added, "The management are lovely. If you are concerned [registered manager] will sit with you."

Whilst people and relative spoke very positively with us about the home, the registered manager told us they had very limited responses when they asked for feedback on the quality of the service provided. They explained this made it difficult for them to act on information, especially as what little feedback they received was positive. The registered manager explained they were looking at different ways to gather this information. For example, they told us there was a 'friends of Orton Manor' meeting in October, to which relatives were invited. They said they hoped to get their views during this, but acknowledged how they gathered and acted on feedback was a 'work in progress.'

Staff were positive about the support they received from the management team, and assured us they were approachable and responsive. Staff also felt there was an open and honest culture within the home which the registered manager had helped to create. One nurse told us, "We get along with the registered manager very well. We all work as a team." "There is an on call number staff can call 24/7 if they need advice, and there is always a trained nurse on shift." A care staff member commented, "I love working here. It's relaxed, it's caring, you don't need to worry. You know everyone will do their job properly." Another staff member said, "I can always knock on the door and air my views. Both [registered manager and deputy manager] are really approachable. They are very open."

Staff told us they were able to share their views at regular staff meetings. Records confirmed staff meetings took place regularly. Minutes of recent staff meetings demonstrated discussions focussed on how the service could be improved for people, and how care and nursing staff should not hesitate to ask for support and guidance from senior staff.