Visram Limited

Ranvilles Nursing & Residential Care Home

Inspection report

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17 November 2017

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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

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on 16 and 17 November 2017. CQC had been made aware of a complaint the home had received in 2016 following the death of a person. This matter was being further investigated and as such was not reviewed as part of this inspection. However, the information shared with CQC about the incident indicated potential concerns about the management of nutrition and hydration for people who lived in the home and poor record keeping. These identified risks were examined in this inspection.

The home is registered to provide accommodation and nursing and personal care for up to 53 older people who live with advanced dementia or mental health conditions. Accommodation is arranged over two floors with access to all areas by stairs and lift. At the time of our inspection 46 people lived at the home.

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

Staff had a good understanding of how to protect people from the risk of infection and policies and procedures were in place for the management of infection control. However, some flooring in the home required replacement as it was difficult to maintain this hygienically.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse, discrimination and harassment and report these appropriately. Robust processes to check the suitability of staff to work with people were in place. There were sufficient staff deployed to meet the needs of people and they received appropriate training and support to ensure people were cared for in line with their needs and preferences.

Risk assessments in place informed plans of care for people to ensure their safety and welfare, and staff had a good awareness of these. Incidents and accidents were clearly documented and investigated. Actions and learning were identified from these and shared with all staff.

Medicines were administered, stored and ordered in a safe and effective way.

People were encouraged and supported to make decisions about their care and welfare. Where people were not able to consent to their care, staff followed legislation designed to protect people's rights and freedom.

People received nutritious meals in line with their needs and preferences, in an environment which provided a calm and relaxing dining experience for them. Those who required specific dietary requirements for a health, cultural or religious need were supported to manage these.

Staff were calm, kind and gentle in their interactions with people and supported them to remain independent whilst maintaining their safety and welfare. People's privacy and dignity was maintained and staff were caring and compassionate as they supported people. Staff knew people in the home very well and involved them and their relatives in the planning of their care.

Care plans were person centred and reflected people's physical, mental, emotional and social needs. The home worked with a multidisciplinary team of health and social care professionals to ensure people's individual needs were met.

The registered manager promoted an open and honest culture for working which was fair and supportive to all staff. Staff felt supported in their roles and provided care in a manner that was in keeping with the provider's philosophy of care. People and their relatives spoke highly of the registered manager and all their staff team.

Effective systems were in place to monitor and evaluate any concerns or complaints received and to ensure learning outcomes or improvements were identified from these. Staff encouraged people and their relatives to share their concerns and experiences with them.

At our last inspection in October 2016, we rated the service as overall Good although improvements were required in the well led domain with regards to audits and record keeping. At this inspection we rated the service as Good in all domains and audits and record keeping had improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	Good
Is the service effective? The home remains effective.	Good
Is the service caring? The home remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service had improved and was well led. The recording of audits had improved since our last inspection and records were well managed.	Good

Ranvilles Nursing & Residential Care 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.

Ranvilles Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Ranvilles Nursing and Care Home accommodates up to 53 people in one adapted building. There were 46 people living at the home at the time of our inspection.

This inspection visit was unannounced and took place over two days. On 16 November 2017 an inspector and an expert by experience visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 17 November 2017 two inspectors visited the home to complete the inspection.

Before our inspection we reviewed the information we held about the home, including previous reports and notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. Due to technical problems, the provider was not required to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with seven people who lived at the home and three relatives. Many of the people who lived at the home lived with complex mental health conditions or dementia and we were unable to talk with them. We

observed care and support being delivered by staff and their interactions with people in communal areas of the home. We spoke with thirteen members of staff, including; the nominated individual for the registered provider, the registered manager, the deputy manager, two registered nurses, four members of care staff, the cook, two cleaners and an activities coordinator. During and after our inspection we spoke with four health and social care professionals about the care people received at the home.

We looked at care plans and associated records for five people and reviewed the medicines administration system in the home. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, four recruitment files and policies and procedures.

Good

Is the service safe?

Our findings

People felt they were safe in the home. One person told us, "Oh yes I am very safe here, I don't have to worry about anything." Two other people expressed their contentment in the home where they felt safe and well cared for. Relatives felt their family members were safe in the home and were cared for by staff who knew them well. Health care professionals told us people were very well supported to manage their complex health needs and ensure their safety and welfare.

There were robust policies and procedures in place for the management of infection control in the home. Staff had a good understanding of their responsibilities in reducing the risk of infection in the home and we saw they used personal protective equipment such as gloves, aprons and hand gel which was readily available in the home.

Cleaning schedules identified that a clear program of cleaning and maintenance was carried out to ensure the home remained fresh and clean to reduce the risk of infection. However, we saw some furniture and carpets in communal and bedroom areas of the home were worn, stained or needed replacement. We discussed this with the registered manager who told us these carpets would be renewed in the near future when more suitable flooring for these areas was decided upon.

Safeguarding policies and procedures were in place to protect people from abuse, neglect, harassment and avoidable harm. Staff had received training on safeguarding and recognised what constitutes abuse and how to report concerns to protect people and prevent the discrimination and harassment of people. One member of staff told us, "The residents come first. I would tell the manager if I thought anyone was being abused."

The registered manager demonstrated a good understanding of their responsibilities in reporting safeguarding matters to the local authority and investigating any concerns which were raised. They promoted an equality of care for people who lived in the home ensuring people were not discriminated against due to their complex mental health conditions and care needs. This included the involvement of independent advocates for people. Learning from any safeguarding investigations was shared with staff to improve the quality of care provided at the home. Staff were confident any concerns they raised would be dealt with swiftly by the registered manager and they were aware of the registered provider's whistleblowing policy.

Risks associated with people's care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for; maintenance of skin integrity, choking, falls, smoking in the home, nutrition, behaviours which may be challenging, moving and handling and constantly walking around the home. Plans of care were in place to mitigate these risks. For example, one person required support as they may display behaviours which could cause harm to themselves or others. A member of staff was available to provide one to one care for them. The risks associated with their behaviours were clearly identified and care plans gave clear information on how to mitigate these risks and support the person to maintain their safety and that of others.

Incidents and accidents were reported, recorded and investigated in a way which ensured any actions or learning from these was completed and shared with staff. For example, a review of incidents of falls for one person had led to the introduction of 15 minute checks of this person's whereabouts and welfare. We saw these were completed.

The risks associated with moving people in the event of an emergency in the home had been assessed. Personal evacuation plans were in place which provided information on how people should be supported to evacuate the home in the event of an emergency. A robust business continuity plan and home emergency evacuation plan were in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

The home was well maintained. Electrical, gas, and water checks were completed routinely in the home to ensure this equipment was safe to use. There were effective systems in place to identify maintenance issues in the home and how or when these were addressed. Equipment in use in the home such as hoist, a lift and specialist bathing equipment was well maintained.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

There were sufficient staff deployed to meet the needs of people. Staff had time to interact and support people in an unhurried and calm way. The staff rotas showed there were consistent numbers of staff deployed each day and although external agency staff worked in the home, there were robust systems in place to ensure these staff were inducted to the home and worked alongside staff who knew people well. People and their relatives told us there were sufficient staff to meet their needs. Health and social care professionals said there was a good ratio of staff in the home to meet people's complex needs.

People received their medicines in a safe and effective way from registered nurses. There was a robust system of audit and review in place for the safe administration of medicines. Medicines were stored and administered safely. For medicines which were prescribed as required (PRN) a protocol was in place to support staff in the safe administration of these. For people who required medicines to reduce anxiety or agitation we saw staff monitored the use and effectiveness of these medicines. They worked closely with health care professionals to ensure people received adequate doses of these medicines without reducing people's independence.

Care records showed some people received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. The home had ensured families and health care professionals had been fully involved in a best interests' decision making process about the administration of these medicines. This was in line with the Mental Capacity Act 2005 to ensure the safety and welfare of the person.

Good

Is the service effective?

Our findings

Most people who lived at Ranvilles Nursing and Residential Home lived with complex mental health needs or advanced dementia. Their physical, mental health and social needs had been holistically assessed to ensure the care they received was in line with their individual needs. Staff worked closely with health and social care professionals to plan people's admission and on-going care at this home and ensure their needs could be met. One health care professional told us how the registered manager had a very 'inclusive' approach to their admission process to the home. They said the registered manager ensured they did not discriminate against people who were not always able to express their wishes or understand their care needs; they did everything they could to meet people's needs whilst maintaining the safety and welfare of everyone who lived and worked at the home. Independent advocates and relatives were welcomed in the home to support people who were unable to express their wishes or understand their own care needs.

People were encouraged to mobilise freely around the home throughout the day. Assistive technologies such as sensor mats and closed circuit television in communal areas of the home were used to promote people's independence, safety and welfare.

A program of appraisal and supervision sessions, induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. Staff felt these sessions supported them to provide safe and effective care for people. One staff member told us, "The training is outstanding I think. If you need it, you can do it." Another told us, "We get supervision every couple of months. I find it fine; it's not a threatening thing at all." A third member of staff told us, "It [induction] was excellent. I did training and worked with staff till I felt comfortable."

Staff were encouraged to develop their skills through the use of external qualifications such as nationally accredited qualifications and The Care Certificate. This certificate is an identified set of standards that care staff adheres to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Registered nurses were supported to develop skills and ensure they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

People enjoyed the food at the home. There was a choice of meals provided each day and food was presented well. The cook had a very good understanding of people's dietary needs, likes and preferences and told us how they were able to meet cultural and religious preferences of people. For example, one person did not eat pork for religious reasons and so separate meals were prepared for them whilst allowing others to enjoy this meat. All foods were freshly prepared in the home and all meat used in the home was prepared using halal methods to ensure the cultural needs of people were met.

Care plans held clear information on people's dietary preferences and their cultural and medical nutritional needs. Risks associated with eating, drinking and choking had been identified and plans of care put in place to mitigate these risks. Staff described how they supported people with nutrition and hydration needs including monitoring their food and fluid intake, if there was a concern, and monitoring their weight. They

described how they fortified or thickened foods and drinks if people needed this and would liaise with the dietician if required.

Mealtimes were unhurried and people could take their meals in an area of the home of their choosing. The dining room was bright and held written and pictorial displays of the food on the menu for the day. Staff showed people both of the menu options for the day presented on a plate to help them choose their preferred meal. Some people were supported with their meals in lounge areas of the home. Staff were attentive to people's needs and supported people when it was required without hurrying them or reducing their independence. We saw people who had their breakfast later in the morning were offered the opportunity to have their lunchtime meal later.

Staff worked closely with health and social care professionals to ensure people received effective care in line with their needs. A weekly GP round was completed to medically review people for whom staff had identified a concern. A GP told us this was very effective as staff were always available to support them on this visit and knew people well. They also said staff requested the GP to visit appropriately at other times when people became unwell and needed medical support. Health and social care professionals told us they felt confident the staff knew people well and requested their support appropriately. This included regular meetings with mental health care professionals, GPs and social care professionals to monitor people's changing clinical conditions and care needs. A health care professional told us the staff at the home were very competent in meeting the needs of people and always ensured they involved a multidisciplinary team of health and social care professionals when needed.

Whilst the home was not purpose built, the environment had been adapted to provide a safe environment for people to mobilise around independently. Corridors were narrow but clear and allowed people to walk in a full circuit around the ground floor of the home. Secure outdoor areas were available during good weather to allow people to walk and sit in the garden and a sensory garden was planned for one area of the home. There were level access areas all around the home for people who required the use of wheelchairs and walking aids and two lifts in place to provide easy access to the two floors of the home. One person who used a walking aid told us, "I can go where I like, it's easy to get around here." Another person said, "There are no bumps to worry about; I do just fine thank you."

There was some pictorial and written signage around the home to help people identify where their rooms, toilets and bathing areas were. The registered manager acknowledged that corridors and room doors were, in most areas of the home, lacking in colour. Coloured walls and furniture can assist people who live with dementia or poor vision to identify particular areas of the home and promote their independence. The registered manager and registered provider told us they had plans in place to add colour to hand rails and people's doors to improve visibility of these.

A large communal area of the home was periodically decorated to celebrate different events throughout the year including Halloween, Easter, spring time and national celebrations. Staff told us a Remembrance theme of poppies and memorabilia had been in place immediately prior to our inspection and plans were in place to decorate the home for Christmas. People were involved in creating decorations and decorating the home for these events if they wanted to. One person told us about the upcoming decoration plans and how they enjoyed being part of this.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The registered manager and all staff had a very good understanding of the processes required to ensure decisions were made in the best interests of people. Care records held clear information on how staff should support people to make decisions they were able to, such as selecting clothing, food choices and when to participate in activity. Decisions made in people's best interests were clearly recorded and showed where people had selected a legal representative such as a Lasting Power of Attorney or independent advocate to make decisions on their behalf.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards. Most people who lived at the home were subject to these safeguards and all staff had a very good understanding of the reasons for these safeguards and the implications this had on people.

Good

Is the service caring?

Our findings

People and their relatives told us staff were always kind and caring. One person told us staff were always, "friendly and supportive," whilst another said, "The staff are really nice, nothing is too much bother." Two professionals told us the staff were very caring and kind and that they would be happy to have any of their relatives live in the home. A third professional told us, "The home has a very good reputation for providing good care, especially for people who have complex mental health needs." Staff felt they offered good care for people. One told us, "I wouldn't work here if I didn't think it was caring." Another member of staff told us, "The care here is great, everyone seems happy."

People were supported in a kind and caring manner. There was a calm and inclusive atmosphere in the home. Staff took time to allow people to express themselves and participate in their care and activities as they preferred. Staff did not talk over people but brought themselves to an appropriate level to have eye contact with the person they were communicating with. As people walked around the home staff interacted with them and encouraged them to remain independent whilst ensuring their safety. For example, for one person who regularly collected cleaning signs or other articles around the home and placed them in other areas, staff encouraged them to replace these without discouraging them or preventing them from participating in this activity. For another person who spontaneously began to sing in a communal area we saw staff joined in with this singing and encouraged them to express themselves.

We saw people responded well to all staff who knew them very well and understood how to meet their needs. Staff had collated information with people and their relatives or representatives in a 'This is me' document about their personal history, likes and preferences including religious and cultural beliefs. Staff we spoke with understood how important it was to embrace people's previous experiences in their daily lives and allow them to reflect on these. For example, for one person who had been involved in professional sport staff were aware of this and tried to use this in conversation or activities for this person. For another person who had enjoyed a particular television program and regularly tried to discuss this with staff, staff did not discourage this conversation but interacted with this person in a meaningful way.

Most people lived with complex mental health conditions or advanced dementia and staff had a very good knowledge of how to interact and communicate with people. Each person's care record held a "Tool to Assess Language Deficits and facilitate Communication". These records held clear information on how best to communicate with each person to ensure they had the opportunity to express themselves and have meaningful interactions with others. For example, one person's care plan encouraged staff to 'respond to the emotion, not the words.' We saw staff responded to how this person communicated rather than what they said and this was very effective in supporting them with their needs. For another person, care records gave clear information about how staff should use short and clear communications with them as they were unable to concentrate for long periods of time. We saw this person frequently slept following interaction with others. However when they were alert staff encouraged them to be involved in short interactions with others.

People often had difficulties expressing their views about how they wished to be supported or involved in

the management of and any changes of the home. The registered manager was proactive in speaking with relatives and advocates for people when they visited to ensure their views were respected and also to encourage them to involve people in discussions about their care and the home. During our inspection relatives were keen to express their views of the home and encouraged their family members to tell us of their thoughts. Relatives felt their views were respected.

People and their relatives felt staff were very respectful of their privacy and dignity. Doors remained closed when people were being supported with personal care and when one person was being visited by a health care professional who needed to examine them in a communal area screens were used to maintain this person's privacy and dignity. Staff asked permission before supporting people to move or participate in any activity and were courteous and respectful at all times. One person became distressed and needed support to access a toilet area urgently. Staff calmly and respectfully supported this person to a toilet area and assisted them with their personal hygiene. Staff reassured them and were kind and compassionate throughout these interventions.

Staff understood the need for information about people to be stored confidentially and not shared unnecessarily. The registered provider was in the process of introducing a computerised system of care records which would provide a more robust and timely system of record keeping in the home. We discussed the display of these new records on a large screen which allowed the registered manager and registered nurses to monitor the care provided. The registered manager assured us all steps would be taken to ensure this information remained confidential.

Good

Is the service responsive?

Our findings

Whilst people did not know if they had a care plan or if they had been involved in planning care to meet their needs, they said staff listened to them and knew what they needed. Relatives told us they and their loved one had been fully involved in the planning of their care and that professionals had also been involved in planning and monitoring the care people needed.

For example, for one person whose health had deteriorated when they were in hospital and this meant they were unable to return home, they and their family had been fully involved in initial assessments and discussions about the suitability of Ranvilles Nursing and Residential Care Home to meet their needs. They had been offered a trial period and had met with staff and health care professionals throughout their initial stay at the home to ensure their needs were being met. Relatives said staff responded to their loved ones changing needs in a sensitive and very supportive way.

Care plans in place were legible and securely stored. They were individualised, person centred and up to date and were reviewed monthly or more frequently if required. They held clear information on people's personal history, preferences, likes and dislikes and staff had a very good understanding of these.

Care plans gave clear information for staff to meet the needs of people with specific health conditions such as diabetes, dementia and other long term mental health conditions. Information clearly demonstrated how people's independence may be reduced with these conditions, how they might present and what support staff should offer people. For example, one person could present with behaviours which they or others could find distressing. A behavioural assessment and care plan outlined potential triggers to behaviours and recommended de-escalation techniques to reduce the risk to themselves, staff and other people. This person was in receipt of one to one care which was authorised by the local authority through a Deprivation of Liberty Safeguard. Staff had appropriately assessed this person's care needs and promoted their independence as much as possible. For another person who was at high risk of developing pressure wounds, their care plans gave clear information on all the support this person would need to maintain their skin integrity. These included mobility, nutrition, hydration and continence care plans which were individualised and encouraged maximum independence for the person. Staff demonstrated a good understanding of these needs.

A new computerised system of records was being introduced in the home and the registered manager showed us how this would improve the monitoring and recording of individualised care needs and input each day. They told us it would allow closer monitoring of fluid and nutrition intake as well as clinical observations such as blood pressures and weight monitoring and that this would significantly reduce the time it took staff to report and record care provided for people allowing them more time to provide individualised care for people.

We spoke with an activities coordinator about activities and meaningful occupations in the home. An activities programme was available in the home and offered the opportunity for people to participate in a wide range of games, entertainment, trips and individual activities in the home. Displays around the home

showed pictures of events or posters for forthcoming family events such as a Christmas party.

We observed staff provide stimulating activities such as dementia dolls, newspapers to read, impromptu singing, looking at pictures whilst people were walking around the home and talking about radio or television programmes. Two people played darts, some people interacted with each other and visitors whilst others did spend time sitting in communal areas asleep. However, there were opportunities for them to be actively involved with others as they chose to be. Mood and wellbeing care plans were in place for people who could display behaviours which may be distressing to themselves or others. These provided staff with information to gauge appropriate themes, times and places to provide meaningful activities and occupations for people.

However, we found during our inspection few people appeared to be engaged in these activities. The activities coordinator explained that a group activity in the home rarely had more than five people attend as, due to the complexity of people's mental health conditions, many people were unable to participate in these activities or chose not to. We spoke with a health care professional who told us the activities within the home were very good and that there had to be recognition that some people in the home would not participate in any activity due to their level of cognition. They described how staff were very good at working with people on a one to one basis for very short periods of time to provide stimulation without distressing them or putting undue pressure on people to complete activities.

Information about the home, how to make complaints and other documents such as menus and activity schedules were displayed in a format which people could easily access and view. This meant people had access to the information they needed in a way they could understand it and the home was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

There were effective systems in place to monitor and evaluate any concerns or complaints and ensure learning outcomes or improvements were identified from these. We saw any concerns raised were investigated and actions from these were implemented. There had been no formal complaints in the home since our last inspection. The staff at the home had received many compliments from people, their families, friends and other visitors to the home, some of which were displayed in the home.

Staff provided care for people at the end of their life although there were no people in the home receiving end of life care at the time of our inspection. Care plans were in place to provide staff with guidance on people's preferences, wishes and any specific instructions including religious, cultural and spiritual needs in the event they required end of life care. Families and representatives could be involved in informing these plans where appropriate.

We saw feedback from families of people who had passed away at the home thanking staff for the support and kindness they had been offered at this difficult time.

Good

Is the service well-led?

Our findings

Relatives, staff and professionals told us the home was well led and spoke highly of the registered manager. One relative told us the home was, "Very well run with good caring staff." A member of staff said, "It really is [well run] I think. We have a great team and the manager really knows her stuff." A professional told us, "[Registered manager] is fantastic, she runs the place well and all the staff really do get a strong sense of team work from her. That's what it's all about."

At our inspection in October 2016 we found that whilst the home was well led, some improvements were required to the governance arrangements within the home. . At this inspection we found a wide range of audits were completed in the home by the registered manager and registered nurses to ensure the safety and welfare of people in the home. This included audits of; infection control practices, medicines, care plans, safety equipment, maintenance and health and safety practices. Actions from these audits were collated and acted upon by the registered provider. The registered provider had recently employed the services of a new external quality assurance auditor who was in the process of reviewing and adapting policies and audits in line with the new key lines of enquiry which inform CQC inspections. The registered manager had a good understanding of these new changes and was working with the registered provider to ensure these were embedded in the home.

The nominated individual for the registered provider told us of resources they had made available to the home to improve the environment such as the introduction of a sensory garden, new equipment in the kitchen and a new package of training to be introduced for all staff in 2018. They were keen to embrace new ideas in the home and had sought support and guidance from other organisations before the implementation of a computerised system of records in the home. They explained how this had come about from learning of an incident where the hydration and nutrition of people was not always being monitored closely and needed improvement.

The registered manager worked closely with other managers within the registered providers group of homes to share good practice and learning from incidents, accidents and events in these homes. They told us how they were piloting the computerised record system for the group and would share this experience with others. Other learning included registered nursing practices and new initiatives, training developments and complaint sharing to ensure service development and learning in these areas.

The philosophy of care within the service was to 'Create a homely environment whilst providing a professional service which is flexible and client centred,' and to, 'Treat all service users as individuals.' This philosophy was evident throughout the home and our observations indicated that staff provided care in a manner in keeping with these aims. Staff reflected the need to provide individualised care for people in our conversations with them and had a good understanding of the complex needs of people who lived at the home and how every day would be different with them.

The registered manager was clearly visible in the home and promoted a strong ethos of homely care in line with people's needs. They communicated in an open and transparent way, encouraging others to do the

same. This promoted an environment where people who lived in the home, their relatives and staff felt able to express any concerns they had and know they would be dealt with fairly and promptly. There was an effective staffing structure in place which provided a good network of support for people who lived and worked at the home. There was a strong sense of team work in the home as staff moved around the home working together to promote good quality care.

People, their relatives and staff were encouraged to feedback on the quality of the service provided through a variety of means. . Whilst there had not been a formal, 'Resident and Relatives' meeting since May 2017, the registered manager was planning a meeting in the new year following the introduction of the new computerised care records. The registered manager prided themselves in being visible and available in the home for people and their relatives to speak with, whenever they chose, to provide feedback and raise any matters of concern with them. One relative told us they felt a 'Resident and Relatives' meeting would be an excellent idea as they had not attended one.

Regular meetings with staff were held and were an opportunity to discuss any matters of concern they may have in the home and receive updates on new concerns, incidents or changes in the service. Daily handover sessions provided staff with up to date information on people's needs and were also used to share any learning from investigations or safeguarding matters.

The registered provider sought annual feedback from people and their relatives through the use of quality surveys. The last survey completed was sent out March 2016 and was collated after our last inspection in October 2016. Responses to these surveys had shown people were very happy with the care provided.

Staff at the home had a good working relationship with health and social care professionals from the local authority, GP surgeries and specialist mental health teams. They held regular multidisciplinary meetings to review people's care needs and explored different ways of working to ensure people received the care they needed. For example, the registered manager told us how they had worked closely with a mental health professional to meet the needs of one person who displayed behaviours which could put them or others at risk of harm. They involved the community mental health team in devising strategies to support this person and worked closely with all professionals to prevent this person having to be admitted to hospital.

The registered manager was very proud of the working relationships they had with other professionals. Feedback we received from professionals showed this respect was mutual and professionals recommended the home regularly to support people who provided complex challenges to meet their needs.