Tamaris Healthcare (England) Limited

Regents View Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place over two days. The first visit on 12 August 2015 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 13 August 2015.

Regents View Care home provides nursing and personal care for older people some of whom have dementia care needs. The home is registered for 50 places but there are only 48 bedrooms following the conversion of two rooms for storage. Since last inspection the provider had created a separate nine-place unit for gentlemen on the ground floor. All bedrooms in the home are single occupancy and have en-suite facilities. The home has two floors of accommodation which are served by a passenger lift. At the time of this inspection there were 39 people using the service.

The home had a new registered manager since June 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

At the last inspection of this care home, which was carried out on 2 and 3 December 2014, we found the provider had breached three regulations. These related to: premises shortfalls such as a poor standard of bathrooms; inadequate cleanliness of the building; and lack of staff supervision.

After the inspection on 2 and 3 December 2014 the provider wrote to us to say what they would do to meet legal requirements.

During this inspection visit we found that work had been carried out to address the premises issues, the cleanliness to the building had improved and staff had received some supervision. This meant the provider had met the assurances they had given in their action plan and were no longer in breach of the regulations.

People were positive about the service they received. People and their relatives felt the care service was safe. Staff attended to people quickly and there were enough staff to support people with their necessary care needs. However relatives and staff felt more staff were needed to provide therapeutic care for people. Also, staffing could be arranged more effectively to meet people needs at key times of the day.

Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. The provider made sure only suitable staff were employed. People were assisted with their medicines in the right way.

People, relatives and healthcare professionals felt staff were competent to meet people's needs. Staff had the relevant training and support to care for people in the right way. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision. People's safety was protected without compromising their rights to lead an independent lifestyle.

Any changes in people's health needs were referred to the relevant health care services. Health care professionals said the service acted on advice and guidance, and responded to any changes in people's well-being. People felt the quality and choices of meals was good. They were supported to eat and drink enough, and this was monitored if people were at risk of losing weight.

People and relatives felt staff were caring and kind. One person told us, "I have some canny conversations with the staff. They are very friendly." Another person commented, "They are kind." One person said, "They will bring you anything you want."

People were encouraged to make their own decisions and choices wherever they could. There was a sociable atmosphere in the home and there were warm and friendly interactions between people and staff. There were opportunities for people to join in activities, events and trips out.

Staff understood what was important to each person and were familiar with their preferences. Records about people's care needs were up to date and reflected the support each person needed.

People had information about how to make a complaint or comment and these were acted upon. People, family members and staff felt they could approach the registered manager at any time and said she was "supportive". The provider's system for checking the quality and safety of the service was used effectively at this 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?

Requires improvement

The service was safe. Staffing levels were not unsafe but meant that care was task-based. These could be arranged more effectively so that people received more therapeutic care and better support at key times of the day.

The standard of the premises and cleanliness had improved. But it would be better if all housekeeping roles were covered during holidays to make sure this improvement was maintained.

People felt safe at the home and with the staff who supported them. Staff knew how to report any concerns about the safety and welfare of people who lived there. The provider made sure only suitable staff were recruited. People's medicines were managed in the right way.

Is the service effective?

Good

The service was effective. People and their relatives felt staff were skilled and competent in their roles. Staff had training and supervision to support them in the professional development.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

People said they enjoyed their meals and had choices. People were helped to access other health care services whenever this was required, and the home staff worked well with those services.

Is the service caring?

Good

The service was caring. People said staff were caring and kind.

Staff knew people's individual preferences and helped them to make choices if they could not do this. Staff were friendly and supportive when assisting people.

Staff treated people with dignity and respect and supported them with their personal appearance.

Is the service responsive?

Good

The service was responsive. People received care from staff who were familiar and knowledgeable about their individual needs and preferences.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they knew how to make a complaint, and would do this if necessary.

Summary of findings

Is the service well-led?

Good

The service was well led. People and relatives felt the service was well organised. There were opportunities for people to give their comments and suggestions at meetings or individually via the new questionnaire machine in the entrance of the home.

Staff felt supported, enjoyed their jobs and worked well as a team. People and staff felt the culture in this home was friendly and welcoming.

The provider had systems for checking the quality and safety of the care service.

Regents View 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.

This inspection started on 12 August 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a bank inspector, a specialist adviser 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. A second visit was carried out on 13 August 2015 by an adult social care inspector which was announced.

Before our inspection, we reviewed all the information we held about the home. We contacted the commissioners, dietitian and speech and language therapy services, and also the safeguarding team of the local authority before the inspection visit to gain their views of the service provided at this home. We contacted the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with ten people living at the home and eight relatives and other visitors. We spoke with the registered manager, two nurses, four care workers, an activity staff member, two housekeeping staff and two members of catering staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of three staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also joined people for a lunchtime meal in one dining room.

Requires improvement

Is the service safe?

Our findings

At the last inspection of this home we found defects to the premises that presented potential risks to the people who lived there. These included bathrooms in a poor state of repair, exposed drain hole in a shower room and armchairs in the first floor lounge had torn covers. During this inspection we found the premises defects had been addressed, and the building was a safe place for people to live.

At the last inspection we found the provider had breached a regulation relating to the cleanliness of the home. This was because bathrooms and toilets were not well maintained and this meant surfaces could not be kept clean. During this inspection we found bathrooms and toilets had been redecorated and repaired so surfaces were now kept clean. Two bedrooms had an unpleasant odour due to the needs of the occupants. The registered manager was aware of this and told us the carpets to these rooms had been deep cleaned but this had not resolved the issue, so laminate flooring was going to be laid the following day.

Many of the people who lived at the home were living with dementia so found it difficult to express a view about the service they received. The people who were able to comment told us they felt safe living at the home and with the staff who cared for them. One person told us, "They look after me well. I love it here." Relatives also commented on the safety of their family members. One visitor told us, "As far as I am aware my family member is safe."

Staff had a good understanding of how to respond to safeguarding concerns. All the staff we spoke with said they would not hesitate to report any allegations or incidents of abuse. Staff told us, and records confirmed, they received training in safeguarding vulnerable adults. All staff, including ancillary staff, had access to on-line training in safeguarding adults which they were required to complete at least annually. The training records showed that 98% of staff had completed safeguarding adults training within the past year. All the staff we spoke with were familiar with the whistleblowing policy and procedures and felt confident in reporting any concerns they may have.

There had been four safeguarding referrals made by the service since the last inspection, three of which were minor concerns. These were managed appropriately and in liaison with the local authority safeguarding team. The safeguarding officers told us they had no current concerns about the home.

Risks to people's safety and health were assessed and recorded in each person's care files. Care records showed that people were assessed against a range of potential risks, such as choking, falls and skin damage and actions to take in the event of emergency evacuation of the home. The required actions set out in these risk assessments were followed in practice. For instance, people assessed as being at risk of possible skin damage had pressure relieving mattresses on their beds and used pressure relieving cushions on their chairs. Others at risk of falling had floor mats next to their beds with integrated sensory devices linked to the nurse call system to alert staff if the person got out of bed and required assistance. We saw examples of staff putting the outcomes of those assessments into practice. We saw that staff used lifting equipment appropriately and confidently when needed.

The provider had a system to check that equipment was safe. A maintenance person was employed full time. We saw there were daily, weekly, and monthly lists of checks recorded in the maintenance log book. These included checks on radiator surface temperatures, window restrictors, electrical safety and electrical appliances, emergency lighting, and call bell and alarms systems.

People and their visitors had mixed views about the staffing levels in the home. Some people felt there were sufficient staff to manage people's needs. For example, one relative told us they thought there were enough staff to make sure people were safe. They commented, "There is always someone around." Another visitor told us, "I think they have enough staff." Other visitors felt that people using the service would benefit from more staff on duty. Their comments included, "They could do with more staff, they're always rushing around" and "It would be better with more carers". A healthcare professional told us, "It can be difficult to locate a member of staff at times."

We found that the atmosphere in the home was calm, staff responded to people's request in a timely way and call bells were answered quickly. Staff told us that when staff were on holiday or sick it was hard to get cover but that the needs of people were still met and they were not unsafe.

Requires improvement

Is the service safe?

The registered manager explained that a recent drop in occupancy had resulted in reduced staffing levels, but that when the occupancy increased by two more people there would be additional staff on the rota.

At the time of this inspection the staffing levels comprised of two nurses and six care workers through the day, and one nurse and four care workers through the night. The registered manager described how staffing was calculated using a staffing tool, called CHESS. The tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing staffing hours required throughout the day and night. We discussed the need for review of some of the dependency scores with the registered manager. For example one person's mobility and nutrition was scored as 'medium' but the person was immobile.

Staff on the first floor unit felt there was only time for general care tasks so little time to provide therapeutic care, which was consistent with our findings at the last inspection. In addition, the ground floor accommodation had recently been split into two units to incorporate a male-only facility for men with challenging behaviours. Staff felt that this made it more difficult to cover the two areas with only three staff members. Our observations on the day of the inspection were that there were adequate staff on duty to deliver the necessary basic care. However we discussed with the registered manager how the service could consider engaging staff for key busy periods, such as meal times and twilight shifts, to cover peak activity periods more effectively.

In addition, we saw a domestic staff member on the ground floor was also working in the laundry area. We were told this is because the laundry staff member was on holiday this week so domestic staff were expected to carry out this role. The laundry area was seen to be disorganised with a pile of soiled linen waiting to be placed into the washing machines. We discussed with the registered manager cover for all roles when staff were on holiday on order to maintain a suitable standard of service for the people who lived there. The registered manager explained that a bank staff had been appointed to cover laundry and domestic hours but their recruitment clearances were still awaited.

The service benefitted from having a core group of qualified, knowledgeable staff who had worked at the home for several years. At this time there were two part-time vacancies for nursing staff and two care workers were on long term sick leave. These hours were being covered by specific relief staff who were familiar with the home. We looked at the recruitment records of three staff members. We found that recruitment practices were satisfactory and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

Medicines were managed in a safe way by the service. All medicines were being administered by nurses on both floors of the home. Individual photographs of each person were held with medication prescription sheets to aid identification. Each person had a medicines file which included their photograph and details of any allergies as well as the contact details for their doctor and supplying pharmacy. Care plans and protocols were in place for any 'as and when required' (PRN) medicines that people had been prescribed. Each person who was prescribed PRN medicines had a laminated guidance sheet with a list of instructions for staff to follow. These included the dose interval, maximum dose to be administered in twenty four hours, and the reasons for administration by this method.

Medicines were appropriately stored and secured within the medicines trolley or treatment room. The service operated a monitored dosage system of medication. The 'lunchtime' drug round was observed, and took place shortly after most people were being served their lunchtime meal. People were observed or helped with medication, and not left unobserved with medication. We saw medicines were administered in a timely manner. We viewed the medicines administration records (MARs) for six people using the service. These were in good order and daily checks were in place to ensure that all MARs were coded to explain the reason why some medicines had not been administered.

Good

Is the service effective?

Our findings

At the last inspection of this home we found the provider had breached a regulation relating to the support of staff. This was because staff had not been given the chance to meet with a line supervisor to discuss any issues, training needs or professional development. During this inspection we found this had improved and individual staff members had taken part in one-to-one and group supervision sessions with a line supervisor. Supervision planners showed there were more supervision planned at regular intervals. Around two thirds of staff had also had an annual appraisal with the registered manager and the remainder of staff were booked in for this.

One care worker told us, "We are well supported. We have regular supervisions and we have allocated named nurses to do this." Another told us, "I have regular supervision and there are always the nurses to go to if I'm unsure of anything, or support from other colleagues."

People and relatives felt staff were suitably skilled to carry out their roles. One person commented, "The staff all seem competent." One relative told us they were "happy with the care" their family member received and said that "staff do a good job in difficult circumstances". Another relative told us, "Most of the staff have the right skills."

The staff we spoke with said they received sufficient training to carry out their roles. Staff told us they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer-based training system for each staff member to complete annual training courses, called e-learning. One member of staff was a trained trainer in moving and assisting, so they provided practical training for staff about how to support people in the right way when they were being hoisted or mobilising.

This home provided care for people living with dementia and staff had had training in dementia awareness and distress reactions. All care staff, except new staff, had attended a training course called 'Caring for Residents Living with Dementia' which was delivered by the organisation's dementia care advisor. At this time 10 of the 24 care staff had a suitable care qualification such as a diploma or national vocational qualification in health and social care, and other care staff were working towards this qualification. Nurses had suitable training in nursing tasks such as venepuncture and end of life care. Other staff members also had relevant training. For example, the activities co-ordinator had a national qualification in activities, catering staff had training in nutrition and dysphagia, and housekeeping staff had training in infection control.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff understood DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. Over the past year home staff had made 18 DoLS applications to the local authority in respect of people who needed supervision and support at all times, and further applications continued to be made where appropriate.

In people's care records we saw assessments of people's capacity before any decisions were made on their behalf. There were reports of 'best interest' decisions involving other relevant agencies, for example about people's advanced care plans. This meant staff were working collaboratively with the local authority and other care professionals to ensure people's best interests were protected without compromising their rights.

The home had achieved the bronze standard of the PEARL Accreditation Scheme. PEARL stands for Positively Enriching And Enhancing Residents Lives. The PEARL programme is an accreditation programme specifically designed by Four Seasons Health Care to ensure that services are providing the most up to date training, communication and interventions for people living with dementia. The training for staff includes a 'residents' experience' day where staff spend the day as if they were a person living at the home.

There were lots of items of visual and tactile interest for people around the home, such as themed areas and reminiscence artefacts. Some corridors had collages of local scenery, such as former coal mines. There were memory boxes outside bedrooms for people to recognise their own room. There were visual signs for different rooms and coloured doors to bathrooms and toilets for people to find their way around. There were sitting areas in corridors so people could have a rest stop if they were walking. There

Good

Is the service effective?

was easy, level access to a secure, well-maintained garden from the ground floor lounges. This meant the home had some specific design features that supported people with dementia.

People and relatives felt the quality of the meals was "very good". One person told us, "I can choose what I want and I can eat in my room if I want, I can have something else if I don't like it and I get more than enough." A relative told us, "My [family member] seems to like the food. He has a good appetite and eats well."

We joined people for a lunchtime meal and found they were offered at least two main choices of hearty, home-cooked traditional meals. The quality of the food was good, and the meals that were serviced were hot. Food was transported to the male-only unit and the first floor dining rooms by hotlock trolley. There were two sittings on the first floor but the food was kept warm in the trolley for those people on the second sitting.

The staff kept a record of people's weight and monitored people's food and fluid intake if they were at risk of losing weight. There were nutritional care plans for most people to guide staff in providing the right dietary support for people. However, we did note that during this visit one person who had diabetes was offered foods and drinks that had a high sugar content. We told the registered manager about this to make sure staff supported this person in the right way with their diet.

Some people had choking risk assessments where this was appropriate and there was evidence of SALT (speech and language therapy) involvement. Food intake and fluid balance charts were recorded for people, where required. Some staff had attended training in dysphagia (swallowing difficulties) and felt confident about supporting people in the right way with drinks and foods. The catering staff had a list of people's dietary needs, and were knowledgeable about how to prepare soft or pureed foods if people required this.

A speech and language therapist told us, "Some staff went on a specialist dysphagia chef training course which has provided kitchen staff with an increased knowledge of the different national food descriptors and how to prepare these for people in nursing homes. The chef and her team appear interested in SALT input, and quality, homemade food has been observed during visits." The therapist also felt there was a variable degree of understanding amongst care workers about supporting people with their meals and drinks depending on whether they had had the dysphagia training.

Throughout the care records we viewed there was evidence of involvement with other health and social care professionals. The home was part of a local community health care pilot, called the Coalfield Initiative. The initiative aimed to improve primary care and nursing care in care homes and to reduce admissions and readmissions to urgent care. As part of the pilot a local GP and community nurse visited the home every week to check people's health care needs. This helped to ensure people received timely support with any changes in their health, which could also help to prevent some admissions to hospital.

A visiting podiatrist told us they had no issues with the home, and staff were responsive in responding to their guidance regarding treatment options for the people they had seen. An instruction sheet was left for staff detailing the actions and treatments each person required. For example these included for one person a course of antibiotics and for another an air flow mattress to reduce the pressure on their ankles. The nurse in charge was seen and heard to deal with these instructions straight away. This meant the service acted on the advice and guidance of health care services.

Good

Is the service caring?

Our findings

The people we spoke with said staff were caring and kind. One person told us, "I have some canny conversations with the staff. They are very friendly." Another person commented, "They are kind." One person said, "They will bring you anything you want." One relative told us, "The staff are kind and I have not seen anything untoward."

Throughout the inspection staff were observed to interact with residents in a professional, caring and appropriate manner. Assistance with dressing and toileting were carried out in a prompt and friendly way. Staff knew each person well and had a good rapport with them. Staff knew how to help people to manage their behaviour and understood their needs when the person was not always able to articulate themselves very well due to their dementia care needs.

People were encouraged to make their own daily decisions wherever possible. The care records showed that people were prompted to make choices about when to get up and go to bed, what to have for meals and what to wear. Some people had care needs which meant they needed guidance from staff with everyday choices. Staff gave people time to express their choices and wishes. We saw support was carried out at a person's own pace so people were not rushed, although one healthcare visitor told us they had previously witnessed staff being a "bit rushed" at mealtimes where aprons had not been provided so some people ended up with stained clothes and had to be changed.

All the people and visitors we spoke with said staff treated people with dignity and respect. We saw people were supported with their personal appearance. We heard staff complimenting people on their hair, nail polish and clothes in a way that made people feel valued and upheld their self-esteem.

We observed how staff were quick to respond when someone appeared distressed or anxious or in need of some support. For example one gentleman was seen walking down the corridor hanging onto his trousers. A member of staff said, "We will have to find you the belt for your trousers", to which the gentlemen smiled and nodded and walked off with the staff member.

Another person .stated "I'm bored and don't know what to do" A care staff suggested to him, "I'll take you outdoors in your wheelchair during my tea break as the sun is shining", to which the person replied, "That will be lovely so long as the sun is still shining."

A health care professional told us they had seen variable levels of compassion by staff. They told us, "I have seen good rapport with some residents. But at times staff have been observed to hold conversations between themselves rather than communicating with the resident they are assisting." We joined people for a lunchtime meal and also noted that the staff did not converse much with the people they were helping. We told the registered manager about this as a learning point for staff.

Relatives and visitors told us the home had a welcoming, friendly atmosphere and that staff seemed happy in their roles. One relative told us, "The staff always seem cheerful. I have never heard them moaning." Relatives told us how some of the staff would come in on their day off to join in social events and to dress up for the entertainment of people.

The home had a large, private garden which was very well maintained. There was plenty of seating, potted plants, a fish pond and water features. There was a gazebo and other shade for people who might find it too hot and this was a very pleasant place for people to enjoy the fresh air. There was level access into the garden from the two lounges on the ground floor and during our visit people spent time in the garden with support from staff.

The member of maintenance staff and some people had been involved in getting the garden to such a good standard that it had won the regional round of the Four Seasons garden competition and was to be entered into the national competition. Relatives had also been involved by donating items for the garden and there was a sense of collective pride amongst people, relatives and the staff about this achievement.

Good

Is the service responsive?

Our findings

In discussions staff were knowledgeable about each person and were able to describe how they responded to people's needs. We saw staff adapted their approach to each person to meet their differing levels of dementia care and communication needs. For example, one person had had a number of falls and continued to be at high risk of falling because of their poor mobility and dementia care needs. Staff had liaised with the falls team and challenging behaviour to find a way of keeping the person safe without compromising their right to move around the building. Staff were using their knowledge of the person to keep them engaged and frequently took the person around the home in their wheelchair whilst they attended to other tasks.

A healthcare professional told us, "Staff show good knowledge of residents and know where to find relevant information requested [about the person's health]." We also saw the activities co-ordinator had completed life stories of the people who lived there and outside each person's door there was a life history and picture to remind staff about the individual person and significant events in their life.

Since the previous inspection the provider had redesigned the care planning documentation which included a comprehensive set of core and optional care plans. In addition there was another folder specific to each person and kept in their room which contained care charts such as positional change charts and moving and assisting assessments and instructions to staff delivering the care. The new system also included hazard warning stickers that could be placed in the person's room folder which brought staffs' attention to key areas of risk such as moving and assisting, medication management and choking risks. These then directed staff to the relevant care plan in the person's main file which were kept in the office. We discussed with the registered manager how this process might be improved by having a copy of the relevant care plan that related to the hazard stickers in the person's room. In that way staff would not have to leave the person to consult the main file in the office.

We looked at the care records for eight people. The care plans were clear, well written and evaluated on a monthly basis. There was good evidence within the care records that staff were responsive to the individual people's needs.

People who were able to express a view told us about a number of activities they enjoyed at the home. For example one person commented, "I watch TV in the lounge, go out shopping in the mini-bus, and I shop for clothes." Another person said, "I go out in the mini-bus, I love it." One relative commented, "My [family member] loves the animals they bring in. They have a Pat-the-dog comes in, rabbits and all sorts. They have said next time I come I can bring in our dog."

The home employed a full-time activities co-ordinator who was enthusiastic in her role. She described a number of activities and social events that people had enjoyed. These included baking dominoes, cards, games and sensory sessions. The administrator was an aromatherapist and they did hand and arm massages. There were trips out in the minibus, for example to the beach and for fish and chips. There were social and entertainment occasions such as an Hawaiian event. People and staff said they had really enjoyed this and were now planning a pirate themed event.

During the inspection staff were observed to be meeting people's needs such as nutrition, personal hygiene and some individual activities were being carried out such as nail manicures and hair dressing. However we did note there were some people on the first floor who spent much of the time in their own rooms alone without much to stimulate them, and other people were observed to be asleep in the various lounges. The registered manager told us that another member of care staff would be rostered when the occupancy rose by two more people and this would improve the therapeutic support for people.

People and their relatives said they felt able to raise any concerns with the registered manager. One person told us, "I would complain – discreetly." A relative said, "I would go to the manager if I had to." One visitor told us they were satisfied with the way their complaint had been managed by the Care Quality Commission and by the home.

There was information about complaints in the service user guide, which was an information pack given to people or their relatives when they moved into the home. There were also posters in the reception area about how to make comments, complaints or compliments. There had been three concerns or complaints raised since the last inspection. These related to broken laundry equipment (which meant people's washing had to be sent to another home), a moving and assisting concern and the transport and temperature of food to taken to the dining rooms. We

Good

Is the service responsive?

saw written reports of the investigation and actions taken to address these issues. All complaints were recorded on the provider's datix system (a management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Good

Is the service well-led?

Our findings

People and relatives we spoke with felt the service was well organised and rated the service as "good". The only area for improvement raised by relatives was "more staff".

Some people were able to discuss with us how their views about the service were sought. One person told us, "All the time they are asking if I am alright." Some relatives had been involved filling in satisfaction questionnaires in the past. There had been two resident/relative meetings in past two months. The meeting in June 2015 was to inform people about the opening of the male-only unit and relatives who had attended had expressed no concerns about this. Another meeting was advertised for July 2015 but no-one attended.

The provider had introduced a new 'quality of life' feedback system in its services, including Regents View Care Home. People, relatives and other visitors could leave their comments about the home at any time on a computer that was sited in the entrance hallway. The comments would be 'live' so that any critical comments would be emailed immediately to the manager for action and this would be recorded on the system.

People, relatives and other visitors told us the ethos in the home was good and the atmosphere welcoming. All the staff we spoke with were happy in their work and said that the "overall" the company was a good one to work for. Staff commented that they enjoyed their work and worked well as a team. A recently appointed care staff member told us "I have only been working here for three weeks and I just love working here, and everyone has been so helpful and supportive." The staff culture presented as one of friendliness towards people using the service, visitors and colleagues.

The operational and clinical management of the service had recently undergone some changes and staff said this had had a "positive impact on the place". Staff commented that they "look forward to coming to work" and "feel supported in their job". The staff members we spoke with had a number of positive comments regarding the registered manager of the service who came into post at the end of March 2015. For instance one staff member commented that the new manager "was lovely". Others commented how supportive the registered manager was towards all the staff. Staff welcomed the improved opportunity for formal clinical supervision since the last inspection.

There were regular meetings between staff at all levels in the home. We saw staff meetings had been held at monthly intervals. There were also health and safety meetings and governance meetings with key members of staff. Staff felt there was clear and consistent direction from nurses, seniors and management within the home. Some staff took the lead role in additional responsibilities, such as infection control champions and moving and assisting champions to check staff practices were meeting expected standards.

The provider had a quality assurance programme which included monthly visits by a regional manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. The registered manager also kept a weekly management report of any safeguarding or complaint issues, training, recruitment and any other issues that needed to be monitored.

Staff at the home carried out a number of regular audits of the service, including medicines, premises and infection control checks. Many of the checks were now recorded on a new quality tool that involved inputting the information onto an iPad. This computer-based system then analysed the results and identified any actions for improvement. For example, staff carried out a daily medicine tracker using the iPad to ensure all medicines were checked against current stock levels, and any omissions or deficits were immediately highlighted so that remedial action could be taken.

The service acted on recommendations by external agencies where applicable. For instance, a recent audit by the supplying pharmacy recommended an air conditioning unit be installed in the first floor clinical room to reduce the temperature of that room. This had since been installed to ensure room temperatures were maintained according to the required storage temperatures of medicines.

At the end of 2014 commissioners had carried out an audit which scored the service at only 45% against expected standards. Recently the home had been audited again and commissioners told us the service had greatly improved

Good

Is the service well-led?

with the score now 82% against expected standards. This meant the provider and registered manager had made sure the actions required in the commissioners' previous audit had been addressed and put into practice.