PHUL Ltd

Wellington Park Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected the service on 5 January 2016. The inspection was unannounced. At our inspection on 7 May 2014 the service met the Regulations that were looked at on the day.

Wellington Park Nursing Home provides accommodation for up to 30 people who require nursing and personal care. The service supports older people with physical disabilities and dementia. The home has four floors. Bedrooms are located on the first and second floors. On the ground floor there are further bedrooms situated alongside the registered manager's office and a nurse's office and on the lower ground floor there is a living room, dining room and the main kitchen. There is lift access to all floors. On the day of our inspection 29 people were living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 that we spoke with were positive about living at the service and the care that they received. People were treated with warmth and kindness. Staff were aware of people's individual needs and knew how they were to meet those needs.

The service had a number of systems in place in order to monitor and maintain people's safety. Medicines were administered safely to people. There were systems in place to support a thorough recruitment process.

Staff had the knowledge and skills they needed to perform their roles. We saw that staff received supervision and had an opportunity to discuss any queries or concerns with the registered manager. Staff spoke positively about their experiences working at the home and with the registered manager.

People told us that they felt safe. The registered manager and staff understood how to protect people from abuse and knew what procedures to follow to report any concerns.

People's nutritional and hydration needs were being met. However, whilst observing lunch we noted that people who required assistance within their own room, had to wait up to 30 minutes before a member of staff supported them with their meal, with their meal being left in their room on a bed side table.

Food looked appetising and the chef manager was aware of any special diets people required either as a result of a medical need or a cultural preference. People and relatives spoke positively about the food at the home.

Care plans were detailed and person centred. People's health and social care needs had been appropriately assessed. Risks associated with people's care were identified and plans were in place to minimise the potential risk to people. Most of these care plans had been reviewed and updated where necessary. However, there were a few care plans where significant change had been noted but this had not been updated within the person's care plan.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected.

An activity plan was on display within the home outlining a variety of different activities that were due to take place over the week. An activity team consisting of three staff members who were responsible for delivering activities within the home. However, on the day of the inspection we observed very little activity taking place.

People using the service and their relatives were positive about the registered manager and the overall management of the home. The service had an open and transparent culture where people were encouraged to have their say and staff were supported to improve their practice.

There was a system in place to monitor and improve the quality of the service which included feedback from people who used the service, staff meetings and a programme of audits and checks.

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?
The service was safe.

Staff were aware of what constitutes abuse and what steps they would take to protect people. Risks to people were identified and managed so that people were safe and their freedom supported and protected.

There were sufficient numbers of staff to meet people's needs.

Safe recruitment processes were followed and the required checks were undertaken prior to staff starting work.

People were support to have their medicines safely.

Good

Is the service effective?
The service was effective. People were provided with a healthy and balanced diet which allowed for choice and preference. However, some people who were supported in their own bedrooms had to wait up to 30 minutes before a staff member assisted them with their meal.

Staff received training to provide them with the skills and knowledge to care for people effectively.

The registered manager and staff members had sound knowledge of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and its importance.

People had access to health and social care professionals to make sure they received appropriate care and treatment.

Good

Is the service caring?
The service was caring. People were treated with kindness and compassion.

People were treated with respect and dignity.

People and their representatives were supported to make informed decisions about their care and support.

Good

Is the service responsive?
The service was responsive.

Care plans were person centred and reflected how people were supported to receive care and treatment in accordance with their needs and preferences.

The home had a complaints procedure and people and their relatives were aware of who to talk to if they had any concerns.

Good

Is the service well-led?
The service was well-led. Relatives and care professionals informed us that the registered manager was approachable.

Staff were positive about the management of the home and felt supported in their role.

Good

Summary of findings

The quality of the service was monitored as regular audits had been carried out by the registered manager.

The service had a system of monitoring the quality of care.

Wellington Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 January 2016 and was unannounced.

The inspection team included one inspector, one specialist advisor nurse, a pharmacist inspector 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.

Before the inspection we reviewed information we held about the provider including notifications and incidents affecting the safety and well-being of people using the service. We also contacted Healthwatch Enfield, the local authority commissioning team and social workers for their views about the home. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

During this inspection we observed how staff interacted with and supported people who used the service. We reviewed 12 care plans, seven staff files, training records and records relating to the management of the service such as policies, audits, risk assessments, meeting minutes, medicine records as well as health and safety documents. We spoke with ten people who used the service and three relatives. We also spoke with the registered manager, owners of the service, a GP and seven staff members.

Good

Is the service safe?

Our findings

People told us that they felt safe in the home and staff treated them well. One person said, “I’m safe here.” Another person when asked if they felt safe told us, “Yes, I think so.”

Staff were aware of what constitutes abuse and the action they must take. Staff told us that they would report any allegation of abuse it to the registered manager. One staff member told us, “If there is a concern I have to talk to my employer.” All staff had received training in safeguarding adults and this was reviewed annually. Staff understood the term ‘whistleblowing’ and to whom this must be reported to. Staff were aware that they would need to report this, even if this involved a colleague with whom they worked with. They were also aware that they could report any concerns to the local authority safeguarding department and the Care Quality Commission (CQC). The service had a safeguarding policy and whistleblowing policy which included details of the local safeguarding team and the CQC.

We spoke with the registered manager about how they determined staffing levels within the home. The registered manager told us, “Staffing is decided on the basis of the number of service users living at the home and their level of need assessment.” The registered manager went on to tell us that they would review this where any changes were noted and the provider was very supportive and responsive in relation to staffing levels and visited the service at least twice a week. On the day of our inspection we observed that staff did not appear to be rushed and were able to complete their tasks. The service did not use any external agency staff and where required used their own pool of staff to cover shifts.

Effective recruitment procedures were in place to ensure people were safe. We looked at the recruitment records of seven staff and found appropriate background checks including criminal record checks. Two written references and proof of their identity and right to work in the United Kingdom had also been obtained. References were verified by the administrator by confirming with the referee to that they had themselves completed the reference. The provider also ensured that they held records of nurses registration with the Nursing and Midwifery Council, their pin numbers and dates of when these were due to expire so that nurses employed by the provider were reminded to renew their registration.

The care needs of people who used the service had been assessed and comprehensive and current risk assessment and management plans were in place. Risk management plans were specific to the individual and were clear and evidence based. These covered areas such as moving and handling, falls/slips/trips, use of call bells, skin integrity and health and safety. It was also positive to note that in people’s rooms there was advice and guidance for staff members on choking and food consistency in relation to that person’s swallowing requirements.

People's medicines were managed so that they were protected against the risk of unsafe administration of medicines. There were appropriate instructions on Medication Administration Records (MAR) and other documentations in individual care plans to ensure that safe process for medicines management and administrations were followed. This included people receiving their medicines via a feeding tube. Medicines administration was audited monthly and staff competency to administer medicines was also assessed as part of staff competency training. Staff told us that the GP visited weekly as well as when needed and undertook monthly medicines reviews at the end of every MAR cycle. We saw documented evidence of these reviews in care plans.

Medicines were stored securely including controlled drugs. There were records of daily room and fridge temperatures monitoring, however on the day of inspection staff told us that the fridge thermometer had broken and was sent for repair. Medicines administration records (MAR) were clear and administrations were accurately recorded. Medicines received from the pharmacy were recorded in the MAR charts and the quantity could be reconciled with the administration record.

Records on people’s care plans confirmed that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed. Also those with high risk medical conditions such as raised blood pressure and diabetes were appropriately monitored.

Staff told us how they rotated the sites used for administering medicines supplied in patch form. There were also detailed medication plans for staff to follow for medicines administered only when needed. Staff told us how they carried out regular pain assessment for people who were not able to communicate by observing facial expressions. We also observed that staff administered the lunch time medication appropriately.

Good

Is the service safe?

In the clinical rooms, there was evidence that recent alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) had been implemented.

People had call bells to enable them to summon assistance if needed. We saw risk assessments in place for those people who were unable to use a call bell. This ensured that people were kept safe whilst encouraging them to be as independent as possible. People also told us that when they pressed the bell someone always came to support them.

Standardised tools were used such as Waterlow, to assess pressure risk, food and fluid charts, Malnutrition Universal Screening Tool (MUST), catheter monitoring charts and nutritional assessments to ensure where people were at risk of weight loss or pressure sores that this was managed appropriately and that the person had access to appropriate equipment and resources to support or heal their condition.

Accident and incident records which had detailed information about the incident, any treatment given, remedial action taken and details of any investigation and follow up actions that were required. The service also completed an analysis of all accidents and incidents which was presented to staff every month with recommendations and advice to support staff in order to highlight any emerging patterns and prevent any re-occurrences.

Risk assessments regarding the safety and security of the premises. We spoke with the maintenance officer who showed us records of health and safety checks of the building. These included gas, electrical and fire safety systems. Fire safety checks were completed daily, weekly and quarterly. Hoists, slings, wheelchairs and stair lifts used to support people were regularly checked. The service had recently carried out a fire evacuation drill which had highlighted issues around staff knowledge and awareness. This was highlighted to the registered manager who immediately organised training for all staff members.

There were clear evacuation plans for all people who were using the service. The plans were attached to the bedroom door of every person. People were categorised into three colour coded groups. People who were coded as green were able to self-evacuate, people coded amber were people who were able to walk and may be able to follow instruction but may become non-compliant and present unpredictable behaviour. Any person colour coded as red, referred to people who were wheelchair users or required hoist transfers.

During our visit we checked communal areas of the service which were all clean and well maintained. There were detailed infection control procedures and staff and nurses demonstrated a good understanding of infection control and how this should be managed within the home. Staff were observed making used of personal protective equipment efficiently. Posters demonstrating effective hand-washing techniques were on display around the home. Housekeeping staff kept records of their daily cleaning activity as well as monthly deep cleaning records.

Good

Is the service effective?

Our findings

People told us that the care they received was good and that staff knew what they were doing and how to support them which took into consideration each individuals needs and requirements. One person told us, "They all do a good job" and "They are very professional."

Mandatory training was provided in the following areas: manual handling, first aid, health and safety, infection control and person centred care. Training records confirmed that staff had completed training in additional areas that helped them when supporting people living at the home. Topics included medicines administration, adult abuse, understanding dignity, fire training, dying, death and bereavement, nutrition and diet and many others. The training matrix recorded when staff had completed training and when they were due for refresher training. Staff also confirmed that they received regular training.

The provider had an induction programme in place for all new staff members employed by the service. This followed the principles of the Care Certificate which was introduced in April 2015. New staff members receive all specific mandatory training within the first five weeks of starting their role. The induction programme was then completed in its entirety within the first 12 weeks of the persons start date.

Records showed that staff were receiving regular supervision and staff members that we spoke with were also able to confirm this. Staff also confirmed that they had received annual appraisals and we saw records that these had taken place. Staff were given the opportunity to review their personal development and progress. The registered manager had kept a supervision matrix which evidenced that staff members were receiving up to six supervisions per year as per the provider's supervision policy.

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). The service had policies and procedures in relation to the MCA and DoLS. The registered manager and staff members demonstrated a good understanding of the MCA and DoLS and issues relating to consent.

Care plans showed that consent to care was sought from people thus giving people the opportunity to be involved in all decision making processes where appropriate. Where this was not possible people's representatives were involved in any decision making process. A general tick box consent form had been completed for each person, which covered support with personal care, general care and treatment and permission to take photographs. However, some care plans did not always reflect adequately the involvement of people and their representatives.

Staff were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and care professionals would be involved in making a decision in the person's best interest. One staff member told us, "The MCA is about assessing the ability of a resident to make decisions for themselves."

The service had applied to the local authority for a DoLS for each person to whom it applied. Some authorisations had been granted and the registered manager had notified CQC of this. Some DoLS applications were still awaiting authorisation. The registered manager also completed a monthly audit to ensure where an authorisation was due to expire that a re-application was made to review and renew the authorisation where required.

Some people using the service had do not attempt cardio-pulmonary resuscitation (DNACPR) orders on their care plan. DNACPR orders alert staff and other healthcare professionals that if a person's heart stopped they would not want to be resuscitated or any resuscitation would not be in their best interest. DNACPR forms had been completed appropriately with clear evidence of a multi-disciplinary approach being taken in order to reach the decision especially where a person lacked capacity. There was also evidence that these were reviewed on a regular basis.

People spoke positively about the food provided. One person told us, "The food is excellent" and "The food is very good and they give us a choice." Another person told us, "It

Good

Is the service effective?

is like home-cooked food." One relative told us that, "staff made an effort to ensure that everyone came to the dining room or lounge for their meal which was better than the previous home where their relative had been placed where they did not even bother to transfer the person into a chair." We saw that there were plenty of drinks available and a variety from which people were able to choose what they wanted. We also saw that drinks were available in people's rooms.

Meal times within the home were protected whereby visitors, relatives, friends and any visiting professional were advised to avoid visiting the home during the designated meal time. A menu for the day was on display in the dining area which also gave information about an alternative menu and a 'nite bite' menu for people who wanted a snack during the late evening or throughout the night. People could choose where they wanted to sit with some choosing to sit in the dining room and some choosing to sit in the lounge area. Some people chose to have their meals delivered to their room.

Some people required support with their meal in their room. On the day of the inspection we observed that people's meals were taken to their room and left on their bed side table for up to 30 minutes before that person receiving any support. We highlighted this to the registered manager and the provider who assured us that they would ensure that a system is in place to ensure people within their own rooms are supported appropriately.

The chef manager was aware of what soft and pureed diets should consist of and these were prepared fresh on a daily basis and presented on the plate whereby people could identify what each food item was. We saw that seasonal menus were set by the chef manager based on people's likes and dislikes. These were then presented to people and their relatives at the residents and relatives meetings for comment and feedback. People were given two options per meal and chose the day before. Staff did confirm that if a person did not like or want the meal they had chosen on the day, an alternative would be offered.

During the meal time we observed there to be a calm atmosphere within the dining and lounge area. There was no music playing in the background and there was very little interaction in terms of staff talking to people. The little interaction we did see was positive. One staff member asked a person they were supporting, "Taste this and tell me if it is nice?" and another staff member was heard asking a person, "Is it good?"

People's weights were checked regularly and recorded. Staff recorded food and fluid intake where appropriate. Appropriate referrals were made to speech and language therapists and diabetic service where needed. Staff we spoke with also demonstrated good knowledge and understanding of why food thickeners were used for and which people were prescribed it as well as what amount of fluid to put with the amount of thickener as per medical advice given.

The kitchen was clean and we noted that sufficient quantities of food was available. Further, we checked a sample of food stored in the kitchen and saw that they were all within their expiry date. Food that had been opened was appropriately labelled with the date they were opened. The kitchen had designated food preparation areas for preparation of meat and vegetables. The service had also received a five star rating for the Environmental Health Agency as a result of a recent inspection.

People were supported to maintain good health and had access to a variety of healthcare services which included GP's, opticians, chiropodists, physiotherapists, psychiatrists and tissue viability nurses. Records were also seen of physical health checks which included results of blood tests, monthly blood sugar level check for clients that were diet controlled diabetics and weekly blood pressure checks. People were also supported to attend diabetic eye screening appointments on an annual basis. We also saw evidence that following appointments, people's care plans were updated accordingly.

People's bedrooms were personalised with pictures, personal items of interest, photographs, flowers, televisions and radios. The provider had also ensured that matching bed linen and curtains were available in each bedroom. People's names were on their bedroom door along with the name of their allocated nurse and key worker. People were free to move around the home as they so wished. Some people liked to smoke and so a seating area outside the front of the home was provided for people to access.

Good

Is the service effective?

The provider had most recently developed the back of the home into an accessible garden area. Wheel chair access was available alongside a stair lift for people to have access to the emergency area in the car park.

Good

Is the service caring?

Our findings

People told us that staff that supported them were kind and caring. People made comments which included, "the staff were kind," "they are very caring" and "I can't praise them enough." One person told us "I get everything I want." Relatives that we spoke with also confirmed how people felt about the care they received. One relative told us, "most of the staff are really friendly and really nice" and another relative said "that their relatives care couldn't be better."

During our visit we observed interaction between staff and people living in the home. People were relaxed with staff. Some staff interacted positively with people, showing them kindness, patience and respect while others were more practical and task focused. Some staff took their time and gave people encouragement whilst supporting them. People had free movement around the home and could choose where to sit and spend their recreational time. People were able to spend time the way they wanted to.

People's needs and preferences were understood. Most staff were aware of what person centred care was and were aware of individual needs when asked about the care people required. We were aware that a female person had received care and support from a male carer. When asked if they had any objection to this they responded "I do not mind, they are very professional." We also made note that a male person had received support from a female carer. Again on asking if they opposed this they replied "they did not mind."

Life history work had been undertaken in the form of life style profiles. This included information about their lifestyle from childhood, their choices, likes, dislikes and preferences. People also had one page "My Name is ….." posters which contained detailed information about the person including their likes and dislikes. However, this was not consistent for all the bedrooms we visited. We highlighted this to the provider who stated they would ensure that each person had this information available in their room. The provider also told us that plans for the future included looking into developing memory boxes and books especially for those people living with dementia.

Staff understood that people's diversity was important and something that needed to be upheld and valued. Care plans took account of people's diverse needs in terms of their culture, religion and gender to ensure that these needs were respected. This information was detailed in people's care plans. The registered manager told us that the vicar/priest visited the home on a weekly basis. People confirmed this and told us that a representative from the church visited the home. People had the option to have mass held within the privacy of their own room. Other people told us that they were not so bothered about receiving a visit from the church.

We saw people being treated with respect and dignity. The service had appointed dignity champions who took a lead in this subject area, guided and supported other staff members to promote peoples dignity and self-respect. The service also provided dignity and respect training and future dates had been advertised for staff members to attend.

We observed staff respecting people's privacy through knocking on people's bedroom doors before entering. People also confirmed this and told us, "Staff always knock on the door" and another person told us, "Ask permission? No they don't have to, they don't have to knock on my door as my door is always open for them." We also observed staff making use of a screen to surround people when they were being hoisted in order to maintain their privacy and dignity.

Relatives and friends were able to visit at any time. Relatives told us that they felt involved in care planning and were confident their comments and concerns would be acted upon. The home had a variety of leaflets available for relatives and visitors which included information on advocacy services, financial support and information about dementia and bereavement services where required.

People had end of life care plans as part of their main care plan. These were detailed and well documented outlining people's choice and preference for their end of life care. One person told us that their "representative", visited regularly along with their partner. They also told us that the representative's partner did not want to be involved in any plans for when they pass away as they were "too emotional." The person told us, "My representative knows what I want."

Good

Is the service responsive?

Our findings

People told us that they received care, support and treatment when they required it. They said staff listened to them and responded to their needs. One person told us, "I am well satisfied" and another person told us, "Even in the night if I ring they come and help me." A third person told us, "I get everything I want." One relative told us, "Our relative can be quite difficult, the home has managed this." All people and relatives that we spoke with told us that they felt able to raise concerns and issues with management if they needed to. One relative told us, "I could complain where required."

People's complaints and comments were recorded in a 'verbal complaint record' and 'niggles complaint record'. This included information about the nature of the complaint, what steps were taken to resolve the complaint and the response provided to the complainant. Information about how to make a complaint was on display at the entrance of the home.

Pre-admission assessment documents were available on file for people whose care plans were looked at. Prior to admission each person was individually assessed by a member of the management team. The registered manager explained to us that these assessments were important as it helped determine whether the home was able to meet the person's individual needs.

Care plans reflected how people were supported to receive care and treatment in accordance with their needs and preferences. Care plan were seen to be comprehensive where needs were clearly stated and were focused on the individual. Information provided included emotional and mental well-being, administration of medicines, behavioural assessment tools, future decision planning, nutrition needs, skin care, breathing and circulation and more. Most care plans were reviewed regularly however, there were a small number of care plans where there had been significant change and this had not been updated within the care plans. We highlighted this to the registered manager who assured us they would look into this immediately.

There was evidence that people and their relatives were involved in completing their care support plan. Relatives that we spoke with also confirmed that they were involved in care planning. We saw that care plans had been signed by people or their relatives to show that they had agreed to the care they received.

Each person, as part of their care planning document, had a daily life and review book. These were completed by nurses and care staff on duty on a daily basis. Information about the person and how they had been on the day and any significant change was recorded within this book on a daily basis. This document was also used as part of staff handover when there was a staff shift change.

The home employed three activity co-ordinators. On the lower ground floor, there were photos on display of the most recent activities that had taken place within the home. An activity planner was also available outlining what activities had been scheduled over the week. There was also a poster advertising a planned entertainer that was due to visit over the forthcoming week, One person we spoke with told us, "One of the carers organises activities and if you want to join you join." On the day of the inspection we observed that the activity co-ordinator who was on duty had established very good relationships with people, understanding their needs and their characters.

During an observation in the afternoon it was positive to note the impact one of the kitchen staff had on people when they entered the living area. They spoke to each person individually, asked them how they were and was very warm and affectionate towards people. We observed the positive impact this had on people and how this left people in positive well-being.

However, on the day of the inspection we observed very little in terms of activities taking place.

During the afternoon we again observed very little interaction between staff and people and the atmosphere felt very task orientated opposed to being individualised and person centred.

Residents and relatives meetings were carried out every two months. Although, the registered manager explained that if on a particular day there was high number of people actively engaged he would hold an ad-hoc meeting so that there was maximum participation. Items discussed included staffing, quality assurance survey results, staff

Good

Is the service responsive?

training, winter menus and care plan reviews. People also confirmed that regular resident meetings were held and they could give requests and feedback as part of the meeting.

Good

Is the service well-led?

Our findings

People told us that they knew who the registered manager was and found them approachable and understanding. One person told us, "The manager is always there for you and If any problem the manager will sort it" and another person told us, "The home and the manager communicate well and the manager has been excellent with our relative." Staff also spoke positively about working at the home. Staff told us that they were very happy with their job and the interaction with the management was very good. Visiting care professionals including a GP also spoke positively about the registered manager and the management within the home. The GP told us, "We work together as a team and if I had any concerns I would speak to the registered manager."

Staff told us that morale within the home was good. One staff member told us, "I love it here, it is a lovely family home." Staff told us that the team worked well together. They also told us that the registered manager and management overall were approachable and they could discuss problems and care issues with them. There was a clear management structure in place and the registered manager and care staff were aware of their roles and responsibilities. Some of the staff we spoke with had worked at the home for a number of years.

At the entrance of the home photographs had been displayed of all staff members including the senior management team and nurses, the activity team, the kitchen team and the domestic team so that people, relatives and visitors could identify staff visible around the home. Also included on the display were photographs of external visiting health care professionals including the GP, chiropodist, optician, beauty therapist and hairdresser.

We found that there was clear communication between the staff team and the managers of the service. Alongside daily handover sessions the registered manager also held daily briefing sessions with staff which were recorded. The registered manager explained that because he tries to ensure that a daily briefing session takes place, staff meetings were not held as frequently with the last one being held in April 2015. However, the registered manager also held quarterly nurses meetings, which covered topics such as care plans, medicine management, and care plan reviews.

In addition to this the registered manager also had implemented 'Walk the floor' reports which managers on duty were to complete especially on the days where the registered manager was not available at the home. These would then be handed in to the registered manager who would check on their return to ensure that he was kept abreast of any developments or changes with people's needs or the running of the service.

The service had a comprehensive range of policies and procedures necessary for the running of the service to ensure that staff were provided with appropriate guidance. In addition the service also produced monthly newsletters to keep people, relatives and visitors updated on any developments within the home.

There were systems in place to ensure that the service sought people's views about the care provided at the home. Surveys had been developed which covered areas such as food, dignity and privacy, housekeeping and laundry services and daily living. A survey for one particular topic was carried out every quarter. The results were then collated and an analysis and actions taken as a result were displayed in the main entrance for relatives and visitors to have a look at. The feedback received was noted to be positive. A compliments book was also available at the entrance. A recent entry stated, "Helpful, friendly, caring staff. Have cared for my relative very well and their health has improved greatly."

The service undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. In the registered managers office a quality calendar was displayed on the wall which outlined every month the type of audit that was scheduled for the registered manager to complete. This covered areas such as medicine management, infection control, care plans, nutrition, dignity, accidents and incidents. We saw evidence that these audits and checks had been completed by the registered manager and in some cases the provider.

The home is a member of the National Activity Provider's Association and also has active links with the community which includes visits from children from local schools, ladies visiting people from the local church and support from volunteers especially from relatives who used to have links to people who lived at the home. The service has also

Good

Is the service well-led?

maintained links with local neighbouring care homes and the local church who are included in the services business continuity plan so that they could support the care home in case of an emergency.