London Residential Healthcare Limited

Steep House 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

Summary of findings

Overall summary

The inspection took place on 4 and 5 January 2018. It was unannounced.

Following our last inspection in September 2016, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and responsive to at least good. At this inspection we found the required improvements had been made and sustained.

Steep House Nursing Home is a care home service with nursing. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. We looked at both during this inspection.

The home accommodates up to 56 people across three floors. At the time of our visit there were 52 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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.

Arrangements were in place to make sure people received care, support and treatment safely. These included processes to identify, manage and avoid risks to people's welfare and wellbeing in ways that did not restrict their freedom unnecessarily. There were enough staff with the right skills who had been assessed for their suitability to work in a care setting. Processes for the management of medicines and prevention and control of infection were in place. If things went wrong, the provider reflected on the experience and identified ways to improve the service.

People received care, support and treatment which were based on effective assessments and care plans which were thorough and based on guidance and good practice. Staff were supported by training and supervision to deliver a high standard of service. Food and menus offered choice and were adapted to meet people's individual needs and preferences. The service worked with a variety of agencies and services to support people's wellbeing and access to healthcare services when needed. The premises were maintained to a good standard with adaptations and decoration suitable to meet the needs of people. Staff were aware of the need to seek consent for care and of the legal requirements where people did not have capacity to consent.

Staff supported people with kindness and compassion, providing emotional support when needed. Staff supported people to express their views and take part in decisions about their care, taking into account people's individual communication needs. There was appropriate focus on respecting people's privacy, dignity and independence.

People received care, support and treatment which met their needs and reflected their preferences. There had been particular focus on improving people's care records and providing high quality care at the end of people's lives. People's wellbeing was supported by a range of leisure activities and entertainments, including access to the community. People's individual communication needs were taken into account. The provider used feedback from people and their families to improve the service they received.

There was effective leadership and team working based on a clearly communicated vision to deliver high quality care. This was supported by an effective system of governance, and thorough and wide-ranging quality assurance processes. Outputs from these processes together with the results of engagement from various stakeholders were used as the basis of actions to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected against risks to their health and wellbeing, including the risks of avoidable harm and abuse.

There were sufficient numbers of suitable staff to support people safely.

There were appropriate processes to manage medicines and to maintain standards of cleanliness and hygiene to prevent the risk of infection.

Is the service effective?

Good

The service was effective.

People's assessments and care planning were evidence-based and led to good outcomes.

Staff had the required skills, knowledge, experience, including around consent and mental capacity.

The service worked with other agencies and professionals to deliver a high standard of care which took into account people's healthcare and nutritional needs.

People lived in premises that were well maintained and adapted to their needs.

Is the service caring?

Good

The service was caring.

People were supported in a caring, compassionate environment where their independence, privacy and individual dignity were respected.

People were supported to make their views and opinions known and to take part when decisions were made about their care.

Is the service responsive?

Good

The service was responsive.

People's care, support and treatment took into account their needs and preferences.

People's wider wellbeing was supported by access to activities which enhanced their quality of life.

There was a complaints process, but people's concerns were dealt with before they became complaints.

Is the service well-led?

Good

The service was well led.

People could be confident the provider's vision and governance were focused on providing high quality care and support, with a focus on continuous improvement.

Systems were in place to engage with people and to monitor, assess and improve the quality of service.

Steep House 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 4 and 5 January 2018 and was unannounced.

The inspection team comprised an inspection manager and two inspectors.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We used information the provider sent us in the Provider Information Return. 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 spoke with five people who lived at Steep House Nursing Home and eight visitors. We observed care and support people received in the shared area of the home, including part of a medicines round.

We spoke with the registered manager, the operations director, and nine members of staff, including the head of care, three care workers, two registered nurses, an activities coordinator, chef and housekeeper. We also spoke with a visiting healthcare professional.

We looked at the care plans and associated records of nine people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, quality assurance survey returns and reports, training and supervision records, medicine administration records, mental capacity assessments, four people's records of Deprivation of Liberty applications and authorizations, and recruitment records for three staff members.

After the inspection, the registered manager sent us softcopy versions of training records, electrical safety checks and a fire risk assessment.

Good

Is the service safe?

Our findings

When we inspected Steep House Nursing Home in September 2016, we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have records to show that they made all the necessary recruitment checks before staff started working. At this inspection we found the provider had taken steps to comply with this regulation, and there was no longer a breach.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. The registered manager described a robust recruitment process, which was followed by an induction. The registered manager signed off the induction checklists for new staff, which allowed them to be confident staff were competent to support people safely.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff. One person said, "Staff always come when I call." Staff told us their workload was manageable. We saw staff were able to carry out their duties in a calm, professional manner without rushing, and were able to spend time engaging with people.

People told us they felt safe at the home. One said, "I do feel safe. It is just when you get to my age you feel a little vulnerable." Visitors told us there was a "very safe" environment. One visitor said they could "walk out and relax" knowing their relation had 24/7 support. Another visitor said it was a "weight off my mind" since their loved one was living at Steep House Nursing Home.

The provider took steps to protect people from the risks of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the provider.

The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse, including notifying us and other relevant agencies. Suitable procedures and policies were in place for staff to refer to. Records showed there had been one safeguarding concern raised in the 12 months before our inspection. It had been followed up appropriately and closed by the local safeguarding authority.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with falls, pressure injuries, and individual medical conditions such as diabetes and epilepsy. Where people were living with diabetes, their associated risk assessment was interlocked with their personal care plans and medicines records. Where people were living with epilepsy, there was information about medicines prescribed to be taken in the event of a seizure, and seizure diaries were in place.

The provider carried out monthly and weekly checks to monitor the safety of the premises and equipment. These included lights, emergency lighting, large items of furniture, windows, call bells, hot and cold water outlets, fire alarms, fire extinguishers and wheelchairs. The provider had recently introduced a new health and safety book, which included electrical testing of portable appliances. Records were in place for regular checks and maintenance of utilities and facilities. These included lifts, water supply, electrical and gas safety, laundry equipment and the nurse call system. The provider took steps to make sure people were living in a safe environment.

People told us they were happy they received their medicines as prescribed and at the correct time. Appropriate arrangements were in place for the safe storage, handling and administration of medicines. Registered nurses administered people's medicines appropriately and took their time to be certain the person had swallowed their tablets before moving on to the next person.

There was a medicines trolley for each floor which was kept in a secure location when not in use. People's medicines records were clear, complete and up to date. Where there were specific instructions for certain medicines, records were in place to show people received these as prescribed. Staff used body maps to record where and how skin patches had been applied.

There were internal and external checks on how medicines were managed. Internal checks made sure medicines were administered as prescribed and according to guidance. In addition there were external audits by the provider's pharmacist. People's medicines were reviewed annually with the person's GP and the community mental health team to make sure their prescription was still valid.

Staff were aware of their responsibilities in the areas of cleanliness, hygiene and infection control. A visitor told us, "The major thing is it is clean. They are very keen on cleanliness. You don't get bad smells." There was a programme of routine daily cleaning of people's rooms and shared areas of the home, supplemented by regular deep cleaning and infection control checks monitored by the head of housekeeping.

Personal protective equipment, in the form of gloves and aprons, and hand sanitizers were available throughout the home. We saw staff followed good practice to maintain hygiene and avoid the risk of infection. The provider kept a focus on this area by weekly infection control updates for staff.

The provider used incidents, accidents and near misses to learn lessons and improve the service people experienced. Staff kept records of accidents and incidents and these were audited monthly to identify trends or patterns. The registered manager and staff reflected on incidents where people's experience could have been better in order to identify improvements. One person had fallen from their chair, and the provider worked with the person to identify a new chair which reduced the risk of them falling again. People benefited from a service in which improvements followed on from learning about incidents.

Good

Is the service effective?

Our findings

People and their visitors told us people's care and treatment led to good outcomes and that all their nursing needs were met at Steep House Nursing Home. One person said, "Staff seem to know exactly what to do." Another person's visiting family considered their loved one had better nursing care, with better outcomes, at the home than they had experienced in hospital.

People's care, support and treatment were based on thorough and detailed assessments. The assessments included medicines, communication, mobility and personal safety. During the assessment staff referred to the person's medical history, any hospital discharge letter, and spoke with the person's family.

Care plans based on people's initial assessments covered a total of 15 care domains and took into account relevant guidance from the National Institute for Health and Care Excellence. The provider reviewed people's care plans with their GP to confirm they included what was necessary for people's healthcare and wellbeing. Wound care plans were in place to inform the treatment of skin flaps, pressure injuries, and ulcers. These reflected good practice, for instance in the use of body maps.

People living at Steep House Nursing Home and their visitors were confident staff had the skills and knowledge to support people according to their needs. Staff were satisfied they received appropriate and timely training and had regular supervision meetings. There was regular refresher training in subjects the provider considered mandatory. These courses were available to all staff, in addition to training in equality, diversity and human rights, behaviour that challenges, safeguarding, dementia, food hygiene and infection control.

Induction and training for care workers was based on the Care Certificate, which is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The registered manager had an effective system for monitoring staff training. Their records showed clearly where staff had completed training, where it was due and where it was overdue.
Staff had annual appraisals and four to six supervisions a year. Records for staff appraisals and supervisions were in place. The registered manager used supervisions to identify training needs. Specific training offered to staff included diabetes, epilepsy, catheterisation, pressure injury care, wound care and dysphagia.

Staff were supported to obtain relevant qualifications and diplomas via in-house training, and registered nurses were supported to complete their continuing professional development and maintain their registration. People could be confident they were supported by staff with the necessary expertise and qualifications.

The provider supported people to eat and drink enough and to maintain a healthy diet. Visitors told us the food was good, people ate well, and special diets such as soft or liquidised food were available. There was a

choice of menu, and other items were offered if people did not like any of the options. The chef linked menus and food options to food events in the calendar, such as Burns' Night, Shrove Tuesday, British Pie Week, and Spam Appreciation Week. This added variety to people's diet and encouraged them to eat enough.

The chef was aware of people's specific dietary needs, such as diabetes, soft diet and slimming diet. They checked regularly with the head of care so they were informed about people's changing needs, and the needs and preferences of people recently moved in to the home. Where appropriate, the recommendations of speech and language therapists were taken into account with respect to people's diet, how their food was presented, and how to assist people to eat their meals.

If people were at risk of poor nutrition, staff recorded their daily food and fluid intake. There were monthly checks on their nutrition risk, using a standard assessment and screening tool.

The provider worked in cooperation with other services to deliver effective care. Care plans benefited from input from the community nursing team, community mental health team and charities specialising in Alzheimer's and Parkinson's disease. At the time of our visit the head of care had qualified as a "dementia friends champion". This meant they were qualified to train and certify colleagues and others as "dementia friends".

The service worked closely with speech and language, physical and occupational therapists. Where there were concerns about people's skin health staff also kept in touch with specialist nurses via email. There were regular visits by opticians, chiropodists, and by a masseuse and a therapy dog. Pets as Therapy is a charity which introduces people with suitable dogs to health and social care services where people's wellbeing is enhanced by visits from the pet. Staff saw these services as part of a wider team. One staff member said, "We help each other. The opticians come in and listen to us about how [people] are wearing their glasses." Staff shared guidance and information internally via shift handovers and staff meetings.

People had access to other healthcare services when they needed them. A visitor said, "If they are at all concerned, they call in the GP." A local GP called once a week. Staff prepared a list of those people who needed a consultation and had the necessary information available for the GP. Where the GP gave advice and guidance, this was listened to and passed on amongst the staff team.

The provider had adapted and decorated the premises with people's needs in mind. The overall impression was that the building was clean, light and spacious. The provider had listened to people's requests and furnished one of the shared lounges in a "retro" style with older radios and other furnishings they had sourced online. They had also built an aviary and fish pond in the enclosed garden to improve people's sense of wellbeing. There was a quiet lounge which was also used as a private space for when people had visitors. People's rooms were personalised with memorabilia reflecting their memories and interests.

People told us staff were conscious of the need to seek consent for care and treatment. One person said, "They always know they need consent." Another person said, "Staff need permission before giving care to me." Records showed that where people were able to, they had agreed to their care plan and signed to that effect. We saw staff supporting people to make everyday choices, for instance about what to wear and what to eat. If people chose to decline support or an activity, this was respected.

The Mental Capacity Act 2005 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 Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Good

Is the service caring?

Our findings

People told us they had caring relationships with staff. One person said, "Staff know me well – the kind of person I am." Another person told us, "Staff … are very nice. They are pleasant to talk to. Very caring." This person went on to say he felt staff were interested in what he had to say. A visitor said staff were always "friendly and welcoming". They said this filtered from the top down and that staff treated people like they would like to be treated. Another visitor said staff were "absolutely superb with the residents".

There was a named nurse and key worker system in place, which meant people and their families had a named staff member they could approach with any questions or concerns about their treatment and support. Staff told us they had information about people which enabled them to build relationships. One staff member said, "We are informed about everything they used to do and like." Another staff member said, "The main thing is to make them happy and make them comfortable, we are almost like a big happy family." The registered manager told us they used the recruitment process to identify candidates who showed caring characteristics, and that there was further emphasis on caring during the induction period.

We saw examples of kindness and compassion in interactions between staff and people. One member of staff was aware a person had a sore shoulder. When the person was taking part in sitting exercises, they reminded them how to avoid pain. They said, "Remember what the OT (occupational therapist) said." When staff supported people to move about using equipment such as wheelchairs and hoists, they explained what was happening and what they were going to do. Once the person was settled in their chair, staff made sure they were comfortable and checked if they would like a drink.

Staff spoke clearly and slowly, making eye contact and making sure people understood. They made use of appropriate, caring touch to reassure people. They supported and guided people using the "hand on hand" technique when appropriate. Staff were aware of people's interests and choices. We heard one staff member say to a person, "Tomorrow I will bring you a nice CD with Oscar Peterson." Staff spent time with people, for instance discussing a picture book a person was looking at. At other times staff laughed, joked and danced with people. There was an upbeat, caring atmosphere in the shared areas of the home.

Staff supported people to express their views and take part in decisions about their care. One staff member said, "We try to adapt the level of communication. We give them time, even if we don't understand what they mean. We try to make them smile. If they feel sad, we always listen to them." Another staff member said, "You can see on their faces if something is wrong."

Records in people's care plans showed they, and their families, were consulted about care decisions. People's care plans had a section called "This is how I want to be cared for". This recorded people's choices and preferences, such as how they liked to be dressed. People were involved in regular discussions about their care, and visitors confirmed they were also invited to take part in these discussions. A staff member said, "Sometimes we ask the families so they have the same comfort like they have at home."

People's care plans contained specific instructions for staff about how to respect people's privacy, dignity

and independence. We saw examples of how staff encouraged people to be independent where possible. A staff member greeted a person by saying, "Good morning, [Name]. Would you like a biscuit? Help yourself."

People told us they were treated as individuals, and that their privacy and dignity were respected. One person told us, "I feel I can be independent here." A visitor confirmed that staff were "respectful with all the residents".

Good

Is the service responsive?

Our findings

When we inspected Steep House Nursing Home in September 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not maintain accurate, complete and up to date care records. At this inspection we found the provider had taken steps to comply with this regulation, and there was no longer a breach.

All registered nurses had undertaken care plan training since our last inspection. There had been a review of all care plans, and they had been rewritten to use less technical wording. This meant they were accessible to all staff, not just the registered nurses. The provider told us the updated care plans had been used as examples of good practice in some of their other homes.

Care plans were detailed, thorough, up to date, and reflected people's individual choices and preferences. Records were in place to show care plans were reviewed with people, their families and their GPs. There were monthly checkpoints to identify if people's needs had changed, which meant staff were kept up to date regularly with changes to people's needs, as well as in response to individual incidents or medical conditions.

People's care plans contains records of interventions by specialist nurses, and there were regular reviews of pressure injuries and other wounds. Staff used photographs to document the rate of healing, and communicated these to specialists involved in people's care and treatment. Daily care logs recorded the care and support people received, and showed this was in line with their plans.

People and their visitors were very complimentary about the responsive care people received. A visitor described the care as "excellent". They said, "I can't fault it. I can talk to any member of staff. They just sort it." Another visitor told us staff "understand [Name]'s needs". A person living at the home said, "The staff are good. The food is good. Anybody would be happy here."

Staff made adjustments where people had a disability or impairment which affected their communication. These took the form of "tell me" cards, other visual prompts and large print copies of policies and procedures. One staff member described how they used them, "We have a folder with signs and letters. We have questions so they can show what they want. When they show you something, you know what they want."

People's wellbeing was enhanced by leisure activities which reflected people's interests. Some people enjoyed gardening, and there was a raised bed so that this activity was accessible to people in wheelchairs. Another person had wild bird feeders outside the window of their room, and staff took care that they always sat in a position where they could see birds in the garden. When a person came to the home who liked to play the piano, the provider had the piano tuned so this was more pleasurable to the person and others.

A variety of games were available for people including snooker, puzzles and chess. Group activities included quizzes, exercise to music and memory games, which took place in the garden if the weather permitted.

Staff were careful to include people being nursed in their rooms, and took individual activities to them such as reminiscence prompts, books and photos. Transport was available to accommodate up to eight wheelchairs. This meant trips to museums, cafes and theatres were sociable events. People were supported to go to church, and one person preferred to go to the pub. Activities and events reflected people's choices and preferences.

The provider had appropriate policies and procedures for handling complaints. People and their visitors told us they were aware of how to complain but they had not had to do so. One visitor told us they were happy that if they did raise any concerns they would be listened to and their views taken into account.

All verbal concerns were logged by the provider as complaints. Examples of these included missing dentures, and post opened in error. All of the concerns logged had been dealt with and there were no ongoing concerns. Formal complaints would go to the provider's head office, but there were none on record.

The registered manager told us people could just go into the office and make their views known. They encouraged people to say what was on their mind, and there was a book for people to record their thoughts. This meant any concerns could be handled without the need for a formal complaint.

There were arrangements in place to support people at the end of their life to have a comfortable, dignified and pain-free death. Staff had been trained and certified by a local hospice in a recognised "six step" protocol for supporting people in their final days. People had end of life care and pain management plans in place. These had been developed with the person's consent in partnership with the person's GP, and other specialists such as a Macmillan Nurse. The plan was signed off by the resident, their next of kin, a registered nurse and their GP. Where the person lacked capacity appropriate mental capacity assessments and best interests decision processes were followed.

Registered nurses working at the home had had training in end of life care and appropriate methods for delivering pain relief. End of life care plans focused on pain relief, dignity and comfort, including mouth care and consideration to people's families. They included the ordering of medicines in advance so there was no delay in relieving people's pain, and instructions to staff on when to contact the person's GP. Arrangements were made to remove medicines that were no longer necessary, and other domains in people's care plans were adapted, such as behaviour, mental health wellbeing and activities. During our feedback to the registered manager at the end of our visit we recommended they made sure end of life care plans took into account the possible comfort from audible stimulus such as music in the person's room if this was in line with their wishes and preferences.

Good

Is the service well-led?

Our findings

The provider had a clear vision to deliver high quality care and support. This was summarised in a mission statement: "To strive for excellence in providing an ethically sound, individualised high quality of nursing care for older people in a homely environment with the support of well trained and highly motivated staff."

People's feedback supported this vision. One person said, "I feel the place is well managed. The manager comes in to say hello." Another person said they had seen recent improvements and they "would recommend this place to anybody". A third person told us, "It feels like home."

The individuality of care and open vision was reflected in policies and care plans which were centred on the individual person, not the home or staff. People's individual preferences were taken into account. For example they could stay in the rooms or go to shared areas of the home as they wished. The registered manager said there was no home routine, in fact there were 52 routines, and people's care and support was based on their individual choices.

The registered manager achieved this with a stable, motivated staff team with low turnover of staff. The staff training and induction together with a buddy system which linked new staff with a more experience colleague helped to embed the provider's vision. The registered manager was proud they had a multi-cultural team, and support for the staff team's diversity put them in a good position to respect people from differing cultures and backgrounds. The provider made appropriate adjustments to accommodate staff with a physical disability, and when a staff member had English as a second language, they were supported by their buddy to improve their communication skills.

The staff team had a clear structure, and staff responsibilities were clearly communicated in a collaborative way. There was a daily meeting for heads of departments, which was an effective way of sharing information and for information to be cascaded to staff in each department. Staff were confident that information was passed on to them, and that senior staff listened to them. One staff member told us, "If we want help or support they show us what to do, involving the team."

The management system included regular supervision, appraisal and spot checks for staff. These were delegated appropriately to registered nurses and team leaders. The registered manager had a system for tracking and reviewing progress of delegated tasks. There was a programme of regular meetings, including monthly clinical governance meetings, and quarterly department meetings. These were opportunities for two way communication.

The provider was aware of and fulfilled their regulatory responsibilities. They notified us of significant events and incidents that happened during the running of the service. People who use services and others have a right to know how care services are performing. To help them do this, the Government introduced a requirement for providers to display our ratings in the home and on any websites for the home. The provider had complied with this requirement. The registered manager's certificate was also displayed which meant people and visitors could be clear about who was responsible for the running of the service.

Systems were in place to monitor, assess and improve the quality of service people received. Internal checks and audits covered areas of the service including infection control, medicines safety, catering, wound care, care planning, nutrition and weight loss, accidents and incidents, call bells and complaints. There were also audits of the registered manager's report and reports from the provider's assessment and monitoring visits. This was a method of making sure actions identified in these reports were followed up.

Records showed concerns identified were followed up and resolved immediately. When a night shift spot check found gaps in a person's care records, there was an immediate group supervision to remind staff of the importance of recording people's care and support accurately. A mealtime audit noticed a staff member wearing an apron which was colour coded for wear during personal care. This was rectified immediately.

Where actions identified were of a longer duration, there were target completion dates. When the provider carried out regular assessment and monitoring visits or full compliance audit, the registered manager received verbal feedback ahead of the formal paperwork. A recent visit had covered areas including operational meetings, staffing, care, medicines, premises include the kitchen, complaints and safeguarding. The "key points for action" had identified a small number of minor items to action. The registered manager had a system for tracking when audits were completed and actions signed off.

The provider had a variety of methods for engaging with people who used the service, their families, staff and others. The provider encouraged people's friends and families to review the service on an internet service. Reviews were positive and Steep House Nursing Home had a high average rating.

The registered manager and senior staff were available on a daily basis to talk with people and their visitors. Points raised by people were recorded in a complaints and concerns log and kitchen feedback book. This had allowed the kitchen staff to cook a person's porridge in a way they liked. There was a suggestion box which had resulted in better communication of the weekly activities timetable, and improvements to the reception area of the home. The provider sought feedback from visiting health and social care professionals. Some of their comments included: "professional and courteous", "good communication", and "assisted with support above and beyond what was requested".

Quality audits and feedback were used to learn and improve the service. Records of accidents and incidents were analysed for trends. This had identified an increase in falls for one person whose care plan was amended to address this. An infection control audit had identified some areas of improvement which had all been actioned and signed off by the registered manager.

The provider had recently introduced new key performance indicators to encourage continuous improvement. Plans were in place to move to more computer based training and care planning. Recent improvements included refurbishment of areas of the home and new furniture. The provider had introduced new processes to support the registered manager with expertise from the wider provider organisation. There was a continuing focus on quality improvement.

The service worked in cooperation with other agencies and organisations. It was a member of a local care home forum and had worked with the local clinical commissioning group to ensure staff skills and knowledge were up to date. There were links with local schools, hospitals and dentists. A local dentist had given staff training and advice on mouth care. The provider had worked closely with a local hospice to make sure care for people at the end of their lives was of a high quality.