Chilton Care Homes Ltd

Chilton Croft 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

This unannounced inspection took place on 14 June 2016. The previous inspection, 2 November 2015, was a responsive visit and we found a breach in regulation 12. This related to equipment in use for pain relief that was not readily available and fit for purpose. At this inspection that had been put right.

Chilton Croft is a nursing home and can accommodate up to 32 people. Some people were living with dementia or had a physical disability.

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

People spoke highly of this service telling us that they were satisfied and happy living here. We observed staff to be kind, patient and demonstrating meaningful relationships with people. Relatives told us that the staff responded to individual health and care needs of people. They had confidence in the clinical and care staff and believed they had the skills to support their relative appropriately. We found that nursing staff had the confidence and skill to provide a good level of clinical intervention that met peoples nursing needs well. Relatives felt that any concern they raised would be addressed and gave us examples of this occurring. Our observations and review of records concurred with these views.

Staff were welcoming and hospitable to everyone who visited. They were positive about working as a team and enjoyed their jobs. Staff spoke of good fluid communication within the team. Staff were appropriately trained and supported as there was always nurses and management of the home available to them. There were known aims and values that staff worked towards. Staffing was structured appropriately with people understanding their role and responsibility.

People experienced an environment that was clean, fresh and ordered. They had access to appetising food that met their needs. People spoke highly of the food. Visiting health professionals also spoke highly of the service and commented that consent was in place. People receiving treatment understood who the health professional was and assessment and treatment options were explained. Nurses were found to have the correct clinical skills to meet people's health needs.

Records were well kept. Care plans were very ordered and staff felt they could rely on the information contained in these records to guide them appropriately.

Management of the home was responsive to ideas and critique no matter from where this came, people, their relatives, staff, other professionals or CQC. We found that issues raised had been addressed well and had been sustained. There were systems to listen and respond as well as monitor the quality and safety of

the service.

There was a Health and Safety Executive [HSE] investigation relating to a moving and handling avoidable harm death still outstanding. Matters are as yet not concluded and we await the outcome from HSE and any potential action they may take on this historic matter.

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

Staff had a good understanding of how to recognise and report any signs of abuse, and acted appropriately to protect people.

Risk had been identified and managed appropriately. Assessments had been carried out in line with individual need to support and protect people.

People's medicine management was robust.

Is the service effective?

Good

The service was effective. People had their health care needs met and received care and support that met their needs.

Staff received a thorough induction and on going training.

Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to maintain a healthy diet.

Is the service caring?

Good

The service was caring. People were looked after by staff that treated them with kindness and respect.

People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive, caring relationships had been formed between people and supportive staff.

People were informed and actively involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive. Care records were personalised and met people's individual needs.

People were involved in planning their care. Staff knew how people wanted to be supported.

Activities were meaningful and were planned in line with people's interests.

People's complaints and concerns were taken seriously. People's experiences were taken into account to drive improvements to the service.

Is the service well-led?

Good

The service was well-led. There was an open culture. The management team were approachable and their roles defined by a clear structure.

Staff were motivated to develop and provide quality care.

Quality assurance systems drove improvements and raised standards of care.

Chilton Croft Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 14 June 2016 and was unannounced.

The membership of the inspection team included 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. Their specify area of expertise was older people and interview skills. The team also had the lead inspector and a specialist adviser. Our specialist adviser was a nurse with expertise in end of life care and wound care.

Information was gathered and reviewed before the inspection. This included statutory notifications. These are events that the care home is legally required to tell us about. We had also spoken to local professionals who had contact with the service.

The methods that were used included talking to three people using the service, five relatives and friends or other visitors, interviewing five staff, pathway tracking, observation of care and support and reviewing seven care plans. We also examined other records in relation to the running of the service. We spoke to three visiting health professionals.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe with all the staff who supported them. One person said, "I am happy as Larry here – they are all so good". A visiting professional said, "It is a safe care home and they know who you are when you come through the door".

Staff had received safeguarding training. Staff were confident they knew how to recognise signs of possible abuse. They felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. We found that there were appropriate policies, procedures and systems in place for dealing with safeguarding adults from abuse. We had been appropriately notified of significant events. Feedback from the local authority was that they had no concerns relating to the protection of people from harm or abuse. Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

There were sufficient staff available to meet people's needs. One person said, "I have a pendent alarm and I use this in conjunction with the carers to call them – the night sisters know when I am ready to go down to the dining room in the morning – I know when they are busy in the mornings so I press it and then carry on doing things in my room – there is no need for them to rush" A relative told us, "All of the carers are fantastic and the one carer permanently in the lounge has made a difference from a safety point of view and if one of them starts to shout out they can go to them and interact with them and take their minds of that". We found that the new initiative of always having a staff member in the main lounge area was welcomed by most people and did indeed make staff easy to locate when needed. Another relative said, "Carers are second to none.

Lately there seems to be more staff than a year ago". Staffing levels were assessed and monitored depending on people's needs. This enabled care and support to be given in a timely manner and adjusted as people's needs changed. People in receipt of care told us they felt there were sufficient numbers of staff to meet their needs and keep them safe. Staff said there were enough staff on duty to support people and they never used agency staff. We looked at the rosters in place and found that these were well organised and stated the full names of staff on duty and the roles that they performed. There was always a registered nurse on the premises and on occasion there were two nurses. The care staff worked flexibly and there were more staff available at peak times such as getting up in a morning and supper time.

People were supported to take everyday risks. We observed people walking freely around the home and going out into the community. Risk assessments recorded concerns and noted actions required to address risk and maintain people's independence. We saw that staff completed risk assessments on the day of admission, which was good practice and ensured that staff were aware of people's needs immediately. The moving and handling information was clear and stated the correct equipment for staff to use to move people safely. For example a new persons moving and handling assessment stated that they required, 'maximum assistance with use of hoist and slide sheet'. It also gave details of the sling that staff needed to use, such as an 'Invacare full body sling – medium (yellow)'. It gave specific detail in how to use the

equipment for the individual concerned such as, 'Position of loops and method of leg support or equipment required. There were clear instructions as to how many staff were needed and any special precautions that staff needed to take. Staff confirmed that they had received appropriate training in moving and handling and the use of equipment. Therefore we were satisfied that the owner of the service had discharged their duties under health and safety legislation as they should have done. These actions showed us that people were as safe as they could and should be whilst being moved because the assessments were thorough and well documented. A visiting professional told us, "Residents being transferred always have 2 carers – the manual handling is of a high standard – staff don't rush that is a nice thing about this care home". We observed five people being hoisted with equipment through the day and all were carried out by friendly staff who gave appropriate reassurance to the people they were assisting. Staff were confident with what they were doing. We heard staff say, "Look at me, you are going up now, you will be safe, look at me", and then, "Lift up your feet so we can put your feet on the foot plates".

Risk assessments highlighted people at risk of skin damage or in some cases falling that may cause injury. We were aware of one person who had fallen recently and spoke with them. They told us, "I had a fall, my legs gave way a few weeks ago, but I walk around in my room with my stick but they wheelchair me to the dining room. On Monday I told them I am going to give up the chair – the staff know that it is more or less up to me". We found that people had falls risk assessments in place and staff were aware of them. In this case action had been taken to reduce the likelihood of another fall, but had also considered the personal choices of the individual.
Care plans had evidence of a range of completed risk assessments that were up to date as they had frequent review. These included fire evacuation risk assessments, and assessments to prevent sore skin from developing. Staff knew who required frequent moving to reduce the likelihood of a pressure ulcer developing. People at risk of skin damage had special mattresses and cushions to maintain their skin integrity. One person had a plan to prevent them falling from bed at night. Both the person and their family were aware of the need to have bed rails and both had consented to their usage.

We found medicines were managed, stored, given to people as prescribed and disposed of safely. A person at the service told us, "They put my tablets on my mat and I take them. They tell me of any changes or increases of tablets". A visiting healthcare professional told us, "Nurses are very good with regard to medication and no medication is misplaced". Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Medicines Administration Records (MAR) were all in place and had been correctly completed. This included records of controlled drugs and details of specific medicines. We saw that there were regular checks to show that controlled drugs were safe and we sample checked stock and found that these were all able to be accounted for.

Medicines were locked away as appropriate and where refrigeration was required temperatures had been logged. Monthly audits monitored medicine management. Staff were assessed and observed to be confident and capable of administering medicines. The clinical room also contained supplies of needles, syringes, clinical waste bin and a Controlled Drug Destruction Kit. We observed a nurse administering medicines. We saw that they ensured the safety of medicines in the trolley when left. They were considerate and gentle in their approach to people. We observed that the nurse carefully explained the reason for the medicine and sought consent at the time. When the person replied, "I think it will help" the nurse spooned the tablet into their mouth then said, "Have a sip of lemonade to wash it down and take away the taste". They also gave them a favoured soft toy to hold. We concluded that people received their medicines as intended by the prescriber.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to carry out their roles and responsibilities. One person at the home said, "If the staff are not doing what I want - I tell them, but I do think they have good training. The new girls can be a bit slow then I see them improve". A relative told us, "Staff appear to have the right training, and show a great deal of care and compassion from the top down".

Staff undertook an induction programme at the start of their employment at the home. The manager made sure staff had completed an introduction to the home and had time to shadow more experienced staff and get to know people. The Care Certificate induction was being implemented. This is an identified set of standards that health and social care workers adhere to in their daily working life to promote consistency amongst staff and high quality care. Induction training included information about the building, fire exits, moving and transferring, care plans and regular support from management. New staff shadowed experienced members of the team until both parties felt confident they could carry out their role competently. Staff training in areas such as food hygiene, infection control, first aid, moving and handling and dementia care were in place to support staff's continued learning and this was updated when required. Records showed that over 50% of care staff had recognised qualifications in care. Nursing staff had the required skill in areas such as catheter care, malnutrition screening, diabetes and venepuncture [taking blood from a vein]. They were also set to receive training in pain management from a local hospice in the weeks following the inspection. A health professional told us, "We have been coming here for last three years. This home is excellent. The bond between the team members they are very professional and very polite – it stands out".

Staff felt supported by a regular system of supervision and appraisal which considered their role, training and future development. Records confirmed this happened consistently for staff. In addition to formal one to one meetings staff also felt they could approach the management informally to discuss any issues at any time. One staff member said they particularly liked that they received notification about training as a text to remind them and went on to say that all communication with the home was effective. The clinical lead regularly worked alongside staff to encourage and maintain good practice.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who may need their liberty restricted to keep them safe and provides protection for people ensuring their safety and human rights are protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The service was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. People's capacity was regularly assessed by staff. Staff showed a good understanding of the main principles of the MCA and followed this in practice. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. Staff members told us they gave people time and encouraged people to make simple day to day decisions. We saw good examples such as decisions being made around people's choices to receive resuscitation. Inside the front cover of care plans there was a yellow wallet with an appropriately consented,

signed by professionals and dated DNACPR form. One person at the home spoke of their experience of being independent and said, "I have got a gate and have a key for it in my pocket, I am allowed a lot of privileges and look after myself to a great extent". One visiting health professional told us that, "Here when we arrive they have completed everything to be prepared for our visit. This includes seeking the appropriate consent. People are aware of what is happening and we check with them they have consented. It is all in place".

People were provided with a healthy diet and encouraged to drink often. All bedrooms had fresh water and regular tea and coffee with snacks provided throughout the day. One person who was unwell and remained in bed had a drinks container attached to the head of the bed where they could access drinks when lying down. The majority of the people spoke highly of the catering. One person said, the "Food choices are good". They were sometimes unwell and said, "I just tell the chef when I see him at breakfast that I don't want much for lunch and he listens". They told us that their individual preferences were known because, "For breakfast I have two cups of coffee made with boiling water and I don't have to ask for the second one as soon as I have finished the first one they put down the second one".

We observed lunchtime and found that people were given options about where to have their meal. One member of staff said. "Do you want your lunch in here (lounge) or in the dining room, are you comfortable sitting here or at the big table". During lunch five staff were assisting with lunch sitting on chairs by the side of people encouraging and not rushing people to eat well. We heard conversation such as, "It is chicken, veg looks nice", and "Shall I mash that for you" and "Would you like to try some of the meat?"

The hot meal was plated nicely and looked attractive and people appeared to enjoy this meal. Meals taken on trays were covered with lids to preserve heat. A variety of crockery was used dependent upon the individual. Plate guards were used and people were offered finger food where appropriate. One person said, "Chicken was very nice, fruit salad and glass of wine – all very nice" This person was being wheeled back to their room carrying an apple and a knife to cut it up.

Where people had concerns about their nutrition then a risk assessment had been completed. A copy of this was placed in the kitchen for the chef to be aware of their needs and a copy given to the manager. If the person had a score of two or above then staff recorded their food and fluid intake to monitor that they were eating and drinking sufficient for their needs.

People had their health needs met. We found that the home had a good relationship with visiting health professionals and feedback was positive about this. A dentist was present in the home during the morning and several people were seen. One health professional said, "They listen to my instructions and implement accordingly". Staff communicated effectively to share information about people, their health needs and any appointments they had such as dentist appointments or GP visits. Relatives confirmed that they were appropriately kept informed and consulted. Records showed that people had access to a range of community healthcare professionals to support their health needs and received on going healthcare support, for example, from opticians, dentists and chiropodists. Staff promptly sought advice when people were not well, for example if they had a suspected urine infection or chest infection. Staff were mindful of each individual's behaviours and mannerisms which might indicate they were not well or in pain. One person told us of their experience, "You talk to the nurse and they arrange for the doctor to visit. You can ask for the Optician, Foot carer comes once a month, I don't need a dentist".

We examined a number of records and observed nursing practices to look at the health care being provided at the home. We concluded that people who required catheter care had their needs well met and systems were in place to change equipment, monitor their healthcare and wellbeing. We found that if a person required emergency nursing intervention such as resuscitation then the equipment was readily available

and the nursing staff knew what to do. We observed nursing staff prepare for complex wound dressing changes. Nurses were proficient and prepared and had all appropriate equipment in place to perform this healthcare intervention. The same person had appropriate equipment such as bed, mattress and bumpers for their bed rails. We concluded that this was a complex, time consuming and resource heavy nursing intervention, But that the person had their nursing care needs well met. Everything was well managed and appropriately documented.

Good

Is the service caring?

Our findings

The atmosphere in the home was calm and the staff were organised and friendly. People using the service all appeared clean, smart and appropriately dressed, Some female residents wore jewellery and had their handbags with them and their demeanours engaged but relaxed. People told us consistently that the staff had a caring attitude. One person said that , "Staff they are brilliant, no doubt about it, they do anything I want". When asked the confirmed, "Yes I trust the staff and I talk to them". A relative said, "Everyone is so caring and they go out of their way – we are very happy with the care [my relative] got". A different relative said, "It is very good – the family are impressed with the personal service and they seem to be very caring. Since [named person] has been here his appearance, physical wellbeing does look better. [Named the person] has said that it is nice here".

Staff were showing kindness, patience and were demonstrated meaningful relationships with people with the staff kneeling, bending, putting their hand on people's hands and making eye contact to gain their attention and to give reassurance and comfort when needed. Even when passing by people the staff would call out and chat to people and all this promoted an inclusive atmosphere of those people in the common areas. We observed good continuity of care. We observed one person calling out in the lounge. One carer went to them to see what they wanted and settled them and two minutes later they called again and a second nurse came and said, "How can I help you, what do you need, are your tired?" When they called out again a third carer went to them and again showed patience and gave reassurance. Staff were consistent in their approach. A visiting health professional told us, "They are cared for with dignity and sympathetic care. The standard of cleanliness is high both for the environment and personal care".

One person told us, "We laugh and we joke and I think I have a good relationship with them". We observed a member of staff collecting cups. We heard lovely banter with people as the carer went from room to room. When one person said she loved her the carer said, "I love you too, but not sure I should say that" and they laughed together. These were nice friendly inclusive interactions.

We saw care staff use patience and empathy and reassurance. Three different staff over some time approached a gentleman asking him to accept support to complete a task. He graciously accepted the third member of staff. This was nicely done and showed good communication between staff. One relative told us that the, "Carers are fantastic and spend time with the residents." They went on to tell us about how the nursing staff were caring too, "[Named] nurse is fantastic. My relative had been taken off some meds and she explained everything about the meds and why he had been taken off these. It did help him. Most of the nurses are very helpful".

People had their privacy and dignity respected. We observed staff knocking on peoples private room doors before entering. Each door had a hook to display the sign, 'Care in Progress , Please knock and wait' when it was needed. We observed this in practice. We observed people being hoisted and this was done with dignity and staff ensured clothes were placed appropriately so no embarrassment was caused should anyone be observing. Each person private rooms had a boxed picture on their door with a photograph of them in it. This enabled people to locate their own room and encourage independence.

People were routinely consulted about their care and welfare. This was evidenced from care planning. We saw that there had been debate and information about the recent political debates and the vote to exit from Europe. People had been registered to vote. Staff told us about meetings that were held with people at the service and relatives. Minutes were kept. But a relative told us, "We did have a problem in the lounge and we talked about this at the relatives meeting a few months ago and now they have allocated one carer to be in there at all times – problem solved". We were told by a staff member that families are encouraged to visit and look around before moving their relative into the service and that they could visit any time. One relative told us that it was "Excellent here, staff are so helpful, my relative is always clean and tidy and anything he and we want he can have. The place is friendly, everywhere spotless and we could not have had a better place". They went on to say, "Staff to not appear to be in a rush to get to another patient"

Good

Is the service responsive?

Our findings

Care records contained detailed information about people's health and social care needs, they were written using the person's preferences that were obtained from detailed assessments before the person moved in. They reflected how the individual wished to receive their care. Preferences such as preferred name, preferred gender of staff to give personal care, people's likes and dislikes, their routine and friend and family contact information gave guidance staff needed to provide personalised care. People, family and professionals were involved as far as possible to develop these. Staff told us that care plans were meaningful and were used to guide them. One staff member said that the life story that set out the history of the person and their interests and hobbies enabled them to develop a rapport with people to enable them to support them with care. We found that care plans were in good order and easy to find information to enable staff to support people appropriately. Healthcare and support was regularly reviewed and done in conjunction with the individual and or their families as appropriate.

People enjoyed a variety of interests and hobbies. One person told us that they had enjoyed the exercise class. "Twice a week there are chair exercises and she comes to my room as I am more able than most. She is extremely friendly and has given me some of the cd's to play in my room. There is community singing – I don't do that – my choice".

We saw that there were individual ways in which people were supported and spent their day. One member of staff gained consent form a person in the lounge to retrieve their personal memory box from their room. "Is it alright if I go and get your box from your room" and on her return they reminded them, "We put your things in here so that we can take them out and chat with you. There that is from your car and here pictures too" This was a positive personalised interaction around memory prompts. Another person had a jar with copper coins and staff undid and reclosed the jar for them. This person used to work with money. Another person had a book to look at, colouring pencils and book. One person was sitting and folding napkins when we arrived and was talking to relatives. We were told that this person helps with the tea trolley and simple domestic chores that they enjoy. One person told us of their regular routine, "I usually wake between four and five, when I get up I wash and dress myself then do my dusting and tidying in my room. If staff move anything and they do not put it back in the exact same place, I have to explain not too to the new ones but it works well. If it is fine I sit out on the balcony, if chilly I spend my mornings reading and have an enlarger and my son takes me to the library". A visiting health professional said, "They arrange regular activities for their dementia patients and have seen physical gentle exercises and singing".

We were told of 'High Tea' held in the dining room twice a week. One person told us, "Yesterday we decorated the cakes". We were told four people participated yesterday and staff on our visit took the cake trays round the lounge and spoke to each individually about the session held yesterday and the fact that there was High Tea in the Dining room today if anyone wanted to go and join in. One relative told us, "They are getting her involved – they got her involved in gardening and last year bought a plastic greenhouse". We concluded that people's aspirations and preferences were well supported.

The provider had a policy and procedure in place for dealing with any concerns or complaints. This was

made available to people, their friends and their families. In the main entrance was a large red post box asking people to post any concerns or complaints. Cards and pens were available to facilitate this. People knew who to contact if they needed to raise a concern or make a complaint. Several people told us that they had not felt the need to complain but they knew who the manager was and found him to be approachable and helpful. A complaints log noted any concerns and the action taken in the past. One person told us, "Everything I want they do. I cannot complain".

Good

Is the service well-led?

Our findings

The registered manager and clinical lead took an active role within the running of the home and had good knowledge of the staff and the people who used the service. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Staff comments about management included; "It is positive here. It is not too serious. It is relaxed and communication is very good". A different staff member said, said, "It's much better, I'm happy now, we are a good nursing team and we value each other". Staff spoken with were clear as to the aims and objectives of this nursing home and felt that the presence and example set by the manager and Clinical Lead led them well to meet these.

Everyone we spoke with confirmed that they knew who the manager was and that they saw him regularly. One relative said the manager was, "Very available for questions and we can pop in or ring anytime – they are very accommodating". A visiting health professional said, "Leadership is very good and when we arrive they know how to split the staff so that we can carry out our work without disruption and pressurising them". The registered manager arrived shortly after we did. The clinical lead was visible throughout the day and the staff seemed well organised and in control. Their attitude in all cases was positive and their moods light, friendly and good humoured throughout the inspection process.

People and their relatives were encouraged to voice their opinion informally and through regular meetings and they felt listened to when they did. One person at the service told us the manager, "Is very good and comes every day to see if I am alright or if there is anything I want – I am happy here". One relative said, "Staff go out of their way to speak to us. [Named the clinical lead] came to the hospital prior to admission and also recently when my relative was in hospital and he then talked to us about how it would be when our relative returned here". They went on to say, "If I need to go into a home this is where I want to come". Another said, "They keep me informed, treat be warmly and the manager says if I am here at meal times to eat dinner".

The manager used events to drive improvement. Examples include the outcomes of investigations and the changes made since our last responsive inspection in to nursing and end of life care. All equipment required was in place to meet peoples nursing needs at the end of their life to enable people to have a good dignified death. One relative said, "I would recommend it [the home] because of the experience I have had".

We observed the relationship between the Clinical Lead and nurses at the home. They had good communication and were working together for the care of people. One nurse has taken the lead with wound care in the home and the Clinical Lead has encouraged this. The Clinical Lead said another nurse takes the lead with medication and ensures all staff are following procedures. The culture and ethos of the home is that staff are working together to improve care to residents. We found that nurses were enthusiastic and motivated and welcomed the lead role responsibilities.

The Clinical Lead maintained the nursing management of the home and had good knowledge of all the people living there. The clinical systems and processes that have been implemented were consistent in the

home, this ensured residents clinical needs were assessed thoroughly and then effectively managed. We spoke with the visiting GP; he has been visiting the home for over 10 years. He told us that they visit the home every Tuesday as a routine. We asked about the leadership in the home and he said, "I have a good relationship here, they are well organised, they have regular nurses and this is the best nursing home in the area ". He went on to say, "The nurses give me detailed observations and I can often deal with it over the phone. I have no concerns; they are on an upward curve".

Audits of the service were carried out. These included medicines, infection control, the kitchen health and safety and maintenance. Areas of any concern from audits or servicing of equipment had been identified and changes made so that quality of care was not compromised.