Visram Limited

Ranvilles Nursing & Residential Care 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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on 13 and 14 October 2016. The home provides accommodation, nursing and personal care for up to 53 older people who live with dementia or mental health conditions. Accommodation is arranged over two floors with stair and lift access to all areas. A third floor of the home accommodated office space for training and management offices. At the time of our inspection 48 people lived at the home. The home was fully occupied as some rooms designated for two people were occupied by one person to accommodate their individual needs.

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

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Whilst processes to check the suitability of staff to work with people were in place, records were not always fully informed with this information. There were sufficient staff available to meet the needs of people and they received appropriate training and support to ensure people were cared for in line with their needs and preferences.

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

Staff had a good awareness of people's needs and the risks associated with these. Risk assessments were in place to identify the risks associated with people's individual needs; however sometimes care plans did not reflect these needs clearly.

External health and social care professionals were involved in the care of people and care plans reflected this.

People were encouraged and supported to make decisions about their care and welfare. Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Where people were legally deprived of their liberty to ensure their safety, appropriate guidance had been followed.

People received nutritious meals in line with their needs and preferences.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. Staff involved people and their relatives in the planning of their care.

Care plans in place for people reflected their identified needs and were person centred. Staff were caring and compassionate and knew people in the home very well.

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

The service had an effective leadership structure in place which provided good support, guidance and stability for people, staff and their relatives. However records of management actions and information were not always kept. We have made a recommendation about this. People, their relatives and staff knew the registered manager and spoke of their clear visibility and support in 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.

Risk assessments were in place to support staff in mitigating the risks associated with people's care.

Staff had been assessed during recruitment as to their suitability to work with people although records did not always reflect this. Staff knew how to keep people safe and there were sufficient staff available to meet people's needs.

Medicines were managed in a safe and effective manner.

Is the service effective?

Good

The service was effective.

People were supported effectively to make decisions about the care and support they received. Where people could not consent to their care the provider was guided by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff had received training to enable them to meet the needs of people. They knew people well and could demonstrate how to meet people's individual needs.

People received nutritious food in line with their needs and preferences

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the home. Visiting professionals said staff were caring and supportive of people and knew them well.

Staff knew people well and respected their privacy and dignity. They cared for people in a kind and empathetic way, providing time and support in a relaxed and friendly manner.

People were able to express their views and be actively involved

in their care planning.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the identified needs of people and the risks associated with these needs. People were supported to participate in events and activities of their choice although the registered manager had identified the need to implement more activities in line with the needs of people who lived with dementia.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well led.

Whilst care records were well organised and personalised, some management records required organisation and clarity. We have made a recommendation about the keeping of records related to the quality and management of the service.

People spoke highly of the registered manager and their team of staff. Staff felt supported in their roles.

Ranvilles Nursing & Residential Care Home

Detailed findings

Background to this inspection

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

One inspector and an expert by experience completed this unannounced comprehensive inspection on 13 and 14 October 2016. 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. On 5 October 2016 the registered provider 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. We reviewed the PIR for this home.

Most people who lived at the home were not able to talk with us about the care they received. We observed care and support being delivered by staff and their interactions with people in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the relatives of six people, an advocate for three people who lived at the home. and one other visitor to gain their views of the home. We spoke with staff, including the nominated individual for the registered provider (referred to as the nominated individual throughout the report), the registered manager, the deputy manager, two registered nurses, three members of care staff, an activities coordinator, a member of kitchen staff, a member of laundry staff and an administrator.

We looked at the care plans and associated records for five people. We looked at medicine administration records for 20 people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, six staff recruitment files and policies and procedures.

Following our visit we received feedback from three health and social care professionals who supported some of the people who lived at the home.

We last visited the service in November and December of 2013 and the service was found to be compliant with the Regulations at that time.

Good

Is the service safe?

Our findings

People were safe in the home. Relatives, representatives and visitors felt people were safe and were looked after by staff who had a very good understanding of their needs and how to ensure their safety. One relative told us, "It definitely feels safe here; you can guarantee there are enough staff around." Another relative told us how their loved one was very vulnerable but that the constant presence of staff reassured them their loved one was safe. Health and social care professionals said they felt people were safe and staff understood how to keep people safe but also how to allow them to maintain their independence. Staff knew people very well and could demonstrate how to support people safely.

Risks associated with people's mental health conditions had been identified and care plans in place reflected the actions staff should take to reduce these risks. For people who displayed behaviours that might present a risk to themselves or others, the behaviours and triggers to these had been identified. Staff had a very good understanding of people's needs and the risks associated with these behaviours. For example, for one person who could display aggressive or challenging behaviour towards others, staff were able to give us clear information on how they supported this person to maintain their safety and that of others. They told us how they supported people to remain calm, access other areas of the home and express their concerns, or provided one to one support to maintain people's safety.

Risks associated with people's nursing and care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for maintenance of skin integrity, nutrition and mobility. The service supported a significant number of people who wandered in the home throughout the day and were at high risk of falls. Risk assessments had been completed and used to informed care plans about their mobility, how staff should support them to ensure they could mobilise safely, and how to avoid the risks of falling around the home. A log of falls was recorded in each person's care records and was used to monitor and identify any patterns in their falls.

Risk assessments relating to the use of equipment such as hoists, electric beds and recliner chairs in the home had been completed for people. However these were generic and lacked information specific to the risks associated with the use of this equipment for each person. We spoke with the registered manager and their deputy about the information held in these risk assessments which needed to be clearly incorporated into care plans for people. They told us they recognised that generic risk assessments needed to be more personalised and inform individual care plans and that this work would be completed. Staff had a good understanding of the risks associated with the equipment they used for people. They were able to demonstrate safe practice in the use of hoists when supporting people to transfer and in the use of recliner chairs to maintain people's comfort.

Recruitment records included proof of identity, an application form and employment history for people. Two references were sought before staff commenced work at the home. However for one of seven members of staff we saw two references held on file for them were over a year old when they were recruited and had been provided in another country with translations of the letters into English. The registered manager had not sought verification of these references from the people who had allegedly written them to ensure they

were authentic. A reference had not been sought from the staff member's most recent employer. The registered manager addressed this concern immediately.

People who work in the United Kingdom as nurses must be registered with the Nursing and Midwifery Council (NMC) and have a personal identification number (PIN) for this. Providers must ensure all registered nurses provide the relevant documentation to show they have this registration. Whilst all registered nurses working in the home had a current PIN, this was not clearly demonstrated in personal files and we had to verify this after our inspection.

Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services.

Whilst appropriate checks had been completed for staff, records which were held for staff lacked order and clarity on the checks which had been competed when a member of staff had been recruited. The registered manager told us how this would be addressed and implemented this action whilst we were in the home.

Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. All staff had received training on safeguarding and knew the types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC.

The registered manager told us of two safeguarding concerns which had been raised by visiting health care or social care professionals. Clear records showed how the registered manager had worked with the local authority to investigate and learn from these events. Staff were confident any concerns they raised would be dealt with swiftly by the registered manager and they were aware of the registered provider's whistleblowing policy.

There were sufficient staff available to meet the needs of people. The nominated individual and registered manager told us they were looking at a range of tools to identify the dependency of people at the home and ensure they were able to demonstrate there were sufficient staff available.

Rotas showed there were consistent numbers of staff available to meet the needs of people and there were always at least two registered nurses on duty at the home. The registered manager employed agency staff to ensure there were adequate numbers of care staff to meet people's needs and were in the process of recruiting additional permanent staff. For people who required one to one support throughout the day, staff were allocated to support them at all times. There was always one member of staff in any communal area of the home when people were present there and call bells were responded to in a timely way. This meant people were able to access a member of staff wherever they were in the home.

Staff felt there were enough staff to meet the needs of people and most relatives and representatives we spoke with thought there were enough staff on duty at any time. One representative told us, "There are always lots of staff around when I visit and I think the ratio seems right". A relative told us, "They [staff] are always around when they are needed, they are quick to see [relative] is okay when she calls them." However one relative told us, "There are occasions where there are a lot of staff around but there are occasions where there are not."

Medicines were always administered by registered nurses and were stored and administered safely. A system of audit was in place to monitor the administration, storage and disposal of medicines.

People received their medicines in a safe and effective way. Two people received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. The home had ensured families and health care professionals had been fully involved in a best interests decision making process in line with the Mental Capacity Act 2005 to ensure the safety and welfare of the person.

There were no gaps in the recordings of medicines given on the medicines administration records. For medicines which were prescribed as required we saw protocols were in place for these and staff had recorded when these medicines were given. For people who required medicines to reduce anxiety or agitation we saw staff monitored the use and effectiveness of these medicines. They worked closely with health care professionals to ensure people received adequate doses of these medicines without reducing people's independence.

Homely remedies were available for registered nurses to administer if these were required. These medicines are available for people to buy over the counter at a pharmacy and were used to support people who may have symptoms such as pain or constipation.

Good

Is the service effective?

Our findings

People were supported by staff who knew them well and were able to help them make choices about the care they received. Staff knew when to involve others when decisions about people's care needed to be made. Relatives felt people were offered sufficient food which looked appetising.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The registered manager and staff had a good understanding of the processes required to ensure decisions were made in the best interests of people.

Where people had fluctuating capacity to consent to their treatment, we saw staff were patient and sought their consent before care or treatment was offered and encouraged people to remain independent. Whilst people were not always able to verbally agree to their care, staff had a very good understanding of how people expressed their wishes and consented to their care. For example, staff were aware of the communication skills people used to demonstrate they did not wish to receive the care. Care records showed staff always respected people's choice when receiving care. For example, for one person who did not always want to have support with personal care, records showed staff would respect this wish and then return to the person later and ask if they needed any support.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For several people who lived at the home an application had been made to the local authority with regard to them leaving the home unescorted and requiring support with all personal care to maintain their safety. We found that the manager understood when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

A program of induction, supervision sessions and annual appraisal was in place for staff. Supervision sessions were supported by the registered manager, their deputy and registered nurses. The nominated individual completed annual appraisals for all staff. Staff spoke highly of the support available to them from the registered manager and the nominated individual to further develop their working roles and enhance their skills during these sessions.

A comprehensive training program was in place for all staff and this was monitored by the registered manager and provider to ensure all staff attended training which had been identified as mandatory for their role. These showed staff had access to a wide range of training which included: moving and handling, fire safety, safeguarding, mental capacity and deprivation of liberty, infection control, dementia awareness and health and safety. In addition, the registered manager had encouraged staff to take on lead roles in some

areas of training and development such as moving and handling, infection control and dignity champions. People received care and support from staff with the appropriate training and skills to meet their needs. All staff had recently been supported to complete a 'Virtual Dementia' course to enhance their understanding of the needs of people who live with dementia. All staff told us this had greatly improved their awareness of the difficulties people who lived with dementia had with every day activities and had helped them to understand how they may be able to support people's needs.

Staff felt supported through the training and supervision they received to deliver safe and effective care for people. One member of staff told us, "I have been given lots of opportunities to develop skills in this job, especially how to communicate effectively with people who have dementia." Another said, "They [registered manager] are very keen to get us all skilled up and have a really good understanding of people's needs."

All staff were encouraged to develop their skills through the use of external qualifications such as National Vocational Qualifications (NVQ) and Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Registered nurses were supported to develop skills and ensure they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

Staff had a good understanding of their role in the home and the management structure which was present in the home to support them and people who lived at the home. The registered manager was very visible in the service and provided clinical and management support to their team of staff. The deputy manager was available most days when the registered manager was away and registered nurses provided clinical leadership and support for all team leaders and care staff. They delegated daily duties and led each shift to ensure people received care and support in line with their needs.

People had a choice of nutritious meals at each meal time and were supported and encouraged to enjoy a sociable experience at mealtimes. There were three main areas of the home where meals were served including a dining room, two lounge areas and also some people chose to eat in their room. Staff sat with people in each area of the home to support people who required this. Mealtimes were relaxed and there was a high level of engagement between people and staff. The cook prepared meals from fresh ingredients daily and meals were well presented. People were offered a choice of two meals which were plated and then shown to each person to help them make a choice. Pictorial menus were also available to help people choose their meals and information was also displayed on a noticeboard to inform people of the daily menus. People were empowered to make choices at mealtimes. If they did not wish the prepared meals other foods were available but the cook had a good awareness of people's special dietary needs, preferences and dislikes and ensured there was always something for each person to enjoy.

Care plans identified specific dietary needs, likes and dislikes of people and care staff maintained records for kitchen staff to ensure the dietary needs of people were updated and reflected in their meal choices. People's weights were monitored regularly and action taken should any significant changes be noted. For people who were at risk of choking, information in care records clearly identified the need for staff to thicken fluids to reduce this risk.

Records showed health and social care professionals visited the service regularly to monitor the mental and physical health needs of people. Three monthly meetings were held with a consultant psychiatrist, GP and team of health and social care professionals to monitor and assess the health and wellbeing of people who lived at the home. Records showed how these meetings had impacted on the change in the care and support people received particularly in relation to their medicines.

Health and social care professionals said staff at the home had a very good understanding of how to meet people's needs, especially those with complex mental health needs or dementia and who presented with behaviours which may put themselves or others at risk. Relatives were assured people received prompt attention from health and social care professional if they required this. One relative told us, "They [staff] called the GP as soon as they felt they were needed. She [registered manager] sat with us and explained what the doctor had said and really helped us to understand what was happening. It has been a real team effort."

Good

Is the service caring?

Our findings

People were cared for in a kind and sensitive way by staff who had a good understanding of their needs. People were valued and respected as individuals and appeared to be happy and contented in the home. Relatives felt people were well cared for by staff who had received the right training to meet their loved ones needs. One relative told us of a time when their loved one had become distressed and staff had spoken with her in a very gentle and reassuring way. Another told us, "I have got to know the [staff] very well and they are all very caring." A third said, "They are all amazing, they do a fantastic job and it's not always easy." Health and social care professionals spoke highly of the home and the good caring relationships staff had with people.

Staff knew people well and used good communication skills as they addressed people by their preferred name and took time to recognise how people were feeling when they spoke with them. For example, one person became distressed and a member of staff spoke calmly, quietly and slowly with them, reassuring them they were there to help and encouraging them to express themselves. The member of staff recognised the person had become agitated because they wanted to access the toilet area quickly and they required the assistance of two members of staff. Whilst a second member of staff was allocated, they spoke calmly with the person and talked them through what they were going to do. For another person who had difficulties with communicating staff recognised the signals they used to express themselves such as when they were in pain or wanted to have a drink or food.

Health and social care professionals said staff were caring and kind and provided good support for people, particularly those who lived with dementia or had complex mental health needs. They spoke of staff who knew people well and this was reflected in the home's reputation for providing good support for people with complex dementia and mental health needs.

At mealtimes, staff were seen to engage positively and cheerfully with people. Throughout the meal there was a high level of engagement between people and staff and people were empowered to express their needs without reducing their independence. Staff offered support with managing meals, cutting up food and providing drinks for people, but always asked permission before completing any intervention. People were respected as individuals and provided time and space to remain independent whilst staff ensured their safety and welfare.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Dignity champions had been appointed in the service and these staff promoted people's rights to dignity and respect at all times. One member of staff told us, "It is really important we don't see them as just a resident but as another person who has exactly the same rights as us." They went on to describe a recent training programme many staff had attended about dementia. This helped them understand the sensory impact of dementia on people and had really helped raise staff awareness of the difficulties people who lived with advanced dementia had. They told us, "This taught me how important it is to be right in front of the person and always introduce myself to them before any interaction, because they cannot always remember me or don't know I am there." We saw some staff always

introduced themselves to people before any interactions and people responded well to this.

Staff always knocked before entering people's rooms and ensured people were provided with privacy when accessing toilets. Doors remained closed to people's rooms at all times through the day and staff knocked and waited for a response before entering people's rooms. Staff had a good understanding of how to ensure people's dignity was maintained. Bedroom doors in the home were locked with a key to ensure the security of people's belongings. All staff and people who were able to use them had access to keys for these rooms. We saw staff were always available to support people with access to their rooms when they chose to.

Closed circuit television cameras (CCTV) were used in the home in communal areas to ensure the safety and security of people, although cameras were not placed in any area which would compromise people's dignity and privacy. A policy was in place for the use of this equipment dated April 2015. Information was available for people who lived at the home and visitors to the home about the use of CCTV in the home. Relatives and staff were aware of these cameras and acknowledged, whilst it had taken some time to get used to these in the home, their use supported the safety and welfare of people who lived at the home.

People and their relatives were actively involved in providing information to inform their care plans. Care records showed staff interacted with people to understand their needs, views, preferences and dislikes. Relatives were fully involved in the planning of care for their loved ones and health and social are professionals were consulted to ensure plans of care fully reflected people's needs.

Good

Is the service responsive?

Our findings

People and their relatives or representatives were actively encouraged to express their views and be involved in making decisions about their care. Staff knew people very well and understood how to support them to be as active and independent as possible whilst maintaining their safety and wellbeing. Relatives told us there were always opportunities to discuss any concerns or ideas they may have. Health and social care professionals said staff knew people well, understood their needs and provided good care in line with people's individual needs.

People were assessed prior to their admission to the home and these assessments helped to inform care plans. Health and social care professionals were involved in assessments of people prior to their admission to help identify their physical and mental health needs prior to admission to the service. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them and who needed to be involved in their lives and in helping them to make decisions.

Staff had a good understanding of the need for clear and accurate information which reflected people's needs. Each person had a nominated keyworker. This was a member of staff who took a key role in coordinating and promoting continuity of care for the person. Care plans were reviewed and updated monthly or more frequently if care needs changed.

Daily handover sheets for staff gave clear information on people's changing needs. Care plans in place clearly guided staff on how to meet the needs of people with specific mental health conditions such as dementia. However, some care records lacked personalised information on physical health conditions such as diabetes or epilepsy. Whilst specific information regarding these conditions was available, and staff had a good understanding of these needs, care plans were not always personalised and fully informed by these. For example, for one person who lived with epilepsy, care plans reflected this condition and the risks associated with this, however they lacked personalised information as to how this condition may present or affect this person.

Two activity coordinators worked at the home through the weekdays to support the coordination and management of activities for people. They told us how they involved people and their relatives to identify the hobbies and interests of people and ensure activities were available to meet people's individual needs. For example, one person enjoyed poetry and an activities coordinator spent time reading poetry with them. They told us most morning activities were based on one to one interactions with people and afternoon activities provided time for group activities in two larger communal areas of the home. An activities board displayed planned activities in the home including games, exercise and music. The ground floor of the home had been divided into several smaller areas where people were able to interact with each other. The room was clear and allowed people to walk in a circuit around the home as they chose and an outside area was

also available for people, weather permitting.

We saw people enjoy some activities such as a hand massage and manicure and another person sorted laundry and told us they enjoyed helping staff. Dementia friendly activities such as the use of dolls had been introduced recently in the home. However there were times, particularly throughout the morning, where some people lacked stimulation to participate in an activity of their choice. One member of staff was always available in communal areas of the home, and often there were several members of staff present in the room, including the activities coordinators. They chatted with people and encouraged them to interact as they were able, however most staff interactions tended to be limited to care needs such as providing drinks or assisting to the toilet. We observed activity staff playing musical bingo with a group of people one afternoon, however there was minimal interaction from people who were not always given time to express themselves and respond to the game. An area of the home had been decorated to reflect Halloween and an activities coordinator told us of the activities they had planned for this, Remembrance Day and Christmas.

Relatives gave mixed views on the activities available for people. One relative told us, "I think there are things going on but [person] doesn't do anything. [They] can't do anything because [they] don't engage." Another said they did not feel their relative did enough and they had asked to speak with staff about this but had not yet had the opportunity to discuss this further. However another relative told us how their loved one always seemed very happy and staff encouraged them to chat and join in activities in the room.

The registered manager told us how they had begun to introduce, "Mattering - The Butterfly Approach" to the home. This is an approach to dementia care where a family like atmosphere is created in the home and activities support people who live with dementia. This work was in its infancy and not all staff had received training to implement it; however the registered manager had identified this would enhance the activities available to people who lived at the home. This new approach to activities was due to be shared with people and their relatives at their next meeting with the registered manager.

The complaints policy was displayed in the entrance to the home. The registered manager and registered provider had effective systems in place to monitor and evaluate any concerns or complaints and ensure learning outcomes or improvements were identified from these. We saw any concerns or complaints were investigated and actions from these were implemented.

Staff welcomed visitors in a warm and friendly way and encouraged them to express any views about the service their relatives received. Relatives were able to express their views or concerns and felt these would be dealt with. One relative told us, "Yes we have a residents meeting once a month and we discuss what is going on" Another said, "I can't get to the monthly meetings but if I have any concerns I know I can go and talk to [registered manager]".

Requires Improvement

Is the service well-led?

Our findings

Relatives knew the registered manager well and appreciated they were very visible in the service and always available to respond to any concerns or comments they may have. One relative told us, "[Registered manager] is a very strong leader who leads by example. She knows people and her staff and is very involved in all the care provided here." Health and social care professionals felt the home was well led and staff had a good understanding of their role in the home.

The registered manager promoted an open and honest working culture in the home. They told us the views of every person mattered and were respected; this was reflected in the way they and staff worked in the home. Staff showed a responsive approach to any concerns raised with them, for example when we identified a person who appeared to be in distress staff responded immediately to the concern. Throughout our inspection the nominated individual and registered manager were keen to identify any areas where improvements might be needed, how they could address these and any learning they could identify. Staff were motivated to provide a very good service.

The registered manager held meetings with people and their relatives and we saw actions from these meetings were followed up and completed. For example, during one meeting relatives had raised concerns about the lack of fresh fruit available for people during the day. This was addressed immediately and people had access to fresh fruit when drinks were served through the day. Another relative had requested the porch to the home was updated to provide better shelter but also an area of information for visitors. We saw this had been completed. Surveys were provided to people and their relatives annually and the feedback from these was positive.

There was a strong management structure in the home. The nominated individual visited the service at least twice per week to support the registered manager and all staff. The registered manager and deputy provided senior leadership in the home whilst registered nurses were responsible for the day to day clinical management of the home. An administrator was also available to support the running of the home. Team leaders and care staff had a clear understanding of the support network available for them and felt supported in their roles. They spoke highly of the support provided for them, particularly in the opportunities available for them to progress their skills with training. Staff meetings provided an opportunity for all members of staff to discuss developments in the service and any concerns they may have.

Care records in the home had a clear format and were organised and easy to follow. However we identified some risk assessments in these records did not fully inform care plans. Other records within the service required attention to ensure they were readily available, easily accessible and available for sharing when they were required. For example, whilst meetings with people, staff and relatives had been completed, minutes of these meetings were held in a notebook and not shared with others. Actions were identified from these meetings and we saw most of these had been completed; however here were no records of these.

Recruitment records were disorganised and did not hold all the necessary information to show staff had been recruited according to the registered provider's recruitment policy. Whilst following our visit, all of the

information was identified as being available, the registered manager was unable to locate all of the necessary information when requested.

People and their relatives and staff had been asked for their views of the service in questionnaires circulated in March 2016. The registered manager was able to provide copies of all the feedback they had received. However this information had not been collated and actions identified from the feedback. The registered manager told us how they had addressed any comments they received with the person who had provided them, and some information had been discussed at meetings with people, relatives and staff, however responses to these actions had not always been recorded.

The registered provider had employed the services of an external quality assurance auditor who had reviewed the quality of the service in October 2015 and July 2016. We saw as a result of the audit in October 2015 staff had received additional training and support to meet the needs of people with dementia. Also the role of team leader was being implemented to support the staffing structure at the home. Whilst action had been taken, records did not always reflect this.

Audits were completed by the registered manager and their staff to monitor the safety and wellbeing of people who lived at the home. This included audits of; infection control practices, medicines, care plans, safety equipment, maintenance and health and safety practices. Whilst actions from these audits were identified action plans were not always in place to identify these actions and the outcome of them. The registered manager was able to identify actions which had been completed as a result of these audits; however records did not always reflect this.

We recommend the registered provider and registered manager seek further guidance on the collation, recording and reporting of actions implemented as a result of audits and meetings and take action to improve the recording of information relating to quality assurance.

Incidents and accidents were recorded and monitored for trends or patterns. The registered manager reviewed all incidents and accidents and ensured appropriate actions were taken to investigate these and share any learning outcomes from these.