The Grange Nursing Home Limited

The Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 5 and 6 January 2016 and was unannounced.

At the last inspection on 6 February 2014 we found the service complied with all of the regulations we inspected.

The Grange Nursing Home provides nursing care and support to a maximum of 63 older people who may also be living with dementia or physical disabilities. There were 56 people using the service at the time of this inspection.

The service has a registered manager. 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.

We received positive feedback about the service from people who lived there and their friends and relatives.

People's care plans did not always fully reflect people's health and nutritional needs to provide staff with up to date information.

There were systems and processes in place to protect people from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns.

Medicines were managed safely as the staff responsible for administering people's medicines were suitably trained and competent.

There were sufficient numbers of staff to meet people's needs. Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home.

Staff were supported to carry out their roles and received an induction and on-going training and supervision. Staff were kind and caring and worked in a manner that respected people's privacy and protected their dignity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received on-going health checks and support to access healthcare services. They were supported to

eat and drink enough to meet their needs.

People were confident they could raise concerns or complaints and that these would be dealt with.

There was a positive and open culture within the service, which encouraged people's involvement and their feedback was used to drive improvements. There were a range of systems in place to assess and monitor the quality and safety of the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff had a clear understanding of what constituted potential abuse and of their responsibilities for reporting suspected abuse.

Identified risks to people were managed effectively to help to keep people safe.

Staffing levels were sufficient and recruitment processes were robust.

People's medicines were managed appropriately so they received them safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care records did not always support staff to fully meet people's nutritional and health needs.

Staff received training that was relevant to their role.

Staff sought people's consent when they provided care and support and worked in line with The Mental capacity Act

Is the service caring?

Good

The service was caring.

Staff had developed positive caring relationships with people using the service.

Staff communicated effectively and encouraged people's involvement in their care.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support in line with their needs and wishes.

There were a range of activities available.

Complaints were listened and responded to.

Is the service well-led?

Good

The service was well led.

There was a positive and open culture within the service and leadership was good.

There were effective quality monitoring systems in place to drive improvement.

The Grange Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 January 2016 and was unannounced.

The inspection was carried out by two inspectors accompanied by a specialist advisor. The specialist advisor had experience and knowledge of best practice relating to the care of older people, particularly those living with dementia and end of life care needs.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 13 people who used the service and eight of their visitors to seek their views about the care and support being provided. We also spent time observing interactions between staff and people who used the service.

We spoke with four nurses, six care staff and three kitchen staff, the registered manager, deputy manager and family liaison manager. We reviewed a range of care and support records for 15 people, including records relating to the delivery of their care and medicine administration records. We also reviewed records about how the service was managed, including risk assessments and quality audits, recruitment records for three staff, staff rotas and training records.

Good

Is the service safe?

Our findings

People felt safe and well treated living at the home. A person who required staff to use a hoist when supporting them with personal care told us they had got used to it and felt safe in the process. Another person told us "Staff are kind" and said if they felt troubled they would talk to the staff. A relative told us a person who had previously become distressed when receiving support with personal care and mobility was now less agitated when this happened. Two staff now provided the support; one member of staff stroked the person's hand and reassured them while the other provided the care.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They gave examples of things they did to safeguard people, such as keeping people physically safe, respecting confidentiality, privacy and dignity, reporting injuries or changes in behaviour. Staff were aware that policies were in place in relation to safeguarding and whistleblowing procedures. They knew how to report any suspicion of abuse to the management team and agencies so that people in their care were protected and their rights upheld. Staff were confident any concerns they raised to the management would be appropriately addressed. Records showed and staff confirmed they had received training in safeguarding adults as part of their training and this was regularly updated.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, risks associated with falls. Before people came into the home their mobility and risk of falling was assessed and guidance provided for staff to follow. Staff were aware of the risk assessment and management plans in place for people. A system of handover meetings and recorded communications took place between staff on each shift to help ensure that changes to people's health and welfare were discussed and any new risks were identified and acted upon.

A relative told us that following a fall when the person had chosen to move without staff support, there had been a discussion between the person, relative and staff to help the person to understand the risks. The person was now mobilising with support from staff.

People told us there were enough staff to meet their needs. We observed staff were present at all times in the lounge, talking with people and responding to their needs. The rota for care staff showed between 10 and 12 care staff on duty throughout the day. The nurse rota was organised around an assessed need for a minimum of two nurses on each shift. However, the rota showed this varied and there were frequently three or four nurses on shift, which enabled them to perform tasks such as ward and medicine rounds and liaising with external health professionals. Staff said they thought there were enough staff to meet people's needs. They told us there was not a high staff turnover in the home and communication was good between all the staff roles.

One person told us the "Organisation overall was good". They commented that, while staffing levels did not affect their own care, they thought sometimes there were not enough staff when there was a handover in the evening, as there were a lot of people in the home who needed a lot of help. A member of the care staff told us the nurses carried out the evening handover to the incoming night staff between 6.50 and 7pm. All the

care staff from the day shift remained on the floor until 7pm and there were enough to respond to people. A senior care worker said that if the evening handover goes on after 7pm, a member of the care staff will come to the lounge to provide cover when the day staff. They did not feel that the evening handover had any effect on the care provided to people. We discussed this with the deputy manager who said she would look into it.

A relative said they were "Amazed at the number of staff in the home". They had visited other homes and commented favourably on staff availability in this home and their positive interactions with people. They told us that when the person was in bed on some days staff visited every hour. Another relative who was a frequent visitor said they were not aware of people having to wait to go to the toilet. Staff were aware of people's needs and explained if waiting was needed. They told us they were not aware of people having accidents or being frustrated at having to wait. Another relative said staff came round to check if people wanted the toilet and while there was sometimes a queue staff did understand individual people's needs.

The service followed safe recruitment practices. We looked at the recruitment records for two nurses and three care staff. Each file included application forms, health checks and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. One member of care staff had completed the initial DBS check and was working supervised while awaiting the full DBS confirmation. Checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC).

Overall, the provider had good systems of medicines management. There were three medicines rooms and each had an oxygen hazard notice on the door. One room contained two oxygen cylinders and one oxygen condenser. The administrator at the home told us these were checked every three months by the supply companies, who did not issue certificates to state the equipment had been checked and was safe to use. The administrator contacted the supply companies immediately and requested that documentation was issued with each service. The registered manager told us a risk assessment and policy for the storage and administration of oxygen would also be put in place.

The medicines rooms had refrigerators and the temperatures of these and the rooms were recorded daily. The storage and records relating to controlled medicines met legislative and regulatory requirements. The provider had an effective system of ordering people's medicines and medicines for disposal were kept securely and in an appropriate container. There was a slight over stock of some medicines, which was due to a system fault that the registered manager was addressing with the supplier.

Two nurses told us they had received medicines training within the past two months and had a competency assessment within the previous six month period. We observed two medicines rounds taking place. The nurses were professional and patient with people as they administered medicines. The nurses explained what the medicine was for and asked people "is this okay" before giving it. They waited until the person had swallowed the medicine before leaving. People told us they received their medicines regularly or when they needed them.

Requires Improvement

Is the service effective?

Our findings

Although people's health and nutritional needs had been assessed and care plans were in place with details of their individual needs, there was sometimes limited information or contradictory information in the plans to help staff keep informed of how to meet each person's needs.

One person told us "I am nothing as bad as yesterday and the days before, I was in agony". They said "It was my bottom, I was sat in that wheelchair all day and it really made me sore and it hurt such a lot". We looked in the person's computerised record and found in their daily records they had a slight moisture lesion in that area. A moisture lesion is a reactive response of the skin to chronic exposure to urine and /or faecal matter. The person had a skin care plan in place but this did not contain a clear and specific preventative care plan. Some records were contradictory, for example one person had a skin care plan stating their diabetes was controlled by insulin but their nutritional assessment stated this was diet controlled. Another person did not have updated records to show they had a pressure area.

One person's records stated that they should be provided with a food supplement three times a day. It was not recorded in the care action plan that this or any other additional food had been offered. The person's records indicated they were losing weight. The person told us they thought their weight was monitored and that it had been maintained. They liked to take the supplement three times a day and felt they needed the calories, but had to ask for it and was not sure if they were on a list or received it three times a day.

Another person's care plan did not describe fully what action staff should take if a supplement was declined, a meal was missed or how to improve the person's intake. The person's records showed that the person had declined to take the supplement approximately 30 times between 8 December 2015 and January 6 2016. There was no list of foods to offer the person. A member of staff told us the person's relative met regularly with kitchen staff to discuss the person's meal plans and we saw a record showing that the kitchen had information about the person's choices.

Another three people's records also showed a number of times supplements were declined or not given because the person was asleep, but there was no record that the supplements were offered again or the reasons why. A senior member of staff agreed that the action plans for some people needed to be developed and recorded to capture all the actions required for improving people's food intake.

The provider used food and fluid charts but the food charts were not sufficiently detailed to demonstrate people's intake. Staff wrote 50% of lunch without recording how much lunch was offered. In addition, on the fluid chart there was no target intake and there was no evidence that staff totalled the records up every day to ensure appropriate monitoring took place.

We found the records did not support staff to clearly meet people's nutritional needs. Staff told us there were other day to day recording sheets that showed when people had last eaten. They showed us a record for one person that demonstrated the food and drink provided, including the time. However, the person was losing weight and needed thickeners in their drink but the staff member told us they were not on an

enhancing nutrition plan.

The failure to maintain and review care and treatment plans and provide staff with up to date information relating to changes in people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The meals appeared well presented and appetising and we observed people receiving individual support to eat and drink. For example, two people who were in their beds were being supported by staff to eat their lunch time meal. The staff gave people their undivided attention and spoke with them about the food in a kind and unhurried manner. As a consequence the mealtime experience appeared to be a good one for the people concerned.

We were told that five staff were available to help seven people eat in the dining room. We saw two people were supported by their relatives. Two other staff supported people in their rooms. This meant two people had to wait to eat. Lunch started at approximately 12.15 and one person was not given their soup until 12.35. Another person who was asking for their food and saying they were hungry had not received their food by 12.35 although we were told they were just about to be given it. Five staff were having their lunch at a table near people living at the home. There was considerable laughter coming from the table. Staff did say they tried to finish helping someone with their meal before having their break and this usually happened. However, on this occasion the system for staff breaks at lunchtime was potentially having an effect on effective food delivery to people. We fed this back to the registered manager who said she would look into it.

We saw staff providing food to a person who had refused food earlier. The person was given fruit after being asked about what they wanted to eat and then a plate of open sandwiches. This was before tea was being served to everyone else and a direct response to their individual request. They were discussing the fact that the person liked specific foods sometimes. The person confirmed they did sometimes have these foods. The member of staff had a good knowledge of what the person liked to eat. Anther staff member told us if people were not gaining weight they were offered food more often. They demonstrated knowledge of the people this applied to.

People told us they liked the food and were able to make choices about what they had to eat. One person told us they could eat what they liked, there was choice from week to week and proper alternatives were provided, such as full meals, if they did not like what was offered. Another person said the food was "Pretty good" and they could have "Tasty, freshly cooked" alternatives to the menu. The person's relative supported them to eat when visiting but they did get the help from staff if the relative was not there. They said they felt consulted about when they would eat and so had a choice. Another person told us "They will give you what you want".

We saw kitchen staff were actively involved in food service delivery to people in the dining room at lunch time. Two kitchen staff told us they felt adequately informed from the care staff about individual people and their nutritional needs. They showed us a form that was completed each time a new person came into the home, indicating their key needs and preferences. They told us they were updated if this changed. They knew who had soft food and pureed food and showed us a record that was kept in the kitchen of people on special diets. This included high protein diets, such as adding extra meat to pureed food; build up (soups or shakes including cream or condensed milk); and diabetic diets including people who were insulin dependent. They knew which of the diabetic people had their blood sugars checked once or twice a day and waited to serve them after this. The carbohydrate content of meals was adjusted accordingly.

Staff we spoke with knew individual people well and said they felt they received the support they needed. The training programme and records showed staff received an induction and further on-going training to carry out their roles and responsibilities. The training included dementia care, mental health awareness, and palliative care. A member of staff spoke enthusiastically about the dementia awareness training staff had received and about meeting the needs of people living with dementia and others who were "Just forgetful". They said staff "Go into their world to bring them back" and "You get to know each individual".

Care practitioners and nurses were supported to undertake Health & Social Care Diplomas level 5 to help equip them to manage the team more effectively and support staff progression. Nurses employed by the service were supported to maintain their professional development. Staff also received support through supervision and appraisal meetings with their supervisors. Supervision and appraisal are processes that offers support, assurances and learning to help staff development.

We saw feedback the service had received in October and November 2015 from external health professionals in response to a survey questionnaire. One had commented: 'Good skill mix within the team. Good training'. Another had written: 'Easy to get through and chat to the nurse, whatever the time of the call'; and 'In general all nurses are up to date with the person being called about'. A third health professional stated: 'Good communication. Friendly. Efficient. Extremely helpful with queries. All seems to work well'.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with had good knowledge of mental capacity assessment and why they were necessary. Before providing care, they sought consent from people and gave them time to respond. One member of staff explained that they were "Checking consent to care all the time". They told us if there was a risk to not giving care, staff would try to find a way around it. They said they explained the benefits of accepting care and that it helped if communication was kept flowing throughout the support: "Working with feelings in dementia care". Where people lacked capacity, best interest decisions had been made and documented, following consultation with family members and other professionals.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

People and their relatives were confident that staff understood their needs and sought other professional advice when needed. A relative told us they were "Delighted " with the care provided. People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, speech and language therapist, chiropody, occupational therapists, opticians and dentistry. A member of staff told us if they had any concerns about people's health they always reported it to the nurse who would take the matter forward. There were clear systems of communication within the home and we observed care staff and nurses worked well together.

Good

Is the service caring?

Our findings

There was a welcoming atmosphere in the home and we observed positive, caring interactions initiated by staff. There was a good rapport between staff and the people they supported with lots of smiles and laughter. Our first observation was in the reception area and was of staff speaking with a person who had been on holiday; they showed an interest and spoke respectfully. This manner was also noted when we spoke with people in the shared areas of the home throughout the day.

People's care was not rushed, enabling staff to spend quality time with them. A person said "I love it here. Staff are very nice". They told us "Staff will stop and talk to me". Another person told us "I am very appreciative of the help I've had here. The care has been spot on". One person said the staff were "Brilliant in every way. If I ask for something and they can do it they do". They told us everyone was "Friendly and helpful". Another person told us staff were friendly and spoke to them, whatever their role. They said they thought the staff "Are marvellous" and "Mix very well and enjoy working here".

A relative told us staff were "So kind, caring and patient" and "They have so much time for the residents". Staff knew the person well and "Lets us know if things have happened". They said the person's room was "Beautifully clean" and staff had put their cards up on string at Christmas without being asked: "They pre-empt things". The relative also told us staff were very approachable, communication had been good and care was individualised. Another relative told us staff were kind and the care was the same at the weekends.

People's care and support plans were written in a way that focussed on them as a person. Staff had a good knowledge of people as individuals and knew what their likes and dislikes were, such as what they liked to drink and those who liked to go for a rest in their room after lunch . They addressed people appropriately in accordance with people's chosen forms of address. A person told us staff knew the name they like to be addressed by and said they felt comfortable and content at the home. We observed staff interacted with people in a kind and compassionate manner. They were attentive and responded promptly to people who were requesting assistance.

People told us felt they were listened to. There was a person centred culture at the home and this was reflected in the systems that were in place to involve people in their care. Care plan review meetings took place every three months, or earlier if necessary, involving people and their relatives or representatives. People and their relatives confirmed their involvement and agreed that people received individualised care. A relative said the staff had been welcoming from the moment they had made an unannounced visit to see if the home was suitable. They told us "Staff have gone out of their way" and "They let me know how (the person) is". The person's other visitor also had a very positive view of the home and confirmed that the staff responses to their friends needs were very effective, as they listened and acted on information.

People and their relatives told us the staff respected people's privacy and protected their dignity. For example, one person told us "They have rooms available so you can have a private discussions". Staff gave examples of respecting people's privacy and dignity, for example keeping a person covered as much as possible while assisting them to wash. Staff spoke with people while they were providing support in ways

that were respectful and kind. We observed staff assisting people to move using equipment such as stand-aids. They did this carefully and at each person's own pace, checking they were comfortable. People told us staff asked them if it was okay to give personal care and support. We saw a sign on a person's door that read: 'At the moment I would appreciate a little peace and quiet please. Thank you'.

People and their relatives were given support when making decisions about their preferences for end of life care. There was a coded system of assessment and prognostic indicators for people at various stages of the end of life. This enabled staff to take anticipatory measures to meet each individual's needs and ensure their comfort. The provider had an 'End of Life Care Pathway' checklist that included, for example, advance care plans, best interest decisions, power of attorney, Do Not Attempt Resuscitation (DNAR) status, communication files, pain assessment and anticipatory medicines.

The provider had produced leaflets and guidance to advance decisions and end of life care and these were available in the home. We saw a record of a meeting that taken place, for those who chose to attend, at which people were asked how they felt about their involvement in making decisions about their lives and care. Another meeting had taken place with relatives to discuss changes in models of end of life care planning and the priorities of care. The service was currently rated beacon status under the Gold Standard Framework for end of life care. The accreditation process includes assessment against 20 clear standards of best practice. To achieve accreditation a home must achieve at least 84% of the standards. To be recognised as a beacon, a home must show innovative and established good practice across at least 12 of the standards.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to people's health and wellbeing. Relatives were kept informed about any significant changes affecting the person receiving care. Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. Involving people and their relatives in the assessment and subsequent regular reviews helped to make sure that care was planned around people's individual care preferences. The service employed a family liaison person who provided a point of contact for people and their relatives starting from the initial visit and assessment.

Personalised care plans provided guidance about how each person would like to receive their care and support, including their preferred routines of care and how they communicated their needs. Any variance to people's preferred routines were recorded, for example if they declined personal care for any reason. The records showed that when people could not communicate their care needs, information about care preferences was gained from their relatives and friends, so that best interest decisions relating to care delivery could be made.

Through talking with people, relatives and staff and through observation, it was evident that staff were aware of people's care needs and acted accordingly. All staff contributed to keeping peoples' care and support plans up to date and accurate. A staff communication book was used along with verbal handovers to help ensure that staff were informed in a timely way about any changes to people's needs. We observed staff responded promptly when a person activated their call bell.

Staff promoted people's mental and emotional wellbeing and encouraged people to socialise. The service employed two full time activities staff. During the first morning of our visit we observed a group of approximately 10-12 people were gathered around a table in the dining room looking at newspapers and having discussions, stimulated by an activities coordinator. A person told us this took place on most days. People later told us the afternoon activity had been arm chair exercises. One person told us the service also provided activities that included entertainers from outside the home.

People and relatives told us staff listened to them and they were confident that any concerns would be addressed. One person gave an example of staff listening and acting on a person's emotional needs; when the person was upset staff had supported them to make a call to their spouse for emotional support. A member of staff we were talking with was concerned about an upset person they could hear and went immediately to help the staff member already there. Another person told us "I can't fault them in anyway" and "you haven't got to ask them twice".

People's comments and those of their relatives indicated that the service sought their views in a number of ways, such as meetings and reviews. One person told us they had been asked for feedback and they had not requested any changes but said "definitely" when we if asked if staff would listen. Another person told us they were consulted; there were occasional meetings every four months or so where "You can say what you like". People told us that new staff were introduced to them.

People were given copies of the complaints procedure as part of the admission process. A copy of the complaints procedure was attached to a noticeboard in the reception area, along with a suggestions box. The complaints record log showed that two complaints had been received within the past year and demonstrated that the provider had listened and taken action on each occasion. The complaints had been investigated and the outcomes recorded in a timely manner in line with the procedure.

Good

Is the service well-led?

Our findings

The majority of people and their relatives we spoke with did not think the service needed to make any improvements. One person said "I am happy and everyone else seems to be". Another person commented "Everything seems to fall into order" and another said "I couldn't fault them, they are very good". One person told us "Brilliant care here, no improvements needed, just the parking". A relative told us staff were friendly and efficient. They said staff other than care workers and nurse stopped to say hello to them. When we asked if the service could be improved, they told us some staff were too loud. They were aware that some people had difficulty hearing but some staff talked across the room to each other and it was too noisy.

Quality assurance questionnaires were sent out to people who used the service and other stakeholders such as families and professionals involved with the home. The registered manager monitored the responses in order to see if any action needed to be taken to improve the service. We saw five responses to the most recent survey and these were all positive. The service had also received positive feedback in October and November 2015 from external health professionals in response to a survey questionnaire. One had remarked about the 'Excellent relationship with the home'.

Staff told us the registered manager and senior staff were approachable and supportive. They felt able to raise any concerns and that they were listened to. For example, one member of staff said if staff suggestions were beneficial they could influence changes in people's care. They had made suggestions about a person's personal care and these had been followed up and resulted in the person having more personalised care. Another member of staff said there was "Good communication between staff" and commented "None of us is slow in coming forward to each other". They confirmed that staff evaluated what each other did and supported each other.

A member of staff said "The manager is very good here, we are lucky. They are keen on our development and know people well. They do set boundaries but these are good ones and they help us all know where we stand. I think this is a very, very good home". Another said "This is a good home, we all work together as a team to ensure our residents have the best care possible and they do. The management are good leaders. I trust the manager totally, she knows a lot and is very fair".

Staff from the various departments, such as care, domestic and laundry staff, spent time 'shadowing' each other to learn more about each other's roles and overall service delivery. Staff were able to give feedback about their experience of this. In addition, staff from all departments were involved in meetings to help promote a personalised service for people. One outcome of such a meeting had been the door signs requesting peace and quiet.

There were clear lines of accountability within the service with each shift having a clearly designated nurse in charge. Staff had a clear understanding of their roles and responsibilities and demonstrated passion and commitment in their work. The registered manager was passionate about investing in staff and increasing their sense of value. She told us how staff could, and had, progressed within the service. For example, a Care Practitioner role had been introduced that enabled senior care staff to develop their skills further.

In addition to handovers between shifts, the senior staff on shift carried out ward rounds on Mondays and Thursdays each week. Discussions about people's individual care needs were recorded in a diary and any subsequent actions were reflected in the person's daily care notes. The daily diary also contained a record of specific tasks, which were signed off when completed or carried forward to the next shift if necessary.

The registered manager continually sought to improve the service and keep herself and staff up to date. For example, the registered manager was undertaking a supplementary nurse prescribing course to support GPs and ensure treatment is commenced promptly and reduce unnecessary hospital admissions. To help support everyone in the service, the registered manager had arranged for a relative to run some individual/group meetings for people, relatives and staff to explore their feelings. They were also looking at establishing a residents/relatives committee to contribute to the open, sharing ethos of the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to maintain and review care and treatment plans and provide staff with up to date information relating to changes in people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 (3) (b)