Care Quality Commission

Mr and Mrs Allison

Halsdown 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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 5 and 11 August 2015 and was unannounced. We last inspected the service in January 2013 and did not identify any concerns or breaches of regulations.

Halsdown Nursing Home provides accommodation for up to 17 older people who may require nursing or personal care. The home has a registered manager, referred to as 'Matron'. 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, relatives and health and social care professionals were overwhelmingly positive about their experiences of the home. They spoke about how friendly and welcoming staff were, the homely atmosphere and said the home was well organised and run.

Staff were kind and compassionate towards people, and had warm and caring relationships with them. They were highly motivated and used innovative ways to respect each person's dignity and maintain their privacy. The home was organised around people's needs, and they were supported by staff who knew what mattered to them.

People were actively involved in making decisions about their care. They were offered day to day choices and staff

Summary of findings

sought people's consent for care and treatment. Where people lacked capacity, staff demonstrated a good understanding of their responsibilities under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty safeguards (DoLs). Mental capacity assessments were undertaken for people who lacked capacity, relatives and health and social care professionals were consulted and involved in decision making in people's 'best interest'.

People were supported to receive ongoing health care support. Staff were knowledgeable about people's care needs, and any risks. Detailed care plans showed each person's care and treatment needs. Care records were up to date and showed accurate records were kept about each person, which were regularly reviewed and updated as people's needs changed.

People were supported to remain active, and be as independent as possible. They were encouraged to mobilise and a regular exercise class was provided. People were assisted to maintain their interests and hobbies and to try new things, and accessed the community regularly.

People and relatives felt safe at the home, although some minor health and safety risks related to the premises were identified. The registered manager addressed most of these during our visit.

The culture of the home was open and friendly. There was clear leadership from the registered manager, and staff had clear roles and responsibilities. The provider had a range of quality monitoring systems in place which were used to continually review and improve the service.

The provider participated in a number of good practice initiatives to encourage high standards of care and keep staff up to date with practice. This included schemes such as Dignity in Care, the Social Care Commitment and the Alzheimer's society's 'Dementia Friends'. There was evidence of continuous improvements being made in response to these initiatives and from people's feedback.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and relatives felt safe at the home. People's risks were assessed and action taken to reduce them as much as possible.

People were protected because staff understood signs of abuse and were confident any concerns reported were investigated and dealt with.

People were supported by enough staff so they could receive care and support at a time convenient for them.

Accidents and incidents were reported and action was taken to reduce the risks of recurrence.

People received their medicines on time and in a safe way.

People were protected because recruitment procedures were robust.

Is the service effective?

Good

The service was effective.

People were supported by skilled and experienced staff, who had regular training and received support with practice through supervision and appraisals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decisions making about people in their 'best interest'.

People were supported to maintain good health and access healthcare services. Staff recognised any deterioration in people's health and sought medical advice appropriately.

People were supported to eat, drink and keep healthy through good nutrition and hydration.

Is the service caring?

Outstanding

The service was caring.

People who used the service, relatives and health and social care professionals were impressed with the service and how people were treated.

Staff were highly motivated and used innovative ways to respect each person's dignity and maintain their privacy and independence.

The home was organised around people's needs. People were supported by staff who knew what mattered to them.

Staff were kind and compassionate towards people, they had warm and caring relationships with them.

Summary of findings

The service supported and involved people to express their views and make their own decisions and staff acted on them.

Is the service responsive?

Good

The service was responsive.

Staff knew people well, understood their needs well and cared for them as individuals.

People's care plans were detailed and accurately reflected how they would like to receive their care, treatment and support.

People felt confident to raise concerns and these were appropriately responded to and used for learning. There was a complaints process which people knew about but no formal complaints had been received since the last inspection.

Is the service well-led?

Good

The service was well-led. There was a registered manager and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management and said the home was well organised and run.

People's, relatives' and staff views were sought and taken into account in how the service was run and suggestions for improvement were implemented.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

Halsdown 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 checked 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 the 5 and 11 August 2015 and was unannounced. One inspector completed the inspection. Prior to the inspection we reviewed information about the service from the Provider Information Return (PIR), and other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore 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 met all 14 people using the service, nine relatives and friends and looked in detail at four people's care records. We spoke with ten staff, and looked at four staff records, and at training and at quality monitoring records. We sought feedback from health and social care professionals who regularly visited the home including GPs, hospice and mental health services, and received a response from six of them.

Good

Is the service safe?

Our findings

People said they felt safe and secure at the home. One person said, “I feel safe here” and a relative said, “They are keeping her safe, I feel much more relaxed, I don’t worry about her.”

The provider's information return (PIR) described how each person received an 'Introduction to Halsdown' information leaflet when they arrived at the home. This was discussed with them and covered what they should do if they ever felt unsafe. Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the registered manager or deputy manager and were confident they would be dealt with. The provider had safeguarding and whistle blowing and policies available so staff were clear how to report concerns. No safeguarding concerns had been identified since the previous inspection.

People’s care records included individual risk assessments and information about how to manage and reduce risks. For example, risks such as malnutrition and dehydration, pressure sores from skin breakdown. One person’s assessment showed they were at increased risk of choking because of swallowing difficulties. A speech and language therapist (SALT) had provided detailed advice about how to support this person. Their care plan included SALT recommendations which we observed were followed at lunchtime. For example, by positioning the person upright for their meals, adding a thickening agent to their drink, and offering them food of a pureed consistency. Kitchen staff were aware of which people had swallowing risks and knew how to prepare their food. A member of staff trained to administer first aid was on duty at all times at the home. This meant choking risks for people with swallowing difficulties were reduced as much as possible.

Accidents and incidents were reported and reviewed monthly to identify ways to reduce risks for each person as much as possible. In the PIR, the provider outlined falls prevention as an area where they had improved people’s safety and reduced their chances of having to go to hospital. They used the National Institute of Clinical Excellence (NICE) guidance on assessment and prevention of falls in older people to carry out a comprehensive risk assessment of each person. Where a person was identified at higher risk of falling, they were referred to the community 'falls' team for assessment to identify further strategies to prevent their risk of falling. People’s care plans were updated with any advice and were reviewed regularly to evaluate their effectiveness. People were also invited to participate in gait balance and mobility strengthening activities provided by the home’s activities co-ordinator.

Environmental risk assessments were completed for each room and showed measures taken to reduce risks. For example, covers on all storage heaters and non slip mats in the hallway. There was a lack of dedicated storage for equipment which meant some equipment had to be stored in corridors and alcoves. For example, an ironing board was stored in an alcove in the corridor, as were wheelchairs, hoists and medicine trolleys. The lack of storage gave the home a more cluttered appearance in some areas. Some stored objects could impact on people’s safety and ability to move easily around the home.

On the first day we visited, we found two rooms near the lifts which had high voltage warning signs displayed were unsecured. The keys to both areas were left in the lock, which could pose a danger for people with cognitive difficulties unable to identify the hazard and for children visiting. We brought this to the attention of the provider and asked for them to be secured. When we returned on the second day, one of these rooms was still not secured. On that day also, we found another cupboard in the hall had been left unlocked, which contained some medicines and other medical equipment. These risks posed a hazard for people, and we asked the registered manager to address them immediately which they did.

All repairs and maintenance were regularly undertaken. Equipment was regularly serviced and tested as were gas, electrical and fire equipment. Weekly fire checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. Individual fire risks assessments were in place and each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire. A written contingency plan was in place in the event of a major emergency requiring evacuation of the home.

Medicines were managed in a way that ensured people received them safely. The home used a monitored dosage system on a monthly cycle. Nurses who administered medicines were trained and assessed to make sure they

Good

Is the service safe?

had the required skills and knowledge. Medicines were checked and medicine administration records were audited regularly and action taken to follow up any discrepancies or gaps in documentation.

Although records of most medicines administered were well documented in people's Medicine Administration Records (MAR), records of prescribed creams applied were less well documented. This was because there were some gaps in recording of prescribed creams on MAR charts. These gaps in signatures meant we could not be assured about whether or not the creams had been applied as prescribed. Documenting prescribed creams were identified as part of the medicines audit and fed back at a staff meeting in June 2015, as an area for improvement and these improvements were still needed.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. People said staff met their needs at a time convenient to them. The atmosphere in the home was calm and organised, staff worked in an unhurried way. Staff responded promptly to call bells. Each person who needed help to eat had one to one support at lunchtime. The home used a dependency tool to identify workload based on individual people's needs. For example, where one person's mental health needs indicated they needed more one to one support from staff, this was provided. The provider did not use agency staff. Any gaps in staffing were met by existing staff working extra shifts. This meant people benefitted from continuity of care by staff who knew about their care needs and preferences.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. All staff had police and disclosure and barring checks (DBS), and checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Checks were made to ensure nurses were registered with the Nursing and Midwifery Council.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. Cleaning schedules included details of daily, weekly, and monthly cleaning. Housekeeping staff had suitable cleaning materials and equipment. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

In a couple of areas there was flaking paint and a few rust patches, such as on the foot of a bath hoist. This would make it more difficult to clean equipment properly to prevent cross infection.

Good

Is the service effective?

Our findings

People felt supported by staff who had an in-depth knowledge of their health needs. When staff first came to work at the home, they undertook a period of induction. This included working alongside the registered manager and other staff to get to know people and their care and support needs.

Nursing and care staff were very experienced and had regular opportunities to update their knowledge and skills. In the PIR, the provider outlined 95% staff had already achieved a nursing or care qualification or were working to achieve one. Staff undertook regular update training such as safeguarding adults, health and safety, and infection control. The deputy manager had undertaken a train the trainer course on moving and handling. This meant they could train other staff, monitor practice and assist with updating people's moving and handling care plans as their needs changed. We observed people being hoisted in the lounge area, and saw they looked relaxed and at ease. Staff had lots of training and updating opportunities relevant to the needs of people they cared for. For example, training on respiratory disorders, dementia, tissue viability and verification of death training for nurses.

Staff received regular one to one supervision every eight weeks, some of which involved observing staff practice and providing constructive feedback. Staff had an annual appraisal where they had an opportunity to discuss their practice and identify any further training and support needs.

Before each person came to live at the home, a detailed assessment of their needs was undertaken. The provider used evidence based tools to assess if people were at risk of developing pressure sores, and of falling, malnutrition and dehydration. Where a person was at risk of developing pressure sores, care plans provided staff with detailed instructions about the person's skin care, pressure relieving equipment and the need for them to be assisted to change their position regularly.

People had access to healthcare services for ongoing healthcare support. This included regular visits by local GPs, physiotherapists, speech and language therapists and a chiropodist. Where any concerns were identified, four health professionals said staff contacted them appropriately and followed any advice given. One healthcare professional said, "This is one of the better homes, they look after people and have a good relationship with them."

One person who lived at the home sometimes exhibited behaviours that challenged the service. Staff at the home involved mental health services who gave advice about their care. The person had a detailed behaviour support plan, which included information about how staff could support the person in the least restrictive way possible. A mental health professional said staff at the home responded well to this person's needs, and used a range of approaches with them. They also said staff kept good records of the person's behaviours which helped reviews of their care. This person's mental health had improved and they were much more settled.

Staff had undertaken appropriate training of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and demonstrated a good understanding of how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments were completed for each person. Where a person was assessed as not having the capacity to make a decision, people who knew the person well and other professionals, were consulted and involved in making a decisions in the person's 'best interest'.

People's consent for day to day care and treatment was sought and they were asked to sign their care plans to confirm they agreed with them. Where a person had nominated a relative as a Lasting Power of Attorney (LPA) to make decisions about their care and treatment, staff involved them appropriately in decision making. LPA is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if either they are unable to at some time in the future or no longer wish to make decisions.

People's liberty was restricted as little as possible for their safety and well-being. For example a careful assessment was undertaken whenever the use of bedrails or a pressure mat was considered for the person's safety. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The home had made one application to the

Good

Is the service effective?

local authority DoLs team to deprive a person of their liberty and was awaiting an assessment visit. This was because the person was showing some signs of wanting to leave the home but did not have mental capacity to make a judgment about their own safety. The Supreme Court judgement on 19 March 2014 widened and clarified the definition of deprivation of liberty. It confirmed that if a person lacking capacity to consent to arrangements is subject to continuous supervision and control and not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

People gave us very positive feedback about the food at the home. There was a weekly menu and staff cooked fresh meals using seasonal produce. One person told us how the green beans and rhubarb, served for lunch had come from the cook's garden, a fact which gave them great pleasure. Catering staff had detailed information about each person's dietary needs and preferences. The cook came around each day to check people were happy with their menu choices and whether anyone had changed their mind and wanted something else. For example, on the first day we visited, there was ham, eggs and chips for dinner, and some people chose an omelette instead. On the second day, there was chicken casserole, one person asked for fish fingers, which was specially prepared for them.

The provider undertook a food and drink survey in 2014 which showed most people found the quality of food excellent. Following the survey a meeting was held to discuss the findings and identify areas for further improvement. This included adding a hot breakfast alternative to the menu, having doughnuts every so often instead of biscuits with tea/coffee and having a weekly menu. People also opted to move the dining tables into the conservatory to make their dining experience more pleasant. This showed the provider listened to people's feedback and acted on it.

Mealtimes were a very sociable occasion, several relatives joined people to eat lunch with them, they chatted and socialised with other people. Where a person had swallowing difficulties, and needed pureed food, each food was separately prepared, which is good practice. Staff waited patiently waited until the person swallowed each mouthful before offering more food.

Where people were identified at risk of malnutrition or dehydration, care plans instructed staff to monitor the person's food and drink intake as well as checking their weight regularly. Staff training included completing a nutrition and hydration workbook. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. For example, staff described to one person what was for lunch, they said, "It's chicken, potatoes and broccoli, mmm it smells delicious." They praised the person and encouraged them to enjoy their meal, they said, "Is it nice?...well done, would you like some more?" People were offered drinks and snacks regularly throughout the day. Staff tried to increase some people's calorie intake by adding cream and butter to their food and by making homemade milkshakes to tempt them. People's weight charts showed staff were managing people's weight well, some people had gained weight and no significant weight loss was seen.

Outstanding ☆

Is the service caring?

Our findings

Staff developed positive caring and compassionate relationships with the people they supported. People really mattered, staff were interested in what people had to say. Staff organised themselves flexibly around people's needs and wishes. Families were welcomed and were very involved with their relatives, they dropped in regularly throughout the day, and chatted easily to staff.

One person said, "It's lovely here, it's the next best thing to home", and another person said, "The care is lovely." A relative said, "I'm very impressed, this is a happy place, they (staff) have become friends and put themselves out." Another relative said, "Staff are very observant, they notice other people, that's impressed me quite a bit." They went onto describe how staff had noticed a person's relative was unwell and rang their daughter to let them know. A third relative said, "Staff really care, they don't just look after the person, they look after the whole family." A health professional said, "The care of patients seems very caring and appears genuine, the patients seem at peace, listened to and cared for." Another said, "They are caring, considerate of each patient as an individual, I wouldn't mind being a patient."

People were supported by staff who knew what mattered to them. Staff interacted well with each person and treated them as an individual, there were lots of gestures of care and affection throughout our visit. Staff popped into people in their rooms, the lounge and conservatory, regularly checking on each person, chatting to them and listening to what they had to say. When staff spoke with people, they were patient with them and gave them time to reply. For another person, staff noticed how they liked to keep busy and feel useful. The person had previously worked in the catering industry and staff invited them to help with buttering bread and folding laundry, whenever they wished, which they enjoyed.

Staff supported people to communicate effectively. Where a person was unable to speak or had limited speech, staff used good eye contact, touched them gently and observed the person's facial features for their response. People were wearing their glasses or they were at hand, and several people were wearing their hearing aids. Care records included detailed information about people's communication aids, and about any specific communication needs. For example, one person's care plan said, "Talk clearly, (the person) does not always understand what is said, they will often answer with a yes when they haven't understood, get her to repeat what was asked to check her understanding." There was appropriate signage to help people find their way around the building and outside areas as independently as possible.

Staff were highly motivated and used innovative ways to respect each person's dignity and maintain their privacy. In the PIR, the provider told us they had signed up to the national Dignity in Care network. When we asked for a bit more information about this they told us a dignity in action day had been held in February 2015 to raise awareness of dignity issues. This included getting people involved in a 'Make a wish day' where they wrote their wishes, which were tied to helium balloons and released. Staff tried to make these wishes come true. For example, one person wished they could go into town to their favourite clothes shop and choose some new clothes, even if it took a long time, which staff helped them to achieve. Another person wanted to smell the sea air and a third person wanted to return to visit their village pub in Dartmoor, both of these wishes were achieved on an outing organised for the week we visited.

People and relatives said staff always treated them with dignity and respect. People were given the opportunity to have privacy when receiving visitors, making telephone calls or opening and reading their mail. In relation to personal appearance, staff ensured a person had their hair styled how they liked it, tied back, and were wearing their preferred jewellery. A relative said they appreciated how a person's clothes were always protected and they had tissues nearby to wipe their mouth regularly, which maintained their dignity.

As part of the Dignity in Care initiative, the service had a dignity champion, whose role was to promote good practice and seek regular feedback from people to check how they felt they were treated in relation to dignity and privacy throughout the year. A privacy and dignity audit was completed in February 2015, which included questions about staff attitude, seeking consent, knocking at people's doors before entering, preserving modesty and respecting people's cultural and religious beliefs.

People's feedback was very positive and showed staff were providing a high standard of care. From the findings, the provider reiterated to staff the importance of making sure people had some private time without the staff member

Is the service caring?

present, but available nearby when they were using the bathroom. Also about checking clothing, to make sure the person's dignity was protected when using the hoist. Following this, a staff training day was held using 'The Common Core principles of Dignity' produced by the national Skills for Care. This included blindfolding staff so they could experience what it was like to have someone feed them and raising awareness about the importance of facial expressions for people who could not speak. This showed the provider was committed to maintaining high standards within the staff team and to identifying ways to further improve privacy and dignity at the home.

Each person was as involved, as able, in an assessment of their needs when they first came to live at the home. Care assessments and care plans were signed by the person and, where appropriate, a relative to show they agreed with the records. After two weeks living at the home, the provider sought feedback from each person about how they were feeling and whether there were any changes needed or anything else they would like. People were supported to express their views and were actively involved in making decisions about their care. In the PIR, the provider outlined how they were trying to provide holistic care that promoted people's individual wellbeing. For example, the deputy manager told us about two people with respiratory problems using continuous oxygen who participated in DVD training with staff about managing their condition, which one person in particular found very helpful. This was because it helped them to understand the importance of relaxed breathing techniques for their comfort and wellbeing.

People's religious beliefs were supported, there was a monthly communion service at the home and staff assisted people to attend regular or special services. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, such as the person's views about resuscitation in the event of unexpected collapse. The provider offered end of life care, although no one needed this when we visited. Two staff attended bimonthly update sessions at the hospice and shared good practice with other staff. Feedback from hospice staff was very positive about how staff supported people to be comfortable, and receive dignified and pain free end of life care. The provider had signed up to the Gold Standard Framework in End of Life Care accreditation scheme and were awaiting a date for a local staff training workshop.

Good

Is the service responsive?

Our findings

People received care that was personalised and responsive, staff knew people well, understood their needs and cared for them as individuals. One person said, “Staff have a great attitude, they mix speed with a relaxed atmosphere.” A relative said, “It’s homely, you feel like you are in your own home” and another said, “They pre-empt everything, they are brilliant.” A third relative said, “They (staff) are doing all they can for (the person), they are very gentle with her.”

People were offered choice about their daily lives and staff worked flexibly around their wishes. For example, around what time the person wanted to get up and go to bed, where and when they wanted their meals. Some people liked to wake up early and have their medicines before breakfast. Others preferred to sleep in and have their medicines later with their breakfast, and staff accommodated their preferences. Each person’s room was personalised with things that were meaningful for them. For example, people were encouraged to bring family photographs, pictures and any furniture or ornaments precious with them when they moved into the home.

When we asked people about their personal care needs, lots of people told us about which day of the week they had their bath or shower. One person said, “Tuesday is my bath day, that’s the routine.” When we asked staff about this, they said these arrangements were a guide only and were very flexible, and people could choose a different day or have a bath or shower more often if they wished. Although people were very happy with these arrangements, some people weren’t aware they could have a bath or shower on a different day or more often if they wished. One said, “I like to fit in” and another said, “I haven’t tried to ask to ask for a bath more often but I haven’t been offered one.”

Care records had detailed information about each person, their family and their life before they came to live at the home. Care plans informed staff about people's health and social care needs. They included detailed information about each person's communication, physical and psychological needs and their levels of cognition. Care plans accurately reflected how individuals said they liked to receive their care and support, and included information about what they could do themselves and what they needed staff to support them with. For example, how one person could wash their upper half but needed support with their lower half.

People’s care records were reviewed and evaluated regularly as their needs changed. One visitor told us how impressed they were with how quickly staff had responded to a change in their relative’s health. When the person developed a sore eye, they said staff noticed it straightaway, called the doctor and the person was seen and had their prescribed eye drops by 11.30 that morning. Daily records provided information about the care provided, people’s physical and psychological wellbeing, their eating and drinking and how they spent their day.

People were encouraged to and supported to mobilise, and the home had a range of moving and handling equipment to support this. There was also a regular exercise class to encourage people to remain active. People were supported to maintain their interests and hobbies and try new things. Some people enjoyed reading and others had their preferred daily paper delivered. There was a wide and varied programme of activities and trips out available. These included games of cards, quizzes, exercise classes, darts, cooking, handicrafts and piano playing. Visits to places of local interest were organised, for example, to the local beach, garden centres and Woodbury Common as well as shopping trips, cream teas and pub lunches. There were lots of art and handiwork on display that people had created. People told us how much they had enjoyed making gingerbread men that week. Visitors and relatives were also encouraged to join in and to help with activities.

People’s care records included details about their hobbies, and interests. For example, one person liked flowers, nature programmes and TV soaps and were supported to maintain these interests. Staff used photographs to help engage people to reminisce about things of interest to them. For example, a staff member had brought in a book with old photographs of Exmouth which a person had enjoyed looking at and recalling their memories of the town. One person told us how much they enjoyed a group of people who played games of cards and scrabble in the afternoons. People said they liked spending time in the conservatory because there was lots of light in there. The home had an attractive garden with a seating area where people regularly enjoyed sitting outside.

Good

Is the service responsive?

People who chose to remain in their room most of the time said staff popped in regularly for a chat. This meant they had companionship and didn't feel isolated. Keeping detailed records of activities meant staff were prompted to make sure each person's needs for meaningful activity were addressed. This included people who were more reluctant to socialise or had more difficulty communicating.

The provider held regular meetings that people and relatives attended during which they were invited to raise any concerns and make suggestions. In the PIR, the provider told us how people had an opportunity to contribute their suggestions to the decoration of communal areas and the choice of chairs. Two people told us about the summer fete they helped to organise, and had hosted the tombola stall. People were consulted about how they wanted to spend the funds they had raised at the fete. Three suggestions were put forward and people settled on the most popular one, a day out to Dartmoor. For those who didn't wish to go or were unable to for health reasons, an aromatherapist was arranged to visit the home and offer them a massage instead.

The Dartmoor trip took place during the period of the inspection and on the second day of our visit, people and staff were still discussing the trip. They told us about their experiences and showed us the photographs, and we saw how much everyone had enjoyed it. For example, a staff member was thrilled that one person who was often sleepy had been alert throughout the day. The person had taken in all the sights from the coach and enjoyed having a drink and chatting in the pub. Other people told us how, on the way back, they stopped for a walk along the beach and had an ice cream.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the nurse in charge or the matron and it would be dealt with straightaway. The provider had a written complaints policy and procedure. Written information was given to people when they came to live at the home, which included how to raise a complaint. A relative said, "If I want to raise any issue, staff see to it straightaway, they're very good." Although, the provider had not received any formal complaints since the previous inspection, the provider kept copies of any grumbles or issues that people or relatives had raised. These showed the provider responded appropriately and professionally to any criticism, offered apologies when things went wrong and outlined what action they had taken to make improvements.

Good

Is the service well-led?

Our findings

People, relatives and staff were positive about the provider and spoke about the culture of the home as being friendly and open. When we asked people and relatives what was the best thing about the home, they spoke about the "atmosphere" of the home and said it was organised and well run. One person said the best thing was the "Good communication, informality and care", and a relative said, "The atmosphere is relaxed and warm." A relative commenting about why they chose the home for the person said, "It was a million miles better than anything else I saw." A health professional said, "The home appears well run and I have never had any concerns." When we asked people, relatives and staff if they could identify any areas for improvement, they couldn't think of anything. People and relatives were regularly asked for feedback and said their views and suggestions were listened and responded to.

In the PIR, the provider outlined a clear vision and values for the service. This included providing people with a secure, relaxed and homely environment. Their aim was to provide people with as normal a life as possible, with the focus on the person's ability not their disability. There was a strong focus on promoting people's privacy and dignity and on involving people and families. These values were demonstrated by staff throughout the inspection.

Leadership at the home was visible, the registered manager, known as 'Matron' was in day to day charge. The registered manager was a practising nurse, they undertook people's assessments of care and managed the nursing staff and oversaw standards of practice. The deputy manager managed care workers and took the lead for quality monitoring. The registered manager said these arrangements worked well as they each had their distinct roles and responsibilities. Both spent a lot of time working with staff and monitoring care practice.

Staff worked well as a team, most had worked at the home for a long time and there was a very low turnover of staff. There were good communication systems in place for staff through daily handover meetings. A communication book was used to remind staff about people's appointments, changes in medicines and other messages. Staff had delegated roles and responsibilities, for example, leads for tissue viability, medicines and end of life care. Staff felt well supported, were consulted and involved in the home and morale was high. One staff member said, "I enjoy it because it's a good home, matron is a good nurse, very hands on, we follow her lead, she has enthusiasm and high standards." Another staff member said, "We all know what we are here to do and are taught well, matron sets high standards and it works." A third staff member said, "It feels like a family, it feels lovely, I'm so happy working here."

The provider had systems in place for staff training and updating, regular supervision and annual appraisals. These were used to re-enforce the values and behaviours expected of staff. This included management development and ongoing training for the registered manager and deputy manager. The provider had a range of policies and procedures to guide staff which were regularly reviewed and updated. This included a whistleblowing policy to encourage staff to raise any concerns in good faith.

In their PIR the provider outlined several good practice initiatives they were participating in. This included being signed up to the Dignity in Care and the Social Care Commitment good practice initiatives. The Social Care Commitment identifies minimum standards expected from staff working with people. The provider had recently joined the Alzheimer's society's 'Dementia Friends' scheme and undertook their training session in July 2015 and the Gold Standard Framework in End of Life Care accreditation system. The matron and deputy manager attended regular local authority update sessions for providers. This meant the provider used evidence based practice to encourage high standards of care and drive continuous improvement by keeping staff up to date.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. These included monitoring cleanliness and infection control, checking of equipment such as hoists, hoist slings and wheelchairs. They also undertook regular audits of medicines management, and record keeping. Where we identified concerns about the recording of creams and ointments, these had been highlighted by the medicines audit. However, improvements in this area were still needed. In several people's care records, we saw very detailed feedback given to staff from audits of care plans. These included constructive advice to nursing staff about how to further improve the person's care plan and suggestions to ensure each aspect of their care was documented in detail.

Good

Is the service well-led?

We asked the registered manager about health and safety checks of the environment. They said they undertook visual checks at the home at regular intervals, although there was no system in place for documenting these checks and any action taken. Some of the environmental risks we highlighted on the first day of the inspection had not been identified by the provider and some hazardous areas remained unsecured on the second day of our visit. When we alerted the registered manager to these risks, they dealt with them immediately.

The provider conducted an annual satisfaction survey to seek feedback from people. The survey results showed high levels of satisfaction were reported by people living at the home. Questionnaires were also used at informal coffee mornings to gain feedback from relatives/friends. Day to day feedback and suggestions for improvements were acted on.

The provider was up to date with recent regulatory changes. In July 2015, the provider undertook a self-audit of how they were meeting the regulations, which they showed us during our visit which included an action plan for further improvements. The registered manager had notified the Care Quality Commission about all important events they were required to tell us about.

Staff were consulted and involved in decision making about the home. The provider held regular staff meetings and minutes showed a variety of issues had been discussed, including staff uniforms, timekeeping. Staff meeting minutes also showed issues raised by people were discussed with staff so that lessons could be learned from people's experiences and improvements made.

A survey of staff had recently been undertaken. The feedback showed staff were generally very satisfied. The findings highlighted that staff were not very aware of the home's business plan and wanted to make some changes to their annual leave booking arrangements. Following this, the provider's business plan was shared with staff at a team meeting and a new annual leave booking scheme was implemented. The provider had introduced an employee of the year scheme last year, for staff to nominate a colleague who had gone "above and beyond" for people. They said this hadn't been that well received by some staff, so they were rethinking other ways to praise and reward staff such as by organising some social and team building events.

The provider had made improvements to the home since we last visited. New doors had been fitted to people's bedrooms and extensive work on pointing the brick work on the outside had been completed. Other proposed improvements for the future included improving the bathroom facilities by installing a wet room facility.

Accident and incidents were monitored to identify any trends or individuals at increased risk and showed that actions were taken to reduce risks. For example, following a hoist incident improvements in practice needed were identified and fed back to staff, so that lessons were learnt. Named nurses and key workers reviewed care plans monthly make sure that risk assessments and management plans were comprehensive and being implemented. Also, to identify any new risks and act promptly to reduce them and keep the person safe. The provider regularly monitored response times to call bells to make sure they were responded to promptly and to check anyone at increased risk of harm had their call bell and was responded to immediately.