Elmbank Nursing Home Limited

Elmbank Care Home

Inspection report

35 Robinson Avenue
Mapperley, Nottingham
Nottinghamshire
NG3 6BB

Tel: 01159621262

Date of inspection visit:
24 March 2016

Date of publication:
26 April 2016

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 24 March 2016 and was unannounced.

Accommodation for up to 35 people is provided in the home on three floors. The service is designed to meet the needs of older people. There were 27 people using the service at the time of our inspection.

There was a registered manager who was available during the inspection. 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 felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were managed to keep people safe. Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Safe medicines and infection control practices were followed though some floors and equipment needed better cleaning.

People were not always appropriately supported to receive sufficient to eat and drink. Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. External professionals were involved in people's care as appropriate. Some adaptations had been made to the design of the home to support people living with dementia.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager and that they would take action. There were systems in place to monitor and improve the quality of the service provided. The provider was meeting their regulatory responsibilities.

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 felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents.

The premises were managed to keep people safe. Sufficient staff were on duty to meet people's needs and they were recruited through safe recruitment practices.

Safe medicines and infection control practices were followed though some floors and equipment needed better cleaning.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always appropriately supported to receive sufficient to eat and drink.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005.

External professionals were involved in people's care as appropriate. Some adaptations had been made to the design of the home to support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were caring and treated people with dignity and respect.

People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager and that they would take action.

There were systems in place to monitor and improve the quality of the service provided. The provider was meeting their regulatory responsibilities.

Elmbank 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.

This inspection took place on 24 March 2016 and was unannounced.

The inspection team consisted of an inspector, an Expert by Experience and a specialist nursing advisor with experience of dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with four people who used the service, four visitors, a visiting professional, the cook, activities coordinator, cleaning and laundry staff, a senior carer, a care worker, a nurse and the registered manager. We looked at the relevant parts of the care records of six people, three staff files and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "It's safe as anything." Another person said, "I love it. I've no worries." Visitors felt their family members were safe at the home. One visitor said, "Oh yes, I feel [my family member] is safe."

When we asked a staff member if people were safe at the home they said, "Yes. That's what we are here for." Staff were aware of the signs of abuse and said if they had concerns they would report them to the nurse in charge or the registered manager. They said if necessary they would go to head office and could ring the local authority safeguarding team or the CQC. They said the telephone numbers were displayed in the service. However, they were confident the registered manager would act to address their concerns.

Appropriate safeguarding records were kept. A safeguarding policy was in place and staff received safeguarding adults training. Information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

Risks were managed so that people were protected and their freedom supported. People told us that staff checked that they were safe. One person said, "They come two hourly and always make sure I'm ok." People told us they were not restricted. A person said, "I can get up when I like and go to bed late." We saw people moved freely around the home and staff did not restrict people but allowed them to walk where they wished in the home whilst supervising them to keep them safe.

Individual risk assessments had been completed to assess people's risks of falls, risks related to moving them, pressure ulcers and nutritional risk. We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans in order to minimise the risk of re-occurrence.

Personal emergency evacuation plans (PEEPs) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. A procedure was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People told us that they felt the premises and their belongings were safe. We saw that the premises were generally safe; however, some radiator covers were not fixed securely to the walls. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified. Staff said they had sufficient equipment to meet people's needs and we observed staff using moving and handling equipment safely. Staff told us that repairs were completed in a timely manner.

People told us there were sufficient staff to meet their needs. A person said, "They're always around. They usually come quick if I ring for them." Another person said, "There's plenty of people around. They come quick when I've rung before." A visitor said, "There's always somebody here."

Staff told us they felt there were enough staff on duty to provide the care people required. They said people were able to choose when they got up and went to bed and that people's wishes often varied and staff were able to accommodate this. On the day of the inspection some communal areas were left unattended at times but we saw that people's requests for attention were met in a timely manner.

Systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The registered manager told us that staffing levels were based on dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be increased. A staffing tool was also used to calculate staffing levels.

Safe recruitment and selection processes were followed. A member of staff who had been recruited recently told us the required checks had been completed prior to them starting work at the service. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

Medicines were safely managed. People told us they got their medicines when they needed them. One person said, "I'm happy with how they give them to me." Another person said, "They do it well." Visitors also confirmed that medicines were safely administered.

We observed the administration of medicines during the morning medicines round to check medicines were administered safely. Staff checked the medicines against the medicines administration record (MAR) and if they were unsure about a person's identity they checked with a carer more familiar with the person (the member of staff administering medicines had started at the service just over two weeks previously and had just completed their induction).

We had concerns about the length of taken to administer the medicines as the morning medicines round was not completed until 11.45am, and as a result the gaps between the morning and lunchtime medicines would be reduced considerably and people may not have been offered pain reducing medicines in a timely manner. We were told it was unusual for medicines administration to take this length of time and the administration normally was completed by 10.30am. The staff member administering the medicines said they had administered the medicines for people who had lunchtime medicines at the beginning of the round so there was an appropriate gap. They had started administering medicines later than usual and were new to the service and therefore administration may have taken longer.

MARs had a front sheet for each person with a photograph of the person, however not all MARs contained a record of the person's allergies and their preferences for taking their medicines. When MARs had had to be handwritten they were signed by two people to indicate they had been checked for accuracy of transcription as required.

PRN protocols were generally in place providing additional information about medicines which had been prescribed to be given only as required. When transdermal patches were prescribed there was a record of the site of application of the patches to enable rotation of the site to which they were applied.

Appropriate health checks were completed for people who were receiving medicines which required aspects of their health to be monitored. A person receiving insulin for diabetes had previously had unstable blood glucose levels and as a result had experienced episodes of hypoglycaemia. There were detailed instructions from the diabetes specialist nurse on the action to be taken by staff in relation to the administration of their insulin depending on the person's blood glucose levels. Records of the person's blood glucose levels had been maintained in line with the advice from the specialist nurse.

Processes were in place for the timely ordering and supply of people's medicines. The schedule for delivery of the medicines to the service was such that staff needed to check them as soon as they were delivered in order to correct any discrepancies prior to them being required. However, we were told arrangements were in place to do this and any issues were resolved in a timely manner, thus avoiding any gaps in administration. When we checked the MARs we did not find any evidence of gaps in administration due to a lack of availability of people's medicines.

A person was receiving their medicines covertly and we saw evidence of the involvement of the pharmacy and the GP in the decision. A mental capacity assessment had been completed and a best interests decision was documented.

Medicines were stored safely and in line with requirements. Temperature checks of the room and the refrigerator used to store medicines were recorded daily and were within acceptable limits. We observed the administration of a controlled medicine and saw two staff checked the medicine and the administration to the person. We checked the number of one controlled medicine against the controlled medicine record book and found the number remaining tallied with the number recorded in the record book. Liquid medicines and topical creams were labelled with the date of opening and cream application records had been completed.

Registered nurses were the only staff to administer medicines. Staff administering medicines completed competency assessments annually and a member of staff who had recently commenced work at the service told us they had shadowed a member of staff administering medicines and had been observed administering medicines prior to administering them independently. Medicines audits had been completed monthly and when issues were identified action had been taken to address them.

People told us they thought the home was clean and clothing well laundered. One person said, "It's fine for me. No smells!" A visitor said, "It's all very clean." We observed staff followed safe infection control practices.

During our inspection we looked at some bedrooms, all toilets and shower rooms and communal areas. Areas were generally clean though some floors were not. Some of the equipment was not clean including a hoist which was used regularly, some wheelchairs and a pressure cushion in the lounge. We were told night staff were asked to clean two wheelchairs each night and we saw the night staff communication record indicated some wheelchairs had been cleaned. The registered manager showed us a cleaning schedule for staff to complete and told us they would initiate use of this document to evidence cleaning and ensure a structured approach to cleaning equipment.

Staff were able to clearly explain their responsibilities to keep the home clean and minimise the risk of infection. They told us they felt the home was clean but a little cluttered due to a lack of storage space. Laundry and cleaning staff confirmed that they had the time and equipment to carry out their roles effectively to minimise the risk of infection, however, they told us that they were very stretched when they were the only cleaner on duty. We raised this with the registered manager who agreed they would review the position.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were sufficiently skilled and experienced to effectively support them. One person said, "Oh yes, I think they're good. When they have new staff, they get help." A visitor said, "They're always good and I've seen new ones shadowing the others. The staff seem to stay here." Another visitor said, "I find [staff] very friendly and capable."

A staff member who had recently started work at the service told us they had received an induction and had completed the Care Certificate. They told us they felt they had the knowledge and skills required for their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Another member of staff who had been at the service for just over two weeks said they had just completed their induction and felt well supported in their role. We noticed them checking with the registered manager about an issue and they clearly were relaxed and comfortable with this.

Staff said they had supervision approximately every two to three months. They said they had an annual appraisal. Supervision records confirmed staff received regular supervision and contained appropriate detail.

A senior carer told us they had completed a NVQ Level 4 management and leadership qualification. When asked if they were up to date with their mandatory training, they said, "[The registered manager] makes sure we are." They said the registered manager sourced additional training they thought would be useful and gave an example of some training they had had on "Common Health Problems" which was a distance learning course covering such issues as diabetes and epilepsy. Training records showed that staff attended a wide range of training which included equality and diversity training.

People told us that staff respected their choices. A person said, "I can get up early – it's my habit to be awake by 5am. At 6.30pm I like to get ready for bed." Another person said, "Oh yes, they come and help me up about 7.30am. Then I decide when to go to bed – it can be late if there's something good on the TV in the evening." People told us that staff explained what they were going to do and checked that they were happy before they did it. We saw that staff talked to people before providing support and where people expressed a preference staff respected them.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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.

Consent forms had been completed giving consent for physical examination, the use of photographs within the care record and their involvement in the care record. When people were not able to consent to these, mental capacity assessments and best interest decisions were documented. For example a person did not have the capacity to be involved in their care plan and their best interest decision identified the need to involve the person's close relative in their care plan reviews.

We noted a person had bed rails in place to prevent them falling out of bed. The person's records indicated they had asked for bed rails to be used and that they had the capacity to make the decision for themselves. Mental capacity assessments and best interest decisions were documented when people were unable to make specific decisions for themselves, for example, the use of a sensor mat to detect when they moved in order to prevent falls, using specific moving and handling equipment and the administration of medicines, including an assessment and best interest decision relating to a referral to a dietician and the use of insulin to control their diabetes.

Staff told us they had received training in the MCA and DoLS. They were able to discuss issues in relation to this and the requirement to act in the person's best interests. DoLS applications had been made appropriately.

DNACPR orders were in place for the three people whose care we reviewed. Two of these had been completely appropriately but one of them had not been fully completed by the GP. We raised this with the registered manager who agreed to ensure that it was reviewed.

People were supported with their behaviour in a way that reduced the risk of harm to themselves or others. For example, we observed that when a person was shouting and becoming agitated at lunchtime, a staff member talked to the person in a calming manner, stood quietly with them and we saw the person becoming progressively calmer and more settled until the carer was able to leave their meal with them and they started to eat. Staff were able to explain how they supported people with behaviours that might challenge others and care records contained guidance for staff in this area. The information in their care plan described the type of behaviour, when it was likely to happen and the actions staff should take when it occurred.

People were generally positive about the food provided at the home. A person said, "It's good – I've got no complaints. I always have a good breakfast and it's always hot – done especially for me. I can choose where I sit." Another person said, "It's nice. I get good choices too." A visitor said, "[My family member] loves [their] food. They know [my family member] and what to pick to give [them] to eat. [My family member] is [assisted to eat] by the staff now as [they] have lost weight and are struggling with [their] shaky hands to eat enough."

People told us they had sufficient to drink. One person said, "I have orange juice at breakfast and tea and coffee in the day." A visitor said, "[My family member] gets plenty to drink." Another visitor said, "[My family member]'s drinking is well supervised, we think."

We observed the lunchtime meal in the dining room and lounge. We saw that the lunchtime experience required improvement.

Most tables in the dining room were bare with no cutlery, condiments or menus. Plates came through the kitchen hatch one at a time and were taken round to people by a staff member, with cutlery by hand. Meals were taken round in no particular order with some people finishing a main course before other people on the same table had been served. Another staff member offered people drinks and again this did not appear to be in any particular order and as a consequence some people did not receive a drink promptly with their meal.

People did not always receive effective assistance to eat their meals. Some staff assisted people to eat; however, this was at the same time as eating their own meals. Although it is can be positive for staff to eat with people to facilitate a social atmosphere at lunch, this person required full assistance and there may have been food hygiene implications in supporting them in this way. Another person waited 45 minutes in the dining room before receiving their meal and assistance from staff to eat their meal. We also saw a number of people who would have benefitted from more prompting to eat their meals.

Nutritional risk assessments had been completed and reviewed monthly. We noted that the people whose care records we reviewed had gained or maintained their weight over a sustained period. Nutritional care plans were in place and gave detailed information about the person's dietary and fluid requirements. Adaptations to the normal diet for a person with diabetes were fully described in the care plan. Food and fluid charts had been completed to record people's intake.

People told us that they saw external professionals when they needed to. A person said, "I saw an optician here for my specs. And a lady comes to do my feet as I've got a bad toenail. The hairdresser is nice and I can have it done whenever I want. Staff do my nails." A visitor said, "The GP comes every week to check on [my family member] and we've had a dietician and diabetic nurse that came from [hospital]. The home always phones us if there's any problems or if an ambulance has been needed."

There was clear evidence of the involvement of a wide range of external professionals in the care and treatment of people using the service. Within the care records there was evidence people had had access to a GP and other health professionals such as a community psychiatric nurse and an occupational therapist. Clear guidance was also available for staff on meeting people's physical health needs.

A person was at very high risk of skin breakdown and we saw the service had sought advice from a tissue viability nurse and had followed their advice. We saw the person who had developed a pressure ulcer had a skin integrity assessment and care plan with detailed information about positioning of pillows and cushions to prevent further skin damage. Records to indicate their position had been changed in line with their care plans were not always appropriately completed. Records of re-positioning every two to three hours were in place in line with the care plan, although these sometimes recorded the location the person was in the home rather than their body position. The person's wounds were reviewed and assessed at least weekly and the dressings required were documented.

Some adaptations had been made to the design of the home to support people living with dementia. Bathrooms, toilets and communal areas were clearly identified, people's individual bedrooms were easily identifiable, however, there was no directional signage to support people to move independently around the home.

Good

Is the service caring?

Our findings

People told us that they found the staff kind and compassionate. A person said, "They're friendly and kind and gentle." A visitor said, "I've always been very pleased with the way they speak to [my family member]."

We observed interactions between staff and people using the service. We saw examples of caring interactions and staff with a positive and encouraging approach when talking with people with dementia to gain their cooperation.

We noted some staff had a good understanding and empathy for a person with dementia and were able to connect with them and calm them even though the person spoke little English. We observed a person using the service being greeted warmly by staff when they came on duty and the person's face lighting up as they gave them a hug.

People told us that staff knew them well. A visitor said, "I think they know [my family member] very well." Another visitor said, "They know [my family member] better than we ever knew them." Staff were knowledgeable about the care people needed and their personal preferences.

People clearly felt comfortable with staff and interacted with them in a relaxed manner. Staff greeted people when they walked into a room or passed them in the corridor. Staff engaged well with people using the service and provided reassurance to those people who were confused or distressed. We saw a staff member was assisting a person to eat. The person coughed and the staff member said, "Are you alright? Shall we just have a little breather?" The staff member then held the person's hand to reassure them.

People were not aware of any care plan and had not seen their file. However, visitors told us that they were involved in care planning. A visitor said, "They keep us up to date. We had a review last week, in fact." Another visitor said, "Any questions I ask are answered. I've a review meeting next week too, I believe." We saw people or their close relatives had signed their care plans to demonstrate their involvement.

Care records documented discussions with the family of people using the service when problems related to their well-being were identified and during regular care plan reviews. A family member of a person with advanced dementia told us, "We come in every so many weeks to speak to [the registered manager]." "[The registered manager] keeps us 100% up to date." Care plans were person-centered and contained information regarding people's life history and their preferences.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. Advocacy information was also available for people if they required support or advice from an independent person.

People told us that staff were good at maintaining privacy during personal care by closing curtains and the door. People also felt they were treated with dignity and respect. A person said, "They're good at knocking and the curtains are always shut. We have all the privacy we want." A visitor said, "They're polite and kind to

[my family member]. They put a screen up in the lounge if the chiropodist is here."

We saw staff take people to private areas to support them with their personal care and saw staff generally knocked on people's doors before entering although we saw one staff member did not do this on one occasion. The home had a number of areas where people could have privacy if they wanted it.

Staff told us they protected people's privacy and dignity by ensuring they were covered as much as possible during personal care, explaining everything to them and checking on their wishes. They said they pulled curtains across and closed doors. Some staff were identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times. We saw that staff treated information confidentially and care records were stored securely. However, we saw information regarding a person who used the service which did not fully protect that person's dignity. We informed the registered manager who removed this information immediately.

People told us that staff supported them to be independent. A person said, "Oh definitely they let me be independent." Another person said, "I wash myself and they shave me. I can choose my clothes as well." Staff told us if they knew someone was capable of doing something for themselves they would provide encouragement and reassurance to enable them to be as independent as possible.

Good

Is the service responsive?

Our findings

People told us they received personalised care that was responsive to their needs. A person said, "I think they do know my routine now." Another person said, "[Staff] come very quickly, bless them." A visiting professional said, "Staff are very responsive to people [who use the service]. They are very focussed on the person and are attentive." We also observed that staff responded quickly to people when they requested support.

People were positive about activities offered at the home. One person said, "I like the singer and we do bingo and quizzes. I like knitting too." Another person said, "I'm always there if they're doing something. My favourite is hymn singing when it's that time. I like the spongey ball, and quizzes and singing." Another person said, "There's seven of us that sit together and throw balls at each other. We've had quizzes and a singsong and some memories of when we were small."

There was a record of people's involvement in activities. For example it was documented that a person had enjoyed music, the sensory box, and had tapped their hands and feet to music, and was swinging their legs to music. The activity records for another person we reviewed stated they had been involved in some reminiscence therapy, had a chat with staff, and had had a hand massage and manicure.

A member of staff said, "Activities are rostered every week, there's arts and crafts, sensory, different things each day." Another member of staff said they felt people had enough to do each day. In the afternoon of the day of the inspection we saw a member of staff facilitating a game with an inflatable ball with people sitting in the lounge.

There was evidence within the care records of a pre-admission assessment of each person's needs and a range of care plans based on people's care and support needs. Care plans were person-centred and detailed as to the assistance the person required and their preferences. When people had health conditions such as diabetes or epilepsy, care plans gave clear information as to the management of these conditions, the signs which may indicate a deterioration in their condition and action to be taken if these occurred. Care plans had been reviewed monthly.

People's care records contained life history information and in addition there was a document indicating things which were important to the person and how to support the person. Staff told us there were several people who preferred a female member of staff to assist them with their personal care and all the staff were aware of this and arranged their work accordingly.

Two people whose first language was not English were using the service. We looked at the care records of one of these people and talked with staff about this. We saw conversation classes in the person's language had been provided for staff and common phrases used in greetings, personal care, bed time, doctor's visits and encouraging and reassuring phrases were given in English and the other language for staff reference. We also saw flash cards to aid communication. Staff told us they had learned some common phrases and that although the person did not speak much English they understood quite a lot of English words and phrases.

Visitors told us they could visit whenever they wanted to. A visitor told us that they were welcome to visit any time and were offered drinks and could book to stay for a meal if they wish. We observed that there were visitors in the home throughout our inspection. Visiting arrangements were set out in the guide for people who used the service.

People told us that they did not know about a formal complaints procedure, however, they had not felt the need to make a complaint. Visitors told us that they felt able to speak to the registered manager and other staff if they had any issue. Staff knew how to respond to complaints.

Complaints had been handled appropriately. Guidance on how to make a complaint was displayed throughout the home and in the guide for people who used the service. There was a clear procedure for staff to follow should a concern be raised.

Good

Is the service well-led?

Our findings

People were not aware of any meetings to discuss their views of the service. Visitors told us that meetings took place. A visitor said, "They have a monthly coffee morning with an open agenda really. We've brought the odd thing up at meetings and they tell us what they'll do about it." Another visitor said, "I've been now and then – it's well publicised and we get feedback afterwards." Visitors told us they definitely felt listened to by staff.

We saw notes taken at the meetings for people who used the service and their visitors and actions had been taken to address any comments made. We saw that surveys had been completed by people who used the service. Responses were positive. There was a notice displayed in the home to inform people and their visitors what action had been taken in response to their comments.

The provider had values in place and we saw that staff acted in line with those values. A member of staff said, "I love this job, I really do." "Seeing people's happy faces and feeling you have made a difference to people's days." Staff told us they would be comfortable raising issues using the processes set out in the whistleblowing policy.

People and visitors were very positive about the registered manager. A person said, "I know her name and can talk to her." Another person said, "She'll come and ask me if I'm okay and ask if they're looking after me." A visitor said, "I see her now and then but I can ring or ask anything." Another visitor told us they were aware of meetings for relatives of people using the service but did not feel the need to attend as they had regular meetings with the registered manager and felt they were kept completely up to date and therefore did not need to attend meetings. They said, "We have a really nice relationship with [the registered manager]."

A member of staff said the registered manager was very approachable and keen to help. They said there was a staff meeting every month and they found it, "Quite helpful." They said they often had a group discussion and felt able to ask other staff how they did something if they experienced difficulties. Another staff member said, "We see the [registered] manager every day. She is very good; she's strict but good. I am very confident she would deal with any concerns." Staff told us the registered manager would hold a meeting with staff to feedback any complaints or areas for improvement. She would then put information into the communication book for staff who were not present.

A registered manager was in post and she was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She felt very well supported by the provider and told us that sufficient resources were available to provide a good quality of care at the home. We saw that all conditions of registration with the CQC were being met and notifications had been sent to the CQC when required.

We saw that regular staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

The provider had an effective system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and other staff. Audits were carried out in the areas of infection control, care records, medication, mealtimes, health and safety and catering. Action plans were in place where required to address any identified issues.

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed. We saw that safeguarding concerns were responded to appropriately and appropriate notifications were made to the CQC as required. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this.

Documentation was generally well completed however we saw that people's hygiene records indicated that at least five people had not had a bath, shower or bed bath for at least eight days. We talked with the registered manager and a senior carer about this, looked at the work allocation records and were satisfied that it was a lapse in documentation rather than a lack of care. We saw the agenda for the staff meeting held earlier in the week had an item on the agenda relating to the need for consistent completion of documentation relating to personal hygiene.