St Dominic's Limited

Birdscroft Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Birdscroft Nursing Home provides accommodation nursing and personal care for up to 28 people, some of whom have dementia. Rooms are arranged over two floors and there is a passenger lift. Communal facilities include a large lounge, a small quiet lounge, a separate dining room and a secluded rear garden which is accessed via a ramp with rails.

Birdscroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Birdscroft is registered to provide accommodation for persons who require nursing or personal care for up to 28 people. There were 26 people living at the service at the time of our inspection.

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

We last carried out a comprehensive inspection of Birdscroft in November 2016 where we found the registered provider was in breach of two regulations. These related to the safe management of people's medicines and the effectiveness of the provider's quality assurance systems. Following this inspection the registered provider sent us an action plan of how they would address these two issues.

We completed a focussed inspection in June 2017 to check that the provider had taken action to address the concerns we had raised. At that inspection we found that both concerns had been addressed by the provider. At this inspection we found that the care and support people received had continued to improve under the guidance of the registered manager.

The inspection took place on 29 November 2017 and was unannounced.

There was positive feedback about the home and caring nature of staff from people who live here. The registered manager had been in post for over six months, and had made many positive changes to the standard of care people received. Quality assurance processes were now picking up day to day issues, so that corrective action could be taken.

People were safe at Birdscroft Nursing Home. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or Care Quality Commission.

Risks of harm to people had been identified and clear plans and guidelines were in place to minimise these

risks. The home was clean, and staff practiced good infection control measures, such as hand washing and correct use of personal protective equipment. In the event of an emergency people would be protected because there were clear procedures in place to evacuate the building.

There were sufficient staff deployed to meet the needs and preferences of the people who lived at the home. There had been a recent issue with staffing, but the registered manager had taken action to prevent a reoccurrence. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff received a comprehensive induction and ongoing training, tailored to the needs of the people they supported. People's nursing needs were met by competent staff.

People received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines. Internal audits continually reviewed staff performance around medicines, and appropriate actions were taken where issues were raised.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Staff were heard to ask people for their permission before they provided care. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and specialist diets either through medical requirements, or personal choices were provided. People who required specialist equipment to help them eat were supported by nursing staff to ensure this was done safely.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. When people's health deteriorated staff responded quickly to help people and made sure they received appropriate treatment. People were supported at the end of their lives to have a dignified death.

People received the care and support as detailed in their care plans. The staff knew the people they cared for as individuals, and were positive in their interactions with them. Staff treated people with kindness and respect. People were involved in their day to day care decisions.

People had access to activities in the home and the registered manager was reviewing the possibility for arranging more external trips for people.

People knew how to make a complaint. Where complaints and comments had been received the staff had responded to try to put things right.

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 living at the home. Staff understood their responsibilities around protecting people from harm.

There were enough staff to meet the needs of the people. Appropriate checks were completed to ensure staff were safe to work at the home.

The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Infection control processes were robust.

Is the service effective?

Good

The service was effective

Peoples needs had been assessed prior to coming to the home, to ensure those needs could be met.

Staff said they felt supported by the registered manager, and had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's liberty may be being restricted, appropriate applications for DoLS authorisations had been completed.

People had enough to eat and drink and had specialist diets where a need, or preference, had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff that showed respect and care.

Staff knew the people they cared for as individuals. Communication was good as staff were able to understand the people they supported.

People could have visits from friends and family, or go out with them, whenever they wanted.

Is the service responsive?

Good

The service was responsive.

Care plans gave detail about the support needs of people. People were involved in their care plans, and their reviews.

Staff offered a range of activities that matched people's interests.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received.

People were supported at the end of their lives.

Is the service well-led?

Good

The service was well- led.

Quality assurance checks were effective at ensuring the home was following best practice. Records management had improved to ensure management oversight of the home was effective.

People and staff were involved in improving the service. Feedback was sought from people via meetings and annual surveys.

Staff felt supported and able to discuss any issues with the registered manager. The provider and registered manager regularly spoke to people and staff to make sure they were happy.

The registered manager understood their responsibilities with regards to the regulations, such as when to notify CQC of events.

Birdscroft 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 29 November 2017 and was unannounced.

The inspection team consisted of one inspector, a nurse specialist who was experienced in care and support for elderly people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. 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 potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed to see if we would need to focus on any particular areas at the home.

We spoke with seven people who lived at the home, four relatives and six staff which included the registered manager who was present on the day. We also spoke to a visiting healthcare professional. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included seven care plans and associated records, seven medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted commissioners of the service to see if they had any information to share about the home.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Birdscroft Nursing Home. One person said, "Oh yes, I feel safe." Another person said, "The main door is locked all the time and there's always staff here to help you."

People were protected from the risk of abuse. People knew who they could speak to if they had any concerns, and believed their concerns would be addressed promptly. Staff had a clear understanding of their responsibilities in relation to safeguarding people. Staff were able to describe the signs that abuse may be taking place, such as bruising or a change in a person's behaviour. Staff understood that a referral to an agency, such as the local Adult Services Safeguarding Team or police should be made.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns that may suggest a person's support needs had changed. Appropriate action following incidents had been taken. At the time of our inspection there had been very few accidents at the home, showing people received a good safe level of care. People confirmed they were involved in reviews if accidents did happen to try and minimise it happening again.

People were kept safe because the risks of harm related to their health and support needs had been assessed. Hazards to people's health had been risk assessed for issues such as tissue viability (people prone to pressure wounds) and choking. When risks had been identified, the care plans contained clear guidance for staff on how to manage these. Two people had been assessed as having a high risk of skin breakdown. Safe working systems had been clearly documented, including tissue viability recommendations for air mattress, MUST screening (This is a form that can be used to establish nutritional risk), creams to be applied, photos of the wound, measurements and body maps. This was in place so that staff could monitor any trends in relation to the healing process and any infections. The risk assessment had been reviewed monthly, and the plan had been changed as the person's needs changed. Daily records and our conversations with staff confirmed these were understood and implemented in line with the guidance. As people's needs changed the staff ensured that risk assessments were updated and appropriate equipment was used to support people.

People were cared for in a clean and safe environment. One person said, "Cleanliness is very good here. They hoover and clean my room every day…they really are very good." Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control. Staff understood their responsibilities around maintaining a safe environment for people. They ensured the floors and doors were kept clean. Equipment such as mobile hoists were regularly serviced and cleaned to make sure they were safe to use.

Staff wore appropriate personal protective equipment when giving personal care, or when serving food to minimise the risk of spreading infection. Where required infection control plans provided clear guidance and protocols for staff to follow, for example, wearing protective clothing when caring for a person, washing hands and other barrier nursing protocols. Where the person's needs had changed positively, the service

had reviewed their care plan. The care plan guidelines were followed. There was protective clothing outside a room and the care staff we spoke with were clear on how to care for the person and reduce cross infection.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. There was also a continuity plan in place to ensure people would be cared for if the home could not be used after an emergency.

There were sufficient staff deployed to keep people safe and support the health and welfare needs of people living at the home. We received feedback from relatives that there had a recent incident where due to sickness on one day, staff had been stretched which resulted in people having to wait for care. The registered manager explained to us how this had happened, and detailed the actions taken to minimise the risk of a reoccurrence. This included better lines of communication to authorise use of agency staff at the weekends. Staffing rotas recorded that the number of staff on duty matched with the numbers specified by the registered manager (except for the one day due to sickness). Staffing levels were based on the individual needs of people, and took into account people who may need two staff to help them mobilise. Our observations on the day that demonstrated a good level of staffing included call bells being answered promptly and two care staff always being involved when moving people.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The registered manager reviewed accidents and incidents and made improvements when things went wrong. In response to the incident with staffing they had changed how staff were deployed around the building, so they had a clear understanding of who they were to support each shift. Therefore if agency staff were required they could be quickly and easily given tasks as it was clear what everyone else was doing. The registered manager was also making continual improvements to the management of medicines through supervision and training of staff where errors in recording had been identified by internal quality checks.

People's medicines were managed and given safely. Staff who administered medicines to people received appropriate training, which was regularly updated. When administering medicines nursing staff were calm and unrushed and ensured people received the support they required. Staff who supported people with medicines were able to describe what the medicine was in a jargon free way to ensure people were safe when taking it. For 'as required' medicine, such as pain killers, there were guidelines in place which told staff when and how to administer the pain relief in a safe way. Where people had allergies this was recorded on the medicine administration record (MAR), and staff who gave medicines knew about them.

The ordering, storage, and disposal of medicines were safe. Medicines were stored safely in locked trolleys. People's medicines were stored in an orderly manner in these trolleys. The agency nurse administering the medicines did not have to spend a considerable amount of time trying to find the correct medicine dosset box, box or bottle. This also reduced the risk of errors. Medicines that required storage in the refrigerator were kept in the fridge. The temperature of the fridge was checked daily and monitored. When medicines were received at the home staff logged them in. They detailed the date received, name of person they were for, the name of the medicine and the quantity. Used medicine was collected by a specialist contractor for safe disposal and a receipt given for records.

Good

Is the service effective?

Our findings

People's needs had been assessed before they moved into the service to ensure that their needs could be met. People were involved in this process. Assessments contained detailed information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility, as well as personal preferences and histories.

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. A relative said, "The long-standing staff are brilliant." The induction process for new staff was robust to ensure they would have the skills to support people effectively. Induction included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Ongoing training and refresher training was well managed, and the registered manager ensured staff kept up to date with current best practice.

Staff were effectively supported. Staff told us that they felt supported in their work. Regular one to one meetings took place with their line manager. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. Staff told us they could approach management anytime with concerns, and that they would be listened to and the management would take action.

People had enough to eat and drink to keep them healthy. Some people felt that more variety would make mealtimes more interesting. One person said, "Oh yes, I like the food…they seem to give us a lot of casserole…. but if you don't like the menu you can choose other option, you can have an omelette." A relative said, "My family member is eating quite well now…. the food here is simple but well cooked."

People were protected from malnutrition and dehydration. Care plans contained nutritional assessments and people's weight was recorded each month. When people had been assessed as being at risk of malnutrition or dehydration, care plans provided clear guidance for staff. In six people's care plans it was documented that they needed a high calorie diet due to weight loss. Staff had asked the GP to review the person and they had subsequently been prescribed food supplements. When we checked with the chef we found a list of these dietary requirements present, and we saw them being added to drinks and meals during the inspection.

People's special dietary needs were met, such as soft diets for people who had difficulty swallowing. Menu plans, and food stored in the kitchen matched with people's preferences and dietary needs. These reflected what people had told us, and were known by the chef. People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. One person had complex nutritional needs. A speech and language therapist (SaLT) had reviewed them and recommendations had been made to staff on how best to support the person. When we spoke with staff they were knowledgeable and knew the care that had been planned for the person. This person was on a PEG feeding regime. (This is where people have their food via a tube directly into the stomach). Their PEG feed equipment was set correctly and clean.

People received support to keep them healthy because staff worked effectively with other healthcare services. People and their relatives told us that the GP and other health professionals visited regularly. To ensure a good standard of care, staff sought support from other health professionals including the GP, physiotherapist, tissue viability nurse, and incontinence specialist.

People who had nursing support needs were effectively cared for by staff. People's health was seen to improve due to the care and support of staff. People were protected against the risk of pressure sores. A relative said, "My family member was moved from another home that closed. She'd had bed-sores for a long time, but they sorted it here." People cared for in bed all had pressure mattresses and there was a culture of routine diligent skin care by staff. No one had any pressure wounds at the time of our inspection. Records of past instances demonstrated that effective care had been given, for example pictures of the wound were taken at regular intervals which showed progress with healing. The daily notes recorded that the wounds were regularly cleansed and dressed. The entries showed the involvement of the tissue viability nurse (TVN), so the person had received appropriate care and support.

People lived in a home that had adaptations made to meet their individual needs. The home was not purpose built, so corridors were narrow, however the provider ensured clutter was kept to a minimum to reduce the risk of trips. Flooring was in good condition, and a plan was in place to replace the carpeted areas with smooth laminate to further reduce the risk of trips. The registered manager was in the process of reviewing the decoration to take into account the needs of people whose eyesight was failing. Large bright signs were on the majority of doors to enable people to identify what the purpose of the room was, such as the lounge, toilets, or bedrooms.

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.

Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

People's decisions were respected by staff. Staff went into one room to support a person with personal care. On two occasions the person declined and asked them to come back later. The staff were quite happy to leave, and return at a more suitable time. Other people that lived at Birdscroft Nursing Home said, "Yes, I make my own choices."

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 are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS Board. People were supported in accordance with these DoLS authorisations. Clear records were in place for where best interest decisions had been made, such as for the use of bedrails to keep people safe from falls out of bed.

Good

Is the service caring?

Our findings

We had positive feedback about the caring nature of the staff. One person said, "Staff are really caring." Another person said, "I'm cared for how I liked to be looked after by the staff."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People looked well cared for, with clean clothes, tidy hair and appropriately dressed for the activities they were doing.

Staff were caring and attentive with people. All the care staff were seen to talk to people, asking their opinions and involving them in what was happening around the home. One person walked freely around the home and staff always spoke to her in a kind and calm manner. Staff were knowledgeable about people and their past histories. Throughout the inspection it was evident the staff knew the people they supported well. Staff were able to tell us a lot about the people they supported without access to the care notes, including their hobbies and interests, as well as medical support needs. Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

Staff communicated effectively with people. Staff communication with people was warm and friendly, showing caring attitudes during their conversations. When providing support staff checked with the person to see what they wanted. Staff spoke to people in a manner and pace which was appropriate to their levels of understanding and communication needs.

People were given information about their care and support in a manner they could understand. Information was available to people around the home, such as the correct time, date, and weather conditions to help people orientate themselves. Other information on notice boards covered topics such as upcoming events that people may be interested in, as well as photographs of past events that people had enjoyed.

Staff treated people with dignity and respect. A relative said, "Yes, they respect her and treat her with dignity." When staff interacted with people they had considerate and respectful attitudes and addressed people by their preferred names. Before changing channels on the television staff asked people if they were watching the programme that was on, and respected their replies. During mealtimes where staff supported people to eat this was unhurried and staff gave the person they supported their full attention.

People were supported to maintain their independence. One relative said, "Care staff do her fingernails with varnish and she helps, and she enjoys." One person mentioned that staff knew that she would not face the day without having her make up on. Consequently, straight after she had finished her breakfast, they would put her make up bag on her table, so that she could use it when she was ready.

People's rooms were personalised which made it individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs, and how the person's care may be affected due to those beliefs. People had access to services in the home so they could

practice their faith. People told us they could have relatives visit when they wanted, or go out on their own or with their relatives if they wished.

Good

Is the service responsive?

Our findings

People were involved in their care and support planning. One relative was really happy that his loved one's health had improved since arriving at the home. They said; "Since being here she's more alert than she was before coming to the home. We, as a family were concerned that she would be institutionalised [which hasn't happened here]." Relatives stated that they were involved in making decisions for their loved one's care needs.

Care plans were based on what people wanted from their care and support. People told us that their care was focussed on their individual needs, and that the care plans were reviewed with them. They were written with the person by the nurses or registered manager. Reviews of the care plans were completed regularly by care staff so they reflected the person's current support needs. The registered manager also kept the care plans under review, and was working on making them more person centred. At the time of our inspection the plans were focussed on medical needs, and information about people's life prior to coming to Birdscroft Nursing Home was sparse. This information would enable staff to better understand the people they supported.

People's choices and preferences were documented and were seen to be met. There was information concerning people's likes and dislikes and the delivery of care. The files gave some overview of the person, their life, preferences and support needs such as, health and physical well-being, medicines, diet and nutrition, personal care, spiritual and religious belief.

Care plans addressed areas such as how people communicated, and what staff needed to know to communicate with them. Other areas covered included keeping safe in the environment, personal care, mobility support needs, behaviour and emotional needs. The information matched with that recorded in the initial assessments, which gave staff the information to be able to care for people.

People had access to a range of activities, to keep them entertained and stimulate their minds. There was a dedicated activities co-ordinator in post; however they were due to leave before the end of the year. The registered manager said they were already in the process of recruiting a replacement. Staff were flexible and were led by people's interests. The home was fortunate to have links within the local community with a 'mother and toddlers' group, and the local church. This gave people access to people outside the home and stimulated conversation. When planning the activities schedule the activity co-ordinator took into account that family visits occurred for a majority of people at the weekends. As a result this time was respected by staff and activities were kept to a minimum so people could focus on their family. `Special' days were celebrated throughout the year, and the home was decorated accordingly. In response to requests by the people who lived at the home they had not celebrated Halloween, people said that they found this scary. People told us that one of their entertainers was in a wheelchair and they really enjoyed the act that she did with her singing partner. This had been a really positive experience for people who used a wheel chair to mobilise within the home. People who lived at Birdscroft Nursing Home currently had no organised trips out. The registered manager said they were aware of this and were in discussion with the area manager to see if this could be improved.

People were supported by staff who listened to and would respond to complaints or comments. People were able to express their points of view through the residents' and relatives' meetings, as well as to individual members of staff. They told us that they were happy to raise any concerns that they might have, and stated that they were listened to, and staff would act on their requests. One relative said that they had made a complaint regarding one particular bank holiday which had been staffed by predominately agency staff. They had been unhappy about the attitude of one of the agency staff. They told us that the registered manager dealt with this immediately, and reported the issue to the agency, stating that this staff member was not welcome at the home in future.

There was a complaints policy in place, in an easy to read format, which was clearly displayed around the home. The policy included clear guidelines, in an easy to read format, on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

People were supported at the end of their life to have a dignified and as far as possible pain free death. A person on end of life care had an advance decision in place and their care plan clearly documented how they wanted to be treated during their end of life care. Their family was actively involved and consulted. 'Just in case' medicines had been requested for and were in place. There was hospice information in their case notes for staff to refer to when it was needed.

Good

Is the service well-led?

Our findings

At our previous focussed inspection in June 2017 we had confirmed that action taken to address concerns with the quality assurance process had been completed. The provider needed time to embed the process to show it was robust and effective at ensuring people received a good standard of care. At this inspection the process had been in use for some time and had enabled the registered manager to monitor and make improvements to the service.

Regular weekly and monthly checks on the quality of service provision took place and results were actioned to improve the standard of care people received. Audits were completed on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. In addition the provider's quality assurance manager had introduced monthly checks to give an independent review of how the service was meeting people's needs. All of these audits generated improvement plans which recorded the action needed, by whom and by when. Actions highlighted were addressed in a timely fashion.

There was a positive culture within the home, between the people that lived here, the staff and the registered manager. Everyone stated that the service was now well-led, and they were happy with the new management. The atmosphere was very welcoming and open during our inspection. The registered manager was visible and polite throughout the inspection and was also approachable to clarify any issues we raised throughout the inspection. This positive approach was continued in staff team meetings, where staff successes were celebrated.

Staff were confident in their roles and had a clear understanding of the values and visions of the service. Their professionalism, kindness and compassion demonstrated over the course of the inspection matched with these values. Relatives and people that lived at the home stated the registered manager had enabled staff to understand their duties and their roles, which had a positive impact on the care people received.

People experienced a level of care and support that promoted their wellbeing because staff understood their roles and were confident about their skills and the management. Staff told us the registered manager had an open door policy and they could approach the manager at any time. Staff felt supported and able to raise any concerns with the registered manager, or senior management within the provider.

People and relatives were asked for feedback about how the service was managed. Regular resident and relatives meetings took place. These were used to share information, as well as seek feedback and ideas from people who were involved in the service. Questionnaires were also used to ask for opinions on all aspects of the home. The results were then reviewed by the provider and a summary report put on display for people, staff and visitors to see the results. A response to the feedback was also generated to address any issues raised.

Staff were involved in how the service was run and improving it. The registered manager had regular meetings in addition to handover meetings. There was a 'huddle meeting' which involved the heads of all departments getting together to discuss the plans for the day, and if they needed support with anything.

This promoted team work, as each staff member gave feedback. It also enabled the registered manager to understand how well the service was running on that day, and if any additional support was required. The registered manager also held meetings with the nurses to discuss people who may be unwell. The focus was to make sure support was in place to ensure the persons health didn't deteriorate. As a result of these meetings and initiatives the number of and GP visits as well as hospital admissions had reduced. A staff member said they found the 'huddle' meeting effective as any issues of the day were addressed in this meeting and this meant risks were identified quickly and managed effectively.

The manager on duty during the inspection was visible around the home, supporting staff and talking with people to make sure they were happy. This made them accessible to people and staff, and enabled him to observe care and practice to ensure it met the home's standards. The manager had a good rapport with the people that lived here, and knew them as individuals.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns. They had also completed the Provider Information Return when it was requested, and the information they gave us matched with what we found when we carried out this inspection.