Pilgrims Way Limited

Pilgrims Way Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection was carried out on 15 March 2016 and was unannounced.

At our previous inspection on 16 June 2015, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to safe recruitment and the management of waterborne infections. The provider sent us an action plan telling us how they would meet the regulations by 8 October 2016. Also, we made two recommendations for the provider to follow-up.

At this inspection, we found that the registered manager and provider had taken action to address the breaches and recommendations from the previous inspection.

The service provided accommodation, personal and nursing care for up to 76 older people. There were 42 people living in the service when we inspected. People predominantly needed nursing care to assist them to manage chronic and longer term health issues associated with aging or after an accident or illness. The accommodation was provided over two floors in a main building and a link attached extension. At the time of this inspection the 34 bedded link attached extension was not in use. A lift was available to take people between floors.

There was a registered manager employed at the service. 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.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred. However, it was not clear how staff were assessing and managing the risks posed to people by hoist slings sizes and how the potential risk of cross infection was controlled when slings were shared and stored together.

We have made a recommendation about this.

The provider and registered manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had been well maintained. However, mattresses that relieved pressure on people's skin were not always adjusted correctly.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of

Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The registered manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. The provider had a dedicated system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. The registered manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council. (NMC.) Nursing staff received regular clinical supervision and support.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. The risk was assessed and the steps to be taken to minimise them were understood by staff.

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service.

There were policies and a procedure in place for the safe administration of medicines. Nursing staff followed these policies and had been trained to administer medicines safely.

We observed staff that were welcoming and friendly. People and their relatives described staff that were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained they were listened to and the registered manager made changes or suggested solutions that people were happy with.

The registered manager of the service, nurses and other senior managers were experienced and provided good leadership. They ensured that they followed their action plans to improve the quality of the service. This was reflected in the changes they had already made within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People experienced a service that made them feel safe. However, the assessment of risk from the use of equipment did not protect people from potential harm. Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted on safeguarding concerns and notified the appropriate agencies.

There were sufficient staff to meet people's needs. The provider used safe recruitment procedures and risks were assessed. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protected people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role. Nurses were supported to continue their professional development.

Staff received an induction and training and were supported to carry out their roles well. The Mental Capacity Act and Deprivation of Liberty Safeguards was followed by staff.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were

comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People told us they were treated with dignity and respect by staff and we observed this happening.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them. Activities were organised to promote involvement and reduce social isolation.

Information about people was updated often and with their involvement so that staff only provided care that was up to date. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Complaints were resolved for people to their satisfaction.

Is the service well-led?

Good

The service was well led.

The registered manager was a qualified nurse with the appropriate skills and experience to lead staff in the service and drive through improvements to people's care.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered and actions were taken to keep people safe from harm.

The provider and registered manager promoted person centred values within the service. They planned to continually improve people's experiences. People were asked their views about the quality of all aspects of the service.

Pilgrims Way Care Home with Nursing

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 15 March 2016 and was unannounced. The inspection team consisted of an inspector and a nurse specialist.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We checked the actions that had been taken against the provider's action plan.

We observed the care provided to people who were unable to verbally tell us about their experiences. We spoke with eight people and six relatives about their experience of the service. We spoke with seven staff including the registered manager, a nurse manager, a nurse and four care workers to gain their views about the service. We asked a health and social care professional for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at eight people's care files, seven staff record files, the staff training programme, the staff rota and medicine records.

Requires Improvement

Is the service safe?

Our findings

People described and we observed a service that was safe. One person said, "I've lived here for three years, I am very safe, the staff are kind and treat me safely, there's no nastiness here." People told us there were enough staff, they did not have to wait for staff to provide care. One relative said, "Mum is safe here, staff are very careful when they use the hoist with her, Mum would tell us if she was not happy." Another said, "Mum had falls before, but she has had none here, we feel she is safe here and have no concerns about leaving her."

At our previous inspection in June 2015 we identified two breaches of regulations. This related to the management of risk around waterborne viruses and the recruitment of staff. We also recommended to the provider that they follow published guidance in relation to planning for effective emergency evacuations of the service. At this inspection, we found the new registered manager had made improvements to these areas, but some further work was still required in others.

Infection control protocols had been implemented and were effectively managed. For example, a legionella risk assessment and stored water management plan were now in place. We saw that the management checks had been carried out and recorded. This protected people by reducing the risk of water borne illnesses within the service.

We observed staff washing their hands before and after delivering care. A small trolley was left outside people's rooms with a plentiful supply of gloves and aprons and we observed these being used. Protocols for barrier nursing had been implemented by the registered manager to prevent the spread of infections within the service. There were supplies of liquid soap and paper towels in the clinical rooms and bathrooms and toilets. The service looked and smelt clean.

People were protected from the risk of receiving care from unsuitable staff. Staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

Staffing levels were planned to meet people's needs and varied depending on people's dependency assessments. Records showed that people's dependency assessments were reviewed at least monthly. In addition to the registered manager, there were up to eight staff available to deliver care managed by an additional three qualified nurses. At night there were up to five care staff managed by an additional two qualified nurses. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal staff.

Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. How staff would be deployed was organised by the nurse in charge before shifts started so that the skills staff had could be matched to the people they would care for. Staff responded to people quickly when they needed care which reduced the risk of people falling or becoming upset. There were enough staff available to walk with people using their walking frames if they were at risks of falls.

When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed. The registered manager told us that each person had the correct sling for their size, weight and any disability they may have. We observed staff lifting people with a hoist, staff worked in pairs, staff spoke to the people to reassure them during the process and used blankets over the knees to preserve people's dignity. However, the moving and handling risk assessments did not always identify the size and type of hoist sling people needed, or describe in detail all of the physical issues people using the sling may have. Staff told us that they knew which slings to use by looking at the size of the person, but were unable to show us where this was assessed and recorded. This had created the potential to put people at risk of slipping from the sling whilst they were being lifted.

The registered manager told us that each person had their own hoist slings and bed slide sheets. These helped staff move people up and down the bed safety. We did not observe any slings or slide sheets that were linked to any individual person. Slings were kept together on hooks in storage areas or had been draped over a hoist where they were stored. People sharing slings or bed slide sheets could increase the risk of the spread of infection. However, the registered manager was able to demonstrate to us that they had already started to implement a new assessment and care planning system which was addressing the issues we had found. The newer care plans we looked at did contain the detailed information required.

We have recommended that the registered manager researches and follows published guidance in relation to the individual assessment and infection control for the use of hoist slings in nursing home settings.

People were protected by the effective implementation of individually assessed evacuation and service continuity plans. The registered manager had reviewed the policies and guidance about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Each person now had a comprehensive and easy to understand emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The registered manager operated an out of hours on call system so that they could support staff if there were any emergencies. This meant that people's care could still be delivered if there were interruptions to the service at Pilgrims Way.

Equipment was serviced and checked by staff who were trained how to use it. However, we noted that four out of five pressure relieving mattresses were not set to the correct weight for the people using them. This created a potential risk to people's skin being damaged. The registered manager showed us a recent mattress setting check list and audit they had completed, but could not explain why the mattress weight settings had been changed. They told us they would get this corrected. The premises were designed for people's needs, with signage that was easy to understand. The premises environment was maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping.

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The registered manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments gave a score for levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough. This ensured that staff knew how to protect people's health and wellbeing.

People were protected from preventable harm and could call for help if needed. The registered manager checked for patterns of risk. Incidents and accidents were checked to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. For example, people who fell were checked for any underlying health issues that may have caused the fall.

Nursing staff followed the provider's policy on the administration of medicines which had been reviewed annually. Nurses told us that their medicines administration competences were checked by the registered manager against the medicines policy and that they had no concerns about the management of medicines in the service. We saw discussions from competency checks had been recorded in staff files. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

The medicine administration record (MAR) showed that people received their medicines at the right times as prescribed by their GP. The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered and signed for by the nurse on shift. Medicines were correctly booked in to the service by nurses and this was done in line with the service procedures and policy. Nurses administered medicines as prescribed by other health and social care professionals. For example, a person on warfarin was receiving the correct amount as prescribed from the anticoagulant service. There were care plans and policies about the management of the administration of warfarin, insulin, glucagon, inhalers, eye drops, ear drops, rectal medication and buccal midazolam. They all followed best practice. Copies of these care plans were placed in people's care records, for example so that staff would have access to information on warfarin therapy and the importance of spotting bleeding and bruising. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Good

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. People said, "I prefer to eat in my room and I am pleased that the food arrives hot." And, "I get plenty to eat and drink and can get snacks at night if I want them." Another person said, "The staff are very helpful, they care for me well." Relatives said, "We see what goes on, they visit Mum and they give good care." Other relatives commented that the food was good and said, "Mum has been here five years and the care Mum gets is excellent."

At our previous inspection in June 2015 we identified issues relating to the effective and on-going supervision of staff.

People received nursing and personal care from staff who were supported and trained to meet their needs. At this inspection we found that staff were provided with regular one to one supervision meetings as well as staff meetings and annual appraisal. These were planned in advance by the registered manager and fully recorded. Training records confirmed staff had attended training courses after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. The provider had systems in place to ensure staff received regular training, could achieve recognised qualifications and were supported to improve their practice. Clinical supervision for nurses was on-going and there were appointed professional leads in areas such as infection control and medical awareness. Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, wound care and gained knowledge of other conditions people may have such as diabetes.

New staff inductions followed nationally recognised standards in social care. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

People's health was protected by proper health assessments and the involvement of health and social care professionals. A GP visited three times a week, and people had access to occupational therapist and other specialist services. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file which covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing

settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Care plans included eating and drinking assessments and gave clear instructions to staff on how to assist people with eating. People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded.

People who had had strokes and were on puréed and soft diets, records showed that that there were care plans/advice sheets on how to help people who were at risk of chocking. There were care plans detailing the positions people needed to be in when they ate to reduce choking risks, information about the consistency of the food and whether to cut it up. The cutlery people were able to use, whether fluids should be thickened and whether people needed assistance to eat were all fully documented for staff. Nursing staff could tell us what action they would take if a person was choking to clear their airway. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and that foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place.

We observed lunch being served in the dining rooms and to people in their bedrooms. Food was presented and served in a way that promoted the social aspect of the occasion. People were not rushed. Staff were on hand to supervise and provide support to those people that needed it. People could choose what they wanted to eat and that if they did not like the main meal an alternative would be provided. We saw staff chatting and laughing with people as they assisted them to prepare for lunch. As people gathered for lunch they were encouraged to take a seat and those who required assistance were gently supported into their seat. People were then given a choice of drinks with their lunch. This encouraged people to stay healthy and reduced the risk of infections.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that relevant people, such as social and health care professionals and people's relatives had been involved. The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff and the registered manager. One person we spoke with said, "Hari, (Registered manager) comes in every morning and say's hello, which I like". A relative said, "All staff are approachable, Mum gets a hug from the staff she knows well." All of the relatives we spoke with told us they were kept updated with what was going on with their loved ones care by staff.

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We observed that staff ensured a lively, jovial atmosphere. We saw staff listening to people, answering questions and taking an interest in what people were saying. Two staff who needed to move a person using a hoist put the person at ease by talking her through the process and confirming with her if it was okay. When speaking to people staff got down to eye level with the person and used proximity and non-verbal gestures (good eye contact, smiles and nods). People responded well to the quality of their engagement with staff. People could choose to stay in their rooms, chat to others in the main lounge and dining room or use the separate lounge to sit quietly and read or meet friends and relatives. This promoted a relaxed and homely atmosphere for people to enjoy.

Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these.

People told us that staff respected their privacy. Staff we spoke with described the steps they took to preserve people's privacy and dignity in the service. We observed that staff knocked on people's doors before entering bedrooms to give care. People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. People told us that their care plans were followed and they could say what they wanted staff to help them with.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. For example, people had asked for their food to be cut up so that they could manage the meal themselves. Or encouraged to maintain their independence when walking but have staff nearby if they needed them. We observed staff followed people's requests. This enabled then to remain independent. People or their representative had signed to agree their consent to the care being provided whenever possible. Staff confirmed they sought people's consent before they provided care for people. This meant

that staff understood how to maintain people's individuality and respect choice.

Staff fully supported people's decisions about their end of life care. Records demonstrated that people's wishes in this area were discussed with relatives and the end of life care facilitator from the local hospice.

People and their relatives told us they had been asked about their views and experiences of using the service. We found that the registered manager used a range of methods to collect feedback from people. There were residents and relatives meetings at which people had been kept updated about new developments in the service. The last quarterly 'Residents' meeting had taken place in January 2016. The provider's quality policy included gaining written feedback from people about the service. We found that the results of the 2015/2016 surveys/questionnaires were analysed by the provider. Information about people's comments and opinions of the service, plus the providers responses were made available to people and their relatives. This enabled people to stay involved with developments and events within the service and give them the opportunity to influence decisions the provider had made about changes in the service.

Information about people was kept securely in the office and the access was restricted to senior staff. When staff completed paperwork they kept this confidential.

Good

Is the service responsive?

Our findings

People's care was kept under review and changes were made to improve their experiences of the service. A relative told us her mother had improved since she had been at the service. They said, "She is walking more with the staff and was happy to sit in the lounge and watch what was going on, rather than sit in her room. Also the afternoon activities had made a difference to the other residents who had "livened up".

At our previous inspection in June 2015 we identified issues and made a recommendation relating to individualised person centred care planning. At this inspection, we found the provider and registered manager had taken action to adopt and start implementing a more robust and individualised planning process to people's care.

People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing home was suited to the person's needs. New care plans were well written; they focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. The care plans were becoming person centred and individualised. For example, they enabled people to tell their life stories, about who they were and about their lives and loves. Recording this would ensure that all staff and new staff would know people's interest and preferences. Knowing about people's histories, hobbies and former life before they needed care assisted staff to help people maintain their dignity and lifestyle choices.

The registered manager and staff responded quickly to maintain people's health and wellbeing. We saw that nurses had implemented weight management plans, these were based on advice from community dietary teams. This had resulted in the people maintaining or gaining weight. We cross checked needs led care planning for particular health concerns, such as diabetes against the care plans and found they were kept under review. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

Staff had arranged GP appointments to monitor people's health and involved other health and social care professionals when needed, like speech and language therapist. There was information about upcoming hospital/other appointments that people needed to attend. The nurse's in charge reviewed these regularly to ensure that arrangements were made so that people were able to attend appointments. Care plans were reviewed monthly and this was recorded.

People had opportunities to take part in activities and mental stimulation. A range of activities were seen happening during the inspection. This included 1-1 chat sessions and group sessions in the lounge. A relative said, "The activities are really good. Mum was a bit down, but the stimulation she got from doing the activities has helped." At least 18 people were engaged in activities in the lounge during the day. People were encouraged to participate by staff with activities to help their dexterity and mobility, like throwing and catching a ball. Some people were colouring, others were reading and others were offered pampering sessions or 1-1 activity sessions in their rooms. There was tea and biscuits and a generally cheerful atmosphere, created by the staff that did their best to include all of the people in the room. This kept people

occupied if they chose to participate and offered opportunities for them to feel less isolated.

Everyone we spoke with was happy with the idea of raising any concerns. One person said, "I don't have any complaints, but would speak to the manager if I did." There was a policy about dealing with complaints that the staff and registered manager followed. This ensured that complaints would be responded to. There were no recorded complaints since our last inspection. Information about how to make complaints was displayed in the service for people to see.

Good

Is the service well-led?

Our findings

The registered manager had been in post for five months and had worked hard to improve people's experiences of the service. They were qualified and experienced in managing nursing home services. They were supported to manage the service by the provider and a team of experienced and competent nurses. People spoke highly of the registered manager and staff team. People and their relatives told us that the registered manager and staff greeted them warmly and with respect. People's comments included, 'We would like to thank the staff for the very high standards of nursing care in the service.' And 'The staff have always showed us consideration, comfort and friendliness.'

At our previous inspection in June 2015 we reported that audits and record keeping in the home were not always effective. At this inspection, we found the provider and registered manager had taken action to improve auditing processes and record keeping standards.

People's positive experiences of the service were underpinned by consistent improvement. The registered manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. The registered manager told us that the provider listened to, considered and acted on requests made for additional resources. For example new care plans had been sourced, new easy to follow personal emergency evacuation plans had been implemented and resources had been put into recruiting to a full staff team which reduced the need for agency use.

General risk assessments affecting everybody in the service were recorded and monitored by the registered manager. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service.

The registered manager reviewed the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. Each audit had an action plan. We could see that issues identified on audits were shared with staff and it had been recorded how and when they would make the improvements. For example, covers had been changed on mattresses, staff training had been updated and health and safety information had been updated. These actions had been signed as completed by the registered manager on their action plan. This ensured that issues identified on audits were actioned and checked to improve service safety and quality.

Staff told us they felt supported by their registered manager and this was different to their previous experiences where the manager was not a nurse. They said, "The manager was approachable and they would take concerns to him." They confirmed they have meetings with the registered manager in the mornings and after lunch. We observed nurses got clinical supervision and noted that the registered manager used feedback from these meeting for service development.

There were a range of policies and procedures governing how the service needed to be run. They were kept

up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The registered manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider was based on site and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels with the organisation so that they were dealt with to people's satisfaction.