Mr Laurence John Waitt

Shottendane Nursing Home

Inspection report

Shottendane Road
Margate
Kent
CT9 4BS

Tel: 01843291888

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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

This inspection took place on 20 September 2016 and was unannounced.

Shottendane Nursing Home is a Grade II listed manor house with extensive grounds in Margate. The service provides accommodation, support and nursing care for up to 38 people with a range of nursing and palliative care needs. At the time of the inspection there were 31 people living at the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Shottendane Nursing Home is owned by a provider who regularly visited the service. The day to day running of the service was manged and overseen by a chief executive and the registered manager.

People and their relatives told us they felt safe living at the service. Risks to people were identified and assessed and guidance was provided for staff to follow to reduce risks to people. People received their medicines safely and on time.

Staff knew about abuse and knew what to do if they suspected any incidents of abuse. Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service. Staff were confident that any concerns they raised would be investigated to ensure people were kept safe.

The provider had a recruitment policy and processes in place to make sure that staff were of good character. Staff completed regular training, had one to one meetings and annual appraisals to discuss their personal development. There were consistent numbers of staff deployed, day and night, to meet people's needs.

The registered manager and staff understood how the Mental Capacity Act (MCA) 2005 was applied to ensure decisions made for people without capacity were only made in their best interests. Staff knew the importance of giving people choices and gaining their consent.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Some people had an authorised DoLS in place and these were regularly reviewed.

People enjoyed a choice of healthy, home-cooked, food and told us they had enough to eat and drink. Relatives often had meals with their loved ones. People's health was assessed and monitored and staff took prompt action when they noticed any changes or a decline in health. Staff worked closely with health professionals and followed and guidance given to them to ensure people received safe and effective care.

People said they were happy living at the service and that their privacy and dignity were respected. Staff spoke with and engaged with people in a kind, caring and compassionate way. People were involved in the planning or their care and support and told us care was provided in the way they chose. Each person had a descriptive care plan which had been written with them. People's religious and cultural needs were recorded and respected.

The provider had a complaints policy and procedure. People knew how to complain and told us they had no complaints about the service received from the staff team.

Staff supported people to maintain friendships and relationships. People's friends and family could visit when they wanted and there were no restrictions on the time of day. Staff, including an activities co-ordinator, spent time with people on a one to one basis. People were encouraged to maintain as much independence and choice as possible.

People, staff and health professionals felt the service was well-led. There was effective and regular auditing and monitoring. People, relatives and health professionals were asked their views on the quality of the service provided.

The provider had submitted notifications to CQC in a timely manner and in line with CQC guidelines.

We last inspected Shottendane Nursing Home in November 2013 when no concerns were identified .

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.

Risks to people were assessed and there was guidance for staff on how to reduce risks. Staff knew how to keep people safe and how to recognise and respond to abuse.

People received their medicines safely and on time. Medicines were stored, managed and disposed of safely.

Recruitment processes were followed to make sure staff employed were of good character. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff completed regular training, had one to one meetings and an annual appraisal to discuss their personal development.

Staff knew the importance of gaining people's consent and giving them choices. People were supported to make decisions. Staff understood the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People's health was assessed, monitored and reviewed. Staff worked with health professionals to make sure people's health care needs were met. People had enough to eat and drink and enjoyed the home-cooked food.

Is the service caring?

Good

The service was caring.

Staff were friendly, compassionate and kind. They promoted people's dignity and treated them and their relatives with respect.

Staff knew people well. Including their likes, dislikes and life histories. They knew how people preferred to be supported.

People's confidentiality was respected and their records were stored securely.

People's choices regarding their end of life care were recorded and regularly reviewed. Staff worked with the local hospice and followed guidance and advice.

Is the service responsive?

Good

The service was responsive

Each person had a care plan which centred on them and their wishes. People told us they had been involved in planning their care. Care plans were regularly reviewed.

People were supported to maintain relationships with the people that mattered to them.

People knew how to complain and said they had no complaints or concerns.

Is the service well-led?

Good

The service was well-led

People, relatives and health professionals were asked their views on the quality of the service provided.

There was an open and transparent culture. People, relatives and staff were encouraged to make suggestions to improve the service.

Regular and effective audits were completed. Actions were taken when shortfalls were identified.

Notifications had been submitted to CQC in line with guidance.

Shottendane 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 20 September 2016 and was unannounced. The inspection was carried out by two inspectors and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone in a care home setting.

Before the inspection the provider 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. We reviewed the information included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury.

We looked around all areas and grounds of the service and talked to people who lived there and their relatives. Conversations took place with people in their own rooms. During our inspection we observed how staff spoke with and engaged with people. We spoke with staff, the registered manager, the chief executive and the provider.

We looked at how people were supported throughout the inspection with their daily routines and activities and assessed if people's needs were being met. We reviewed care plans and associated risk assessments. We looked at a range of other records, including safety checks, staff files and records about how the quality of the service was monitored and managed.

We last inspected Shottendane Nursing Home in November 2013 when no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living at Shottendane Nursing Home. People said, "I feel very safe here. The staff are wonderful" and "Oh yes, I am safe and well looked after". A relative commented, "[My loved one] is safe and seems very happy. Their care is excellent".

People were protected from the risks of abuse. Staff knew what to do if they suspected any incidents of abuse. The provider had systems in place, including policies and procedures, for staff to refer to. Staff told us they had completed training about keeping people safe and this was confirmed by the training records. Staff felt confident they could speak with the registered manager if they had a concern and that they would be listened to and action would be taken if needed. The registered manager knew what should be reported in line with current guidance. When there had been notifiable incidents these had been consistently reported to CQC and / or the local authority.

Staff knew how to keep people safe and understood their responsibilities for reporting accidents, incidents or concerns. Staff reported any accidents, incidents or near misses to the registered manager. The registered manager monitored and reviewed these and raised concerns with the relevant authorities in line with guidance. The registered manager analysed accidents to identify any trends. When a pattern had been identified action was taken to refer people to health professionals, such as the dietician and community nurses, to reduce the risks and keep people safe. The registered manager told us incidents were discussed with staff and used as a learning opportunity to reduce the risk of them happening again. Records of a recent staff meeting noted, 'Reflective practice helps with continuous learning and our experience to improve the way we work'.

Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly. Staff told us they were confident that any concerns they raised would be listened to and fully investigated to ensure people were protected.

Risk assessments detailed the potential risk and gave staff guidance on how to reduce risks and keep people safe. For example, when people were at risk of having urinary tract infections (UTI) there was guidance for staff on what signs to look for which might indicate a UTI. Staff acted quickly to discuss concerns with nurses when they noticed these signs so that the correct action could be taken. People had risk assessments to help staff manage things like people's pain levels, skin health and mobility. Risk assessments were updated as changes occurred in people's needs. These were reviewed regularly to make sure they were up to date.

When people had difficulty moving around the service there was guidance for staff about what people could do independently. This included what level of support people needed and any equipment they needed, such as a walking frame, to help them stay as independent and safe as possible. At the time of the inspection most people were being supported in bed due to their health conditions.

Staff knew how to prevent pressure areas and support people to keep their skin healthy. The registered

manager and staff spoke passionately about the importance of looking after people's skin and took pride in the fact that people had healthy skin. When people were at risk of developing pressure areas action was taken to reduce the risk and a 'skin integrity care plan' implemented. Special equipment was used to reduce risks to of people's skin deteriorating. For example, people had profiling beds with air mattresses and staff regularly applied barrier creams to people's skin. Staff knew how to recognise changes on people's skin and discussed any changes with the nurse so the appropriate action could be taken. Staff told us, and records confirmed, that prompt referrals were made to health professionals, such as tissue viability nurses and GPs, to make sure people received the right treatment in good time. One member of staff commented, "When someone moves to Shottendane with a pressure area we regularly change their dressings and keep them comfortable. We make sure the area is clean to prevent infections and observe the area daily. People are regularly turned which helps the area heal". Some people had 'turn charts' in their room and staff recorded every time they supported people to change position.

The provider had recruitment and disciplinary policies and processes which were followed. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with people. Information had been requested about staff's employment history and any gaps in people's employment history were discussed and recorded at an interview. Written references, including the most recent employer, were obtained. Nurses Personal Identification Numbers (PIN) were checked to make sure they were registered with the Nursing and Midwifery Council (NMC) and regularly checked to make sure the PIN was kept in date. Nurses were aware of the importance of the revalidation process. (This was a new process that nurses in the UK needed to follow to maintain their registration with the NMC). Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People told us staff were quick to respond when they needed support. Staffing levels were constantly monitored and assessed by the registered manager to ensure there were enough staff, with the right skills, on each shift to meet people's needs and keep people safe. Catering, housekeeping, administration and maintenance staff were employed so care staff could concentrate on providing care and support. The duty rotas showed there were consistent numbers of staff throughout the day and night. There were contingency plans to cover emergencies, such as, sick leave.

Each person had a personal emergency evacuation plan which set out their specific physical and communication needs to ensure they could be safely evacuated from the service in an emergency. A folder containing essential information about people's individual needs, including health conditions and medicines, was easily accessible for staff to pass to other health professionals in an emergency.

People were supported to take their medicines safely and on time. Staff were trained in how to manage medicines safely and their competence to do this was regularly checked and recorded. Medicines were stored, managed and disposed of safely. The medicines store was clean, tidy and not over-stocked. Medicines were rotated to make sure they did not go out of date. Temperatures in the medicines store and fridge were checked each day to make sure the medicines would work as they were meant to. An air cooler was used if the weather was particularly hot.

People's medicines were reviewed regularly by a GP to make sure they were still suitable and working effectively. Some medicines were prescribed on an 'as and when' basis, such as pain relief. Staff asked people if they needed pain relief and their response was recorded on a pain assessment chart so their pain level could be monitored. Staff recorded if the pain relief was offered or not needed in line with best practice. Staff had a gentle manner and engaged with people when giving them their medicines. A member

of staff told us, "For people with severe dementia it's very difficult. We don't want to give it, if they don't want it. We get to know people and the carers know we need to learn about people's facial expressions or other ways of showing pain". The registered manager and staff completed regular medicines audits.

Good

Is the service effective?

Our findings

People and their relatives told us they had confidence in the staff and were supported when they needed to be. People said the food at the service was good. A relative who had eaten at the service said, "The food is very good". Staff told us, "People's tastes change. If someone wants something that isn't on the menu we will do our best to arrange it for them. If people want a glass of wine or a drink then they have it. Nothing is ever a problem. It's so important people have what they want, when they want it".

People received effective care from staff that were trained in their roles. When staff began working at the service they completed an induction. Newly employed staff worked towards achieving the Care Certificate. This is a nationally recognised set of standards that social care workers adhere to in their daily life. New staff shadowed experienced colleagues to get to know people, their preferences and routines.

Staff completed regular training to keep up to date with current best practice. Records of the training undertaken were kept in the office and updated by the administrator. Training courses were relevant to people's needs and included end of life care, dementia care and basic life support. Staff were encouraged and supported to complete additional training for their personal development. For example, staff completed, or were working towards, adult social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications staff must prove they have the ability (competence) to carry out their role to the required standard. A member of staff returned from a 'Verification of expected death' training course during the inspection and commented, "You always learn something new and it's always for the good. I love going and training with the hospice nurses."

Staff said they felt supported by the registered manager and that they all worked closely as a team. Staff had regular one to one supervision meetings to discuss their performance and learning and development choices. Nurses received clinical supervision which included specialist training, such as, wound assessments, catheter care, syringe driver management and managing chronic pain. All staff had an annual appraisal which included a self-appraisal which was then discussed and recorded.

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

People were empowered to have as much choice as possible. For example, care plans included mental capacity assessments which noted examples of how people had control over things like their daily care decisions, continence management and use of call bell. People were offered choices and made decisions which were respected and supported by the staff. People had a communications care plan which noted their wishes and capacity to be involved in their daily care decisions. Some people living at the service were able to make decisions about their care and support and others needed support from their relatives or

advocates to make complex decisions. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. When people did not have the capacity to make complex decisions, meetings were held with the person, their representatives and health professionals to make sure decisions were being made in the person's best interest. Staff had completed training on the MCA and knew how the principles of the MCA impacted on the people they supported.

When people had a Last Power of Attorney (LPA) in place, a copy of this was checked by the registered manager and was recorded in the person's care plan. Staff liaised with the LPA about people's care and treatment needs. Some people had made advanced decisions, such as 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR), this was recorded and kept at the front of people's care plans so that people's wishes could be acted on. These were reviewed to make sure they were still what the person wanted.

People can only be deprived of their liberty so that they can 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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager and staff understood their responsibilities in relation to DoLS. The registered manager had submitted DoLS applications in line with guidance. Staff recorded the expiry date of authorised DoLS to make sure, if needed, a new application would be submitted on time. Checklists were completed to assess people's restriction or deprivation of liberty and were regularly reviewed by the registered manager to make sure people were not being restricted unlawfully. When a DoLS application was authorised a copy was placed in the person's care plan.

People were offered a choice of healthy food and drinks which they enjoyed. Menus were displayed in the service. A full cooked breakfast was offered everyday as well as cereals, toast, fruits and yoghurts. Staff told us there was always plenty of choice for people and said, "People can have whatever they want. If we haven't got it here we will get it for them". The breakfast menu noted, 'Choice of cereals – if we don't have your favourite let us know' and 'wholemeal or white toast freshly toasted to order – let us know if you would prefer another choice'. Lunch had a choice of two main meals and a vegetarian option if required and a dessert. Supper was a choice of soups, sandwiches and hot snacks, such as, omelettes or jacket potatoes, followed by homemade cakes. Visitors told us they ate with their loved ones and that staff were, "Always accommodating".

Each person had a nutrition care plan. These included guidance for staff on people's food preferences, how to offer alternatives and meal sizes. For example, people's likes and dislikes of particular food, such as, 'Prefers coffee' and 'Does not like butter' were noted and the kitchen staff were also aware of people's preferences.

Some people were at risk of dehydration or malnutrition. When people were not eating their meals because their health was deteriorating staff encouraged them to have regular snacks. Staff monitored people's weight closely to make sure their weight remained as stable as possible. Staff followed guidance given by specialist health professionals, such as dieticians. For example, some people had their meals fortified with full fat milk, cream, cheese and other high fat products. Staff told us that when people did not want to eat a meal they offered them alternatives and one staff commented, "We ask people if there is anything they fancy so we can get it for them". Meals were home cooked. Catering staff used good quality fresh foods to create a range of meals and took pride in their work. People living with diabetes were made diabetic drinks, cakes

and desserts to ensure they received the same options as others.

People had access to specialist health professionals when they needed it. Staff monitored people's health and took prompt action if they noticed any changes. Staff spoke with people and their families to make sure they had the information they needed about their care and treatment.

Good

Is the service caring?

Our findings

People said they were happy and settled at Shottendane Nursing Home and that the staff were caring. People said, "You can ask any one of them [staff] and they will help you" and "The staff are very, very friendly". Relatives told us, "It's the best place I have ever seen" and "The staff are very caring".

The provider noted on the provider information return, 'Compassion, kindness, dignity, respect, and person-centred care, are at the heart of Shottendane's ethos. Staff always adhere to the Home's policies on dignity, respect, equality and diversity'. The provider's 'Philosophy of care' noted, 'Whatever your needs, our Home is your home by your choice – our services are your services'. Staff were motivated and passionate about providing care and support tailored to people's individual needs. Staff told us, "Everything we do is about the people and what they want and need" and "This is an important stage in people's life and we support them and their families". During the inspection staff spoke with people, their families and each other in kind, respectful and compassionate way.

The registered manager and staff had received many 'thank you' cards. Comments noted, 'Thank you all so much for the wonderful care you have given [my loved one]. They arrived in a very poor state and thanks to you and all the staff we were able to enjoy a few weeks, free of pain together. Shottendane will always have good memories for both myself and my family" and 'Thank you for the wonderful care you showed [my late loved one]. You made their last few months so comfortable, for which we are eternally grateful, with dignity, care and love'.

There was a strong, visible culture which centred on each individual and their needs. The registered manager and staff knew people well and had built strong, positive and trusting relationships with people and their relatives. Staff communicated effectively with people, speaking quietly and calmly and allowing people to respond in their own time. Staff spoke with people with warmth, empathy, compassion and a genuine concern for their wellbeing. When people were not able to communicate verbally there was guidance, in the care plan, for staff on what worked best for people. For example, 'hand holding', 'watching eye movements' and 'talk normally and maintain conversational style'. During the inspection we observed staff using different ways to communicate with people to support them to express their needs and wishes and to make sure they were understood.

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People were involved in the planning of their care and told us it was provided in the way they had chosen. The emphasis of giving people choices was reflected in the way people's care plans were written. For example, 'Ensure [person's] bedside light is on overnight'. At lunchtime a person was given sandwiches, salad and cake. Staff explained they preferred to eat their main meal in the evening as they always had. The member of staff commented, "So naturally we accommodate that. It's not a problem to accord with people's wishes". This choice was recorded in the person's care plan.

Staff listened to people and respected their views. People were encouraged to personalise their rooms in the way they chose and many had personal effects, such as photographs, pictures and furniture, to help them feel at home. Staff knew people's individual preferences and personal histories and spoke with them

about things and people that were important to them. The registered manager told us, "We try to learn about the person's history so we can engage in meaningful conversation with them".

People were involved in making choices and decisions about their care and support. Some people had family members to support them if they needed to make complex decisions about their care and support. The registered manager ensured advocacy services were available to people if they wanted them to be involved.
People told us they were treated with respect and their privacy and dignity was promoted. Staff gave us various examples of how they promoted people's dignity, such as, knocking on people's doors and waiting for an answer and making sure people were covered up during personal care. Staff completed training on dignity which reinforced the need to promote treating people with dignity and respect at all times. Conversations about people's care and support were held in private and people's records were stored securely to protect confidentiality. Records were located promptly when we asked to see them.

Staff supported people to maintain friendships and relationships. People, their relatives and staff told us that visitors were welcome at any time and there were no restrictions. The provider noted on the provider information return, 'Relatives are encouraged to take advantage of our relaxed visiting, and to invite friends to visit, giving even more of a sense of normality in their new home'.

People's choices and preferences for their end of life care were clearly recorded and kept under review to make sure their care and support was provided in the way they had chosen. People had an 'advanced care plan' which had been written with the person and their relatives. (When people have a terminal illness or are approaching the end of their life an advanced care plan involves thinking and talking about their wishes for how they are cared for in the final few months of their life). The registered manager told us this was treated with the utmost sensitivity and that they explained the reasons for the advanced care plan and the available support and treatment. They said, "All decisions are carefully recorded so that they can be acted upon at the appropriate time".

The registered manager told us that special training such as, 'Six steps to success in end of life care', 'Dying does matter' and 'Compassion awareness' had allowed staff to be more sensitive and made sure they had the right skills to support people and their relatives at such a difficult time. A relative had noted on a recent survey, '[My loved one] had the best end of life care. My family was also supported by the home and its wonderful staff'. The registered manager commented, "We are very conscious too of the impact on staff for whom emotional support is available". Comments on cards from relatives after their loved ones had passed away included, 'Thanks you for your compassion during the final hours of [our loved one's] life; and '[Our loved one] could not have had better care and you made their last few days comfortable and bearable for all of us'.

The staff team worked closely with specialist health professionals, such as the local hospice, and followed guidance provided by them to ensure people had a comfortable, dignified and pain free death. Staff had received additional support from health professionals such as 'Aftercare training from funeral directors' and 'Hospice best practice forum'.

People's religious and cultural needs were recorded and respected. People were not always able to go to their local places of worship and staff arranged for clergy to visit when people requested this. Care plans showed what people's different beliefs were and how to support them. For example, 'X watches church services on television and listens on the radio when less well'. Staff told us they organised this for them. Staff made arrangements for visiting clergy from different denominations so people could continue to follow their beliefs.

Good

Is the service responsive?

Our findings

People told us they received care and support when they needed it and that staff were responsive to their needs. During the inspection staff were responsive to people's needs. Call bells were answered promptly. A person had noted on a recent quality survey, 'Happy with the response time when I use the call bell'. Staff were not rushed and spent time with people making sure they had everything they needed.

People were involved in the planning, management and reviewing of their care, treatment and support. When people were thinking of moving to Shottendane Nursing Home a pre-assessment was completed so the registered manager could check whether they could meet people's needs or not. From this information an individual care plan was developed, with people, to give staff the guidance and information they needed to look after the person in the way they preferred. Each person had a keyworker and a named nurse. A keyworker was a member of staff who was allocated to take the lead in co-ordinating someone's care. Information that was important to people, such as, their likes, dislikes, life histories and any preferred routines, was recorded in their care plan. Staff noted when people or relatives declined to give information. Staff told us that when people moved to the service they were welcomed by three staff who stayed with the person "Until they feel comfortable in their new surroundings".

Each person had a care plan written with them and their relatives which centred on them, their preferences and wishes. Care plans included details about people's health needs and risk assessments were in place and applicable for each person. Records were regularly reviewed and updated. When people's health declined or their needs changed the care plans and risk assessments were amended to make sure staff had up to date guidance on how to provide the right care.

People's health care needs often changed frequently. Records contained the most up to date information, however, sometimes there was old information left in the care plan which could be confusing for staff. The registered manager had identified this shortfall, recognising it was an area for improvement and was taking action to have the care plans rewritten and to archive older records.

Health professionals, such as GPs, were involved in reviewing people's care and medicines. Any changes, like a change to a person's medicines were recorded in the care plan and followed by staff.

People were supported to maintain as much independence and choice as possible. Staff recorded in people's care plans what they could do for themselves and what level of support was needed so they could provide care and support in the person's preferred way.

Staff chatted with people and their relatives throughout the day. An activities co-ordinator was employed by the provider. The activities offered depended on people's health. At the time of the inspection everyone was supported in their own room. When people were able to they could spend time together in the lounge and take part in group activities. The activities co-ordinator worked with people on a one to one basis. Staff spent time with people and told us they brought in photographs and postcards of places they knew people were familiar with and talked with them about their memories. People had their newspapers delivered to

them each day and staff sat with people and read to them when they wanted some company.

People and their relatives told us they had no complaints or concerns about the service or the support received from staff. People said they would speak to staff if they had any worries and that they would take any action needed. The provider had a complaints policy which was displayed in the service. When a complaint was received the registered manager followed the policy and procedures to make sure it was dealt with correctly. The registered manager showed us that they logged all concerns and issues raised even though they may not be official complaints so they could be resolved quickly. Any complaints or compliments received were shared with staff and used as a learning opportunity.

Customer satisfaction surveys were placed in the entrance area for visitors to fill in. People, relatives and health professionals were asked to complete quality surveys. These were reviewed by the registered manager so that action could be taken if needed. The most recent survey results were positive and people comments included, 'Staff are very good, always kind and friendly', 'Staff often pop in for a chat which is great – we have a good laugh' and 'The staff are excellent'. A health professional had noted, 'The standards of care and continuing care are absolutely excellent. The staff cater for all needs in a very professional manner. Excellent, friendly staff who are always willing to help'.

Good

Is the service well-led?

Our findings

People, staff and health professionals felt the service was well-led. People knew the staff team and management by name. All staff wore a uniform and a name badge. The entrance was staffed by an administrator who greeted people when they arrived at Shottendane Nursing Home. A board in the entrance noted the names of each staff member on the shift. A 'thank you' card noted the staff team were 'A credit to the profession of caring'.

The registered manager told us they were "Well supported" by the chief executive and the provider. The registered manager worked cohesively with the staff team, mentoring, coaching and providing advice and guidance. Staff handovers between shifts made sure that staff were kept up to date with any changes in people's needs. Staff discussed what care and support had been given, how the person was, if they had eaten and drunk well and if they had declined any care. Handovers were 'chaired' by a nurse; however, they were two way, open, group discussions. A communications book was used by the nurses to record clinical information to ensure other nurses were up to date on any changes.

The registered manager had systems in place to seek the views of a wide range of stakeholders about their experience and views of the service. People, their relatives and health professionals had taken part in questionnaires about the quality of the service. These were analysed by the registered manager to see if any actions were needed.

Residents and relatives meetings had been held to give people the opportunity to make suggestions about the day to day running of the service. The registered manager explained, due to people's health needs, these were not always possible. The registered manager made sure they saw every person living at the service at least twice a day to check on their well-being and to make sure they had everything they needed. They also spoke with relatives when they visited to gain additional feedback on the quality of care provided by them and their staff team.

There was a clear and open dialogue between people, staff and the registered manager. Staff spoke with people and each other in a kind and respectful way and showed empathy and compassion.

Staff told us they were able to give honest views about the service and that they would be listened to. Staff said there was a strong team ethos and they felt valued by their colleagues, the registered manager and the organisation. There were regular staff meetings held to give staff the opportunity to voice their opinions and discuss the service. Minutes of the meetings, including any actions needed, were taken so that all the staff were aware of discussions.

Staff understood what was expected of them and their roles and responsibilities. The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely. Staff knew where to access the information they needed. Records were in good order and kept up to date. When we asked for any information it was immediately available and records were stored securely to protect people's confidentiality.

The registered manager worked with organisations that promoted best practice and guidance. They kept themselves up to date with new research, guidance and developments, making improvements as a result. They shared information and guidance with people, their relatives and staff. For example, leaflets on topics, such as, hydration, living with a terminal illness and dementia research were readily available to support people. Staff worked closely with the local hospice staff to widen their knowledge of palliative care and to enable them to provide support to people and their families when they were approaching the end of their life.

The registered manager observed staff throughout the day and carried out informal checks, such as, making sure the appropriate aprons and gloves were worn and checking staff hand hygiene. Regular quality checks were carried out on key things, such as, moving and handling equipment, infection control, health and safety, the environment and medicines management. Audits were recorded, analysed and a summary of the findings with actions produced. When a shortfall was identified the registered manager held group supervision meetings with staff to discuss the issues and decide what action to take to resolve them.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner and in line with guidance.