A Spellman

Steeton Court Nursing Home

Inspection report

Steeton Hall Gardens
Steeton
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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

Our inspection of Steeton Court Nursing Home took place on 3 May 2017 and was unannounced.

Steeton Court Nursing Home is located in the residential area of Steeton. The home is registered to provide care to a total of 71 people and on the day of our inspection there were 54 people living at the service. The home is built on two floors with access to the first floor by means of two passenger lifts and a stair lift. The majority of bedrooms are single rooms with en-suite facilities. The communal areas of the home include lounges, dining rooms and conservatories. There is an enclosed sensory garden to the outside of the property.

A registered manager was in post and had employed in this capacity since 2010. 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.

At our last inspection in 2015 we rated the service 'good' overall and 'requires improvement' in the well led domain, as we needed assurance that previous concerns were sustained. At this inspection we concluded improvements had been sustained.

People told us they felt safe living at the service and in the company of staff. Staff had received safeguarding training and understood their responsibilities regarding keeping people safe. Appropriate assessments were in place in people's care records to identify and mitigate risk and incidents/accidents documented. However, a more robust audit record of the number of incidents individual people had experienced would assist the service monitor individual trends.

Sufficient staff were deployed to keep people safe and we saw training was up to date or booked. Staff told us the training provided was of a good standard and enabled them to carry out effective care and support. We saw staff were kind and compassionate in their approach and there was a stable staff team which meant staff knew people well. Morale was good amongst staff who felt able to voice any concerns to the management team.

The service was acting in accordance with the Mental Capacity Act (2005) and the requirements of the Deprivation of Liberty Safeguards. People's consent was sought wherever possible and evidence of best interest decisions were in place. People's choice and preferences were respected.

People mostly told us they enjoyed the food provided although some people would like to see a greater variety and choice. Nutritional risk assessments were in place and people found to be at risk referred to the GP or dietician. We saw where people's intake was recorded and nutritionally supplements prescribed and correctly administered.

People were given the choice to participate in a variety of activities on a group or one to one basis.

Complaints were taken seriously and addressed although a low level of complaints had been received.

People's care was planned following needs assessments and kept up to date. We saw and people told us the care provided was in line with people's care plans. People's healthcare needs were effectively supported.

A range of quality audit processes were in place to identify and drive improvements in the service. Meetings and surveys were in place to gauge satisfaction among people who lived at the service and actions taken as a result. Staff attended regular meetings to discuss relevant topics and any issues or service developments.

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 told us they felt safe at the service.

Staff had received safeguarding training, understood how to keep people safe and how to recognise and report any safeguarding concerns.

Overall, medicines were managed in a safe and proper way.

Sufficient staff were deployed to keep people safe.

Is the service effective?

Good

The service was effective.

Care and support was provided by a stable team who had received up to date training.

People were encouraged to consume a healthy and nutritious diet.

Best interest decisions were in place and people's consent was sought.

Is the service caring?

Good

The service was caring.

People were supported to remain as independent as possible.

Staff knew people well and treated them with care and compassion.

Visitors were welcomed at all times.

Is the service responsive?

Good

The service was responsive.

A range of activities were on offer according to people's preferences. Activities were either group based or on a one to one basis.

Complaints were taken seriously and investigated with outcomes noted. A low number of complaints had been received.

Care records reflected people's care and support needs accurately and were up to date.

Is the service well-led?

Good

The service was well led.

Staff morale was good and staff told us they felt able to approach the management team with any concerns.

A range of audits was in place to monitor and improve the service.

Satisfaction surveys and residents/relatives meetings were held at regular intervals.

Steeton Court 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 3 May 2017 and was unannounced. The inspection team consisted of two adult social care inspectors 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. The expert used on this occasion had experience in caring for older people with dementia.

We used various methods to help inform our inspection. We reviewed notifications received from the provider, information received from the local authority commissioning and safeguarding teams as well as looking at the Provider Information Return. 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. The provider returned this in a timely manner and we took this into account when making our judgements.

During the inspection we observed care and support during the day, spoke with nine people who used the service, five relatives, the registered manager, two nurses, five care staff, the head of activities and the cook. We also completed a short observational framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at elements of seven people's care records, four staff files, medicines records and the training matrix as well as records relating to the management of the service. We looked round the building including people's bedrooms, bathrooms and communal areas.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home, said nothing bad had ever happened and they were not worried or anxious about being hurt. People said the staff were gentle when providing care. Comments included, "Yes, I do feel safe here", "Nothing bad has ever happened to me or heard anything happen to anyone else," and, "It's safe, there is never any type of sadness."

Staff had received safeguarding training and understood how to identify and act on allegations of abuse. Staff told us they were confident people were safe in the home and would recommend the home to their own relatives. We saw following incidents referral and/or liaison took place with the local authority safeguarding unit.

Incidents and accidents were recorded, investigated and monitored for any themes and trends. We saw where patterns were identified, such as an increase in falls, risk assessments and care plans were updated to help protect people from harm.

Overall we found medicines were managed safely. Medicines were administered by registered nurses who had their competency to administer medicines assessed.

We observed the medicines round and saw medicines were administered in a kind and patient way by nursing staff. Staff explained the medicines they were giving to people and what they were for. People told us, "Always get them on time; they bring them out at breakfast. I'm a diabetic and need insulin they're well trained and there's never been any problems", "No problems," and, "I don't have any problems with my tablets. I keep tabs on them; know what I take and what it's for."

Each person had a detailed medicine care plan in place which detailed how staff should provide appropriate medicine support. Arrangements were in place to provide medicines at the time people needed them. For example, some people required medicines before food and these were given early in the morning before breakfast.

We looked at medicine administration records (MAR) and saw they were well completed, demonstrating people had received their medicines as prescribed. However although we felt assured that people received their medicines as prescribed, stock balances of medicines were not always carried over from the previous month which meant there was not a complete audit trail of the booking in and administration of these medicines.

Some people were prescribed topical medicines such as creams. Body maps were in place which provided guidance to staff on how to apply these medicines. Separate topical medicine administration records were maintained by care staff. We saw these were well completed indicating people regularly received their prescribed creams.

Some people were prescribed nutritional supplements and thickeners. Systems were in place to ensure

people received these as prescribed. However we saw thickeners were used communally on the dementia unit. Prescribed medicines should only be used for the person they are prescribed for. We raised this with the registered manager who agreed to put an immediate stop to the practice. From our discussions during the inspection we were confident this would take place.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

In most cases, where people were prescribed 'as required' medicines we saw protocols were in place describing when they should be offered. We saw these were in a range of different formats and would benefit from standardising.

Medicines were stored securely within locked trolleys and the medicines room was kept locked. The date of opening was written on the side of bottled medicines to ensure that staff were clear when they expired. Room and fridge temperatures were taken to ensure the temperature remained within safe levels.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. These included ensuring a Disclosure and Barring Service (DBS) check was made and two written references were obtained before new employees started work. We saw nurses registrations were periodically checked to ensure they remained registered to practice as nurses.

During observations of care and support we saw there were sufficient quantities of staff to help ensure people remained safe. For example, on the dementia unit, there were three care workers and one registered nurse to care for the 15 people living in the unit. We saw staff were visible and attentive to people's requests for care and support and the communal areas were appropriately supervised. Staff we spoke with reported there were enough staff to ensure care and support tasks were completed to a high standard and that prompt assistance was provide when required. A dependency tool was used by the registered manager to calculate staffing levels. We saw the service had good retention of nursing and care staff and seldom needed to use agency staff.

People we spoke with told us there were enough staff on duty and staff responded promptly when they called for help. We saw call bells were in reach in all the rooms we checked. For example, we saw one person had his call bell placed in his hand. Comments included, "If I buzz they come quick, they do very well," and, "They come straight away but if you have to wait because they are with someone else they come and tell you. The call bell is always within reach although I have had to tell them a couple of times."

The premises was safely maintained and suitable for its purpose. People had access to a range of communal areas they could spent time including dining areas, and a selection of lounges. Bedrooms were homely and pleasantly decorated and contained personal items such as dressing tables, ornaments, pictures and photographs. One person told us, "I like my room, I brought my own things. I'm quite happy with it."

The home was situated in large grounds including an enclosed sensory garden where people could spend time securely. Maintenance staff were employed and we found the home was in a good state of repair. Checks took place on equipment such as hoists and mattresses to ensure they remained in safe and working condition. Checks took place on the fire, gas, electric and water systems to help ensure they remained safe.

Good

Is the service effective?

Our findings

Staff were assigned to set floors within the home which meant people were cared for by 'familiar faces.' We found a stable staff team which allowed staff to build up knowledge and understanding of the people they were caring for, to help meet their individual needs.

A range of training was in place for staff who told us the training provided was good and equipped them with the required skills to offer effective care and support. We saw a training programme had been formulated for the year to ensure staff completed all subjects required by the service which included first aid, safeguarding, MCA/DoLS, fire safety, infection control, dementia awareness, moving and handling, end of life care, falls prevention and health and safety. This meant training was largely up to date or booked. Staff we spoke with told us they were supported to complete additional training. For example, one staff member told us they were completing team leadership training.

The registered manager told us there was no fixed induction period and this took as long as required for the staff member. Induction included staff reading the service policies and procedures, completing service required training and shadowing experienced staff members. At the end of the first week, the registered manager had a meeting with the staff member to discuss what further training they required.

We saw a schedule for regular supervision and annual appraisal which evidenced these took place. This was confirmed by our review of staff files and through discussions with staff members.

The service was appointing 'champions' in various subjects such as dementia, infection control, first aid, continence, moving and handling and palliative care and we saw further training had been organised to enhance these staff members' knowledge and ensure the role was meaningful when fully implemented.

We saw people's nutritional needs were usually met. People were provided with a varied menu which rotated on a four weekly basis. People had a choice at each mealtime. For example at breakfast time people could choose to have one or more of cereals, toasts, porridge and a cooked option. We saw one person eat crumpets and grapefruit in line with their individual preferences. At lunchtime, there were two main options available, and hot and cold options available in the evening.

People told us they received plenty to eat and drink throughout the day. A number of people were complementary about the food on offer, with comments such as, "I'm trying to put on weight, have put on 2lb since I've been here. The food is good", "We have a new chef now, thankfully. It's a pleasure to get your meals. There's plenty to eat and drink", "The food is very good. I like shredded wheat and my daughter asked them to get me some and they did", "The food is excellent. Plenty to drink," and, "The food is ok, choice of menu; if it's not on the menu they will try their best to get it for you."

However some staff and people we spoke with said they thought more choice was required in the evening and in particular for people who required a soft diet. A staff member commented, "I think the food lets us down. Sometimes our soft option is soup and mashed potatoes. A lot of food is bought in. A lot of things

used to be homemade but not as much now. All the kitchen staff go on their break at the same time. Means there's no-one in the kitchen to assist." One person and their visiting relatives told us they had been at the service for two months but no one had discussed their dietary requirements. They commented, "I have lost my appetite and need to put on some weight. I can't eat meat but don't like the other dishes. They don't offer options that I can eat. I need soft food." Another person told us, "The food is hit and miss, can't always get an alternative. They ought to offer more choice."

We spoke with the cook, who told us they fortified food for example with full fat milk and cream to help ensure people received sufficient calories. Nutritious smoothies were available to people throughout the day as well as snacks which included cakes, biscuits, yoghurt and fruit. Information on people's individual dietary requirements was kept in the kitchen and in each unit so staff were aware of any specific requirements.

Nutritional risk was assessed using recognised screening tools and care plans formulated to help protect people from harm. Where people had lost weight we saw appropriate action had been taken, including offering nutritious snacks, monitoring dietary intake and referring to the person's GP. We looked at a sample of food charts for a person who was deemed nutritionally at risk. We saw they were well completed showing the home had provided a range of meals as well as nutritious snacks between meals.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had made appropriate DoLS referrals for people who they believed were being deprived of their liberty. These were re-applied for by the registered manager when they expired in a timely way. However many applications and reapplications were currently with the supervisory body awaiting assessment due to backlogs within the supervisory body. Care and support was delivered in the least restrictive way possible, for example people were encouraged to use the outside grounds, participate in activities and maintain links with the local community. We saw one person had previously had a condition around medication and this had been complied with by the home. Another person had a DoLS in place which had three conditions. We found better documentation of their instances of behaviours that challenge would provide assurance that the condition was fully complied with.

Staff had received training in DoLS and the MCA and understood how to act within the legal framework Mental Capacity Assessments (MCA) were carried out where the service suspected people lacked capacity. For example, we saw capacity assessments over the decision to administer medicines and other elements of care and support. These demonstrated decisions had been made in people's best interests, protecting their rights. We saw evidence of people's consent being sought, for example, before delivering personal care. Consent forms were present in people's care records, signed by the person or their relatives, with explanation. For example, we saw one person's consent was signed by their relative with additional information stating the person had given verbal consent with their relative present.

Adaptions had been made to the building to make it suitable for people living with dementia. For example, the dementia unit was on the ground floor and people had access to an enclosed sensory garden which was used for therapeutic purposes. Memory boxes were displayed outside people's bedrooms and signage was clear and dementia friendly. Bespoke dementia activities were provided tailored to people's individual needs.

There was evidence that best practice guidance such as the National Institute for Health and Care Excellence (NICE) Guidelines were used to inform and improve care practice for example, in relation to dementia care. We saw health care plans included references to published sources such as National Institute for Health and Care Excellence (NICE) and published journal articles to provide rationale as to why care was planned and delivered in a particular way.

People's healthcare needs were supported. For example, we saw evidence in people's care records of health care professional visits such as GPs, district nurses, podiatrists, opticians and dieticians.

Good

Is the service caring?

Our findings

Most people spoke positively about the standard of care and the attitude of care staff. Comments included, "It's been grand; the staff are lovely, always there to help you. I've been well cared for", "All the staff are lovely and friendly and polite. They are treating me well", "The carers are very, very good. There's one or two who are a bit sulky but most of them are sweet. [Care staff name] is a poppet, [Care staff] is an amazing (person). They pay attention to the small things, brought and extra chair in for when both my sons visit. Iced drinks like today when it's hot weather," and, "It's been wonderful. They are gentle and kind and do a proper job." However, one person told us they felt night staff on one occasion had been, "A little lack lustre," when they needed reassurance and suggested it would be a, "Nice touch if carers popped their head around the door and said when they were going at the end of their shift so people would know who is there. It would be nice to show they care."

Relatives we spoke with praised staff, saying, "The carers are exceptionally good; I made a good choice bringing [person] here. Can't fault it. We are very lucky, this is a good place. [Staff name] is exceptionally good", "At first it was difficult but they got [person] settled in with love and kindness. I can go home with peace of mind now," and, "They're well looked after here. It's like a big family. Residents' staff and family are all part of the big family. It's lovely."

We observed care and support and found all interactions between staff and people that used the service were positive. Staff greeted people warmly and used non-verbal communication as well as verbal to interact with people.

We saw staff took the time to talk to people both during care and support tasks and when they had spare time they sat with people to provide companionship. Staff addressed people by their preferred name and it was clear some good relationships had developed and staff knew people well, including their preferences and care needs.

We saw staff had regard for people's privacy. For example, we saw staff knocking on bedroom doors before entering and allowing people to use the toilet independently where they could. Staff we spoke with confirmed they understood the need to maintain dignity and respect and were able to give examples, such as covering people when supporting with personal cares and ensuring curtains and doors were closed.

People were listened to by the service. For example we saw staff asked people what they wanted to do, where they wanted to sit and what they wanted to eat. Staff patiently waited for people to respond before complying with people's requests. We saw a range of more formal mechanisms were used to listen to people including surveys about food, activities and the general care experience. Where some people had no relatives to speak on their behalf, we saw independent mental capacity advocates (IMCA) were used.

We saw staff encouraged people to lead as independent lives as possible. For example, we saw people used a range of walking aids to mobilise independently and staff made sure these were within people's reach. One person was supported by staff to go for a walk around the building and grounds since this was

something they had enjoyed doing before they came to live at the service.

We saw visitors were warmly welcomed at all times. One person's relatives told us they felt staff were, "Open, friendly and welcoming." Other comments included, "Residents are one big happy family. I visit every other day. [Relative] is happy and content. I have worked in the industry and know what to look for", "Friendly and welcoming. Visitors can make a cup of tea if they want.", "I have young granddaughters and they always make the children welcome," and, "I come every day to sit with my [relative] for lunch. They will make me a hot meal as well or sandwiches."

End of life care plans were in place. Following any death within the home, a post death reflection was carried out reflecting on 'what went well' and 'what did not' to help ensure continuous improvement of this aspect of the service.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs and clergy from local churches regularly visited to conduct services. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

Most people we spoke with were not familiar with their care plans and could not remember being involved in any reviews. However, relatives told us staff were open and approachable and kept them informed of any changes or issues. People all told us their care reflected their current needs. Comments included, "I am aware of the plan but have not seen it. I get everything done that should be done; there's nothing missing", "I'm not aware of any plan or reviews but [relative] is monitored by the doctor", "I visit every day. They are open and approachable and let me know if there are any problems. I don't know about a care plan but I've not had anything to worry about regarding [relative's] care," and, "I have been involved in [relative's] care plan, they involve you in everything."

We saw care records accurately reflected people's required care and support needs and included clear aims and objectives. Care plans contained clear, person centred information on how staff should meet people's needs in areas such as dignity, independence, eating and drinking and social activities. For example, we saw one person's care plan contained information for staff when transferring them safely from their bed. A detailed manual handling assessment and plan was in place including step by step guidance for all procedures such as turning in bed, 'sit and stand' and walking. Staff we spoke with demonstrated a good understanding of the people they were caring for and how to meet their needs.

Prior to people coming to live at the home an assessment was completed to gauge if the home would suit their needs. Upon admission, an 'activities of daily living' assessment was done and from this care plans with any associated risk assessments were formulated.

People had completed 'my life' booklets in their care records. Some of these included detailed information about people's history, activities they enjoyed and their families. This meant staff had good information about people to engage in meaningful activities and conversation and provided some evidence of person centred planning. More detailed information about people's preferences and choice in care records would further evidence a person centred approach. However, we saw people's preferences and choices were considered and respected by staff during our observations of care and support.

Care records including plans of care and risk assessments were regularly updated to reflect people's changing needs.

Air mattresses were checked daily and records kept in people's rooms stated the setting they should be on. Mattresses we checked were on the correct setting, increasing the chances they would be effect in reducing the risk of pressure sores. No pressure sores had occurred within the home within 2016 or 2017. This showed the service practiced effective pressure ulcer preventative care.

We saw people had access to a range of activities. Three activities co-ordinators were employed by the service, with two of these working in the building on any given day. This meant multiple activities could take place at any one time, for example in the main lounge and the dementia unit. Activities staff were well qualified, having all achieved an NVQ in Activities Leadership. We spoke with an activities co-ordinator who

told us they thought the home was, "Very, very lucky," in terms of the resources allocated to activities.

An activities board provided information on what was on offer. This included activities such as reminiscence, board games, jigsaws as well as visits from external entertainers. A mobile sweet shop selling classic sweets went around the home each week which as well as providing a reminiscence activity was an opportunity to provide extra calories to people. Monthly themes were held, where areas of the home were decorated, for example, in a Hollywood theme, or 'All the Fun of the Fair.' These were designed to be a visual experience and were accompanied by activities in keeping with the theme. We observed the activities and saw staff took the time to include everyone in the activities, visiting people who were in their rooms to offer them the chance to participate. People we spoke with said they were stimulated and not bored. A number of people told us about the concerts held at the service and a planned VE Day party planned for the following week. One person told us, "There have been some very good singers, very well organised. They come and fetch you if you want to go down. Tea and cakes served. So many people enjoy it. Tapping their feet and clapping their hands." A relative commented, "That's the beauty of this place, there's plenty going on, they keep their minds active. Even the people in wheelchairs they bring them down (from the upstairs floor) to join in."

One to one sessions were also held with those who did not want to participate in group activities. Two trips out were held each month, for example, to scenic sites in the Yorkshire dales. We saw people had activities information noted in their care records which highlighted which activities they had participated in, or if they had received one to one visits from the activities staff. Each month an activities book was produced highlighting the events that took place the previous month as well as the upcoming schedule. We looked at this which showed a range of varied activities took place each day.

The home maintained links with the local community, with clergy from the local church of England and catholic churches visiting to meet people's religious needs.

A system was in place to log, investigate and respond to complaints. Information was on display instructing people how to make a complaint and the information was also within the booklet given to people who used the service. We looked at the complaints register and saw a low number of complaints had been received with no concerning trends or themes. The small number of complaints that had been received had been properly investigated by the registered manager and responded to in a timely manner. People told us they felt able to raise concerns and complaints were dealt with effectively. For example, one person told us they had spoken with the manager about a member of staff who had been 'bossy' with them. The manager responded and appropriate disciplinary action was taken. Other comments included, "I've no complaints but if I had I would speak to the nurse," and, "I would speak to the management if I had a complaint. I won't let people walk all over me." Compliments were also recorded so the service knew the areas it exceeded expectations.

Good

Is the service well-led?

Our findings

Staff spoke positively about the home, said it was a good place to work and that morale was good. During our inspection, staff appeared confident in their role, welcoming and introduced themselves to us. All the staff we spoke with told us they would feel able to approach the registered manager if they had any concerns and said the staff team worked well together. One staff member said, "Brilliant staff team," and another told us, "I'm really happy here. We've been the same team for four to five years. It's a nice place to work. Morale on my floor is excellent. I get a lot of support from [deputy manager] or [registered manager]. If she can do it, she will." Staff said they were confident the home provided high quality care and they would recommend the service both as a place to live and a place to work.

A range of audits and checks were undertaking as part of a system to monitor and continuously improve the service. This included medicines, care plan and health and safety audits. We saw evidence that action plans were generated following audits which the registered manager or nursing staff worked through to drive improvement. For example, we saw care plan audits regularly identified issues which were then signed off as they were resolved. Incidents and accidents were subject to monthly audit to look for any themes and trends. Whilst this was positive, more information could have been recorded about the number of incidents individual people had experienced to monitor individual trends.

The registered manager also undertook night checks and an overall monthly audit which looked at a range of areas including medicines and people's care and support experiences. The provider completed a monthly audit of the service to assure themselves it was operating to a high standard. External consultants had also conducted a quality audit and an action plan had been produced which the registered manager was working through. These systems provided us with assurance that shortfalls would continue to be identified and resolved by the service.

A range of staff meetings took place including manager meetings, governance meetings, nursing meetings, senior meetings, activities meetings and general staff meetings. We looked at meeting minutes and saw these were an opportunity to review practice, discuss improvement plans and address any quality issues that had arisen. We saw topics such as safeguarding and DoLS were discussed in staff meetings to check and enhance knowledge.

We saw a number of improvements were planned to the service. For example, staff champions were in the process of being appointed in areas such as pressure area care and infection control. Each named staff champion was responsible for promoting and improving practice in each area.

People's feedback was regularly sought and used to make improvements to the service. We saw regular dining, activity and general care surveys were carried out which showed most people were very happy with the service provided. Surveys of activities and food were used to make changes to activity programmes and menu's respectively. General care surveys were also completed by relatives and health professionals. We looked at the latest surveys from January 2017 where 27 surveys were returned from relatives and 10 from health professionals. Responses were generally very positive indicative of a high quality service.

We saw quarterly residents/relatives meetings were in place. We saw any issues raised at these meetings were addressed by the management team. For example, one person told the length of time between the evening meal and breakfast had been raised at a previous meeting. As a result, the service now served a supper at 9pm.

People we spoke with appeared satisfied with the home, describing themselves as, "Happy," and, "Content," and said they would recommend it to others, with some telling us they already had done so.