Tollgate Healthcare Limited

Mary Rose Manor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this nursing home on 3 and 4 January 2017. The home is registered to provide accommodation, nursing and personal care for up to 50 older people some of whom live with dementia. Accommodation is arranged over three floors with lift and stair access to each floor. At the time of our inspection the third floor of the nursing home was not open and 35 people lived in the home.

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

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Robust processes to check the suitability of staff to work with people were in place. There were sufficient staff available to meet the needs of people and they received appropriate training and support to ensure people were cared for in line with their needs and preferences.

Medicines were administered, stored and ordered in a safe and effective way, work was in progress to improve protocols for as required medicines.

Most risks associated with people's care were identified and clear plans of care were in place to ensure staff knew how to mitigate these risks. Staff had a very good understanding of these risks and how to ensure the safety and welfare of people. Incidents and accidents were clearly documented and investigated and work was in progress to review patterns and trends in these events. Actions and learning were identified from these and shared with all staff.

People were encouraged and supported to make decisions about their care and welfare. Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Where people were legally deprived of their liberty to ensure their safety, appropriate guidance had been followed.

People received nutritious meals in line with their needs and preferences. Those who required specific dietary requirements for a health need were supported to manage these.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. People were encouraged to share their views of the home at meetings and through questionnaires. Information from these was shared on noticeboards in the home.

Care plans in place reflected people's identified needs and most of the associated risks. A new format of care plans had been introduced to provide clear and concise plans of care in line with people's needs and preferences.

Staff were caring and compassionate and knew people in the home very well. External health and social care professionals spoke highly of the care and support people received at the home. They were involved in the care of people and care plans reflected this.

Effective systems were in place to monitor and evaluate any concerns or complaints received and to ensure learning outcomes or improvements were identified from these. Staff encouraged people and their relatives to share their concerns and experiences with them.

The registered manager was very visible in the service and provided strong and effective leadership. They promoted an ethos of open and honest communication within the home. Staff felt respected and valued in the home and this was reflected in the way they supported each other and promoted person centred and efficient care for people.

A robust system of audits was in place at the home to ensure the safety and welfare of people. Any actions required from these audits informed an overall action plan for the home which was monitored and actioned by the registered manager and registered provider.

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.

Staff knew how to keep people safe and had a good understanding of safeguarding policies and procedures.

Risk assessments were in place to support staff in identifying and mitigating most of the risks associated with people's care.

Staff had been assessed during recruitment as to their suitability to work with people and there were sufficient staff available to meet people's needs.

Medicines were managed in a safe and effective manner.

Is the service effective?

Good

The service was effective.

People were supported effectively to make decisions about the care and support they received. Where people could not consent to their care the provider was guided by the Mental Capacity Act 2005.

Staff had received training to enable them to meet the needs of people. They knew people well and could demonstrate how to meet people's individual needs.

People were provided with nutritious meals in line with their needs and preferences.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. People were valued and respected as individuals and were happy and content in the home.

Arrangements were in place to ensure people were involved in planning their care and their views were listened too.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the identified needs of people and the risks associated with these needs.

A range of activities were in place to provide stimulation for people. People were encouraged to remain independent.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way.

Is the service well-led?

Good

The service was well led.

The registered manager was very visible in the service and promoted an ethos of open and honest communication within the home. Staff felt respected and valued in the home.

Robust audits and systems were in place to ensure the safety and welfare of people in the home. These audits had identified areas of improvement within the service which were being addressed.

Mary Rose Manor

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.

One inspector and an expert by experience in the care of older people carried out the inspection on 3 and 4 January 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. In December 2016, the registered 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 PIR for this home.

We spoke with eight people who lived at the home and observed care and support being delivered by staff and their interactions with people in all areas of the home including communal lounges and in people's individual rooms. We spoke with six relatives or visitors and fourteen members of staff including; the registered manager, the quality director of the registered provider, four registered nurses, a cook and kitchen assistant, two shift coordinators, an administrator and three care staff. We received feedback from four health and social care professionals who supported people who lived at the home.

We looked at care plans and associated records for six people. We reviewed the medicines administration records for 35 people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, nine staff recruitment files and policies and procedures.

This was our first visit to this home since it registered with CQC in November 2015.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. They felt staff knew them well and were able to meet all their needs to ensure their safety. One person told us, "I feel extremely safe here as my mobility isn't so good anymore, the staff need to help me out, they are so good and when they assist me to move they make me feel safe." Another person told us, "Of course I am safe here, I have everything I want and need and the staff are just great." Relatives felt staff knew people well and they were safe in the home. Health and social care professionals told us they felt the home excelled at supporting people with complex health needs and ensuring their safety.

Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. They were confident to report any concerns to the registered manager who they said would take any necessary action immediately. Staff had received training on safeguarding and knew the types of abuse they might witness and how to report this both in the service and externally to the local authority and CQC. Staff were aware of the provider's whistleblowing policy and said they would be happy to go to more senior management if they felt their concerns were not addressed appropriately by the registered manager.

Risks associated with people's nursing and care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for maintenance of skin integrity, nutrition, mobility and specific health conditions such as diabetes. For people who were at risk of falls, risk assessments had been completed and used to inform care plans about their mobility and how to avoid the risks of falling around the home. Incidents of falls were logged for each person in their records and these logs were used to identify any patterns and trends in falls for the individual.

However, for people who lived with epilepsy care plans were not always informed of the risks associated with this condition. Staff told us these people had not had a seizure or any concerns associated with this condition for a long period of time; however the registered manager told us these care plans would be updated with information about the condition. Staff's knowledge of people and the support they required to reduce the risks associated with their care was good. They were able to describe potential risks and what support they gave as a result. For example, some people were at high risk of falls as they mobilised independently around the home. Staff had a good awareness of where these people were and how they could support them to ensure they had a safe environment to mobilise in. For people who were at risk of displaying behaviours which may cause themselves or others distress, staff had a very good knowledge of how to support people with these behaviours and ensure the safety and welfare of all people.

A system to record incidents and accidents which occurred within the home was in place and staff were aware of this. The registered manager had reviewed, logged and investigated any incidents and this informed their monthly manager's report to the registered provider, however it was not always clear what actions had been taken to prevent a recurrence of the incident, or to review patterns and trends in these events.

We discussed this with the registered manager and the quality director for the registered provider who told us this work was in progress as it had been identified in an audit of the home's records in November 2016. Records showed this action had been identified and was on-going with the registered manager.

Medicines were always administered by registered nurses and were stored and administered safely. There were no gaps in the recordings of medicines given on the medicines administration records (MAR). People received their medicines in a safe and effective way. Several people received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. The home had ensured families and health care professionals had been fully involved in a best interests decision making process in line with the Mental Capacity Act 2005 to ensure the safety and welfare of the person.

For medicines which were prescribed as required (PRN) we saw staff recorded when these medicines were given although records did not always provide information on the effectiveness of these medicines. There were not always clear protocols in place for staff to follow in the administration of these medicines. For example, for two people who had been prescribed a medicine PRN to support them if they became agitated, there was no clear guidance in place as to when this should be given and how this was monitored for its effectiveness. Whilst staff were clear on how and when this medicine should be administered, records did not always reflect why the medicine had been given and the effect these medicines had on the person. However this concern had already been identified through an audit of medicines in the home and a "Medication Management Plan" dated October 2016 had been implemented. This action had been identified as being required and was in the process of being completed by the end of January 2017.

A system of audit was in place to monitor the administration, storage and disposal of medicines weekly. An overall audit of medicines had been completed by a nominated registered nurse in October 2016. From this audit we saw actions had been taken to ensure the safety and welfare of people. For example, records with regard to the administration of covert medicines had required improvement during this audit. We saw this action had been completed. Medicine administration records had not always been completed accurately at this audit. A system of weekly audits had been introduced following the audit to monitor these records and we saw this was effective. We were assured the audit of medicines in the home was effective and ensured the safety and welfare of people during the administration of their medicines.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, an application form and employment history for people. Two references were sought before people commenced work at the home. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. People who work in the United Kingdom as nurses must be registered with the Nursing and Midwifery Council (NMC) and have a personal identification number (PIN) for this. Providers must ensure all registered nurses provide the relevant documentation to show they have this registration. This information was held on file for registered nurses employed at the home.

There were sufficient staff available to meet the needs of people. The registered manager had a very good understanding of the skill mix of staff employed at the home and the needs of people who lived at the home. The home did not employ the use of agency registered nurses but did require the use of agency care staff to support staff absence and holidays. Staff rotas showed there were consistent numbers of staff available each day to meet the needs of people. The registered provider had a dependency tool available which they would request information for should the home require additional staffing to support people. At the time of our inspection the registered manager told us staffing levels were good and above the required need for the

dependency of people in the home. They told us as additional beds in the home became available for new people staffing levels would be reviewed using this tool and would be increased accordingly.

People and their relatives told us there were sufficient staff to meet their needs and staff responded to their needs in a prompt and unhurried manner. A system of call bells in place alerted staff via a pager system to identify where people required support. This system meant staff were easily made aware when people required support but that the call bell system was not disturbing to other people in the home. We saw staff responded promptly to people's request for help.

Staff worked effectively as a team to ensure there were sufficient numbers of staff in all areas of the home to meet people's needs and ensure their safety. For example, on the first floor of the home a member of staff was always available in the main communal area to ensure people received the support they required and ensure their safety.

Good

Is the service effective?

Our findings

People said they were offered choice, were supported to make their own decisions and these were respected. One said, "I know what I like and how I like it and the staff are very good, they respect this, even if they don't like what I say." Health and social care professionals felt staff had a good understanding of how to support people in making decisions and when to involve other professionals or family members in this process.

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. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The registered manager and staff had a good understanding of the processes required to ensure decisions were made in the best interests of people.

All staff had a good understanding of the MCA and they gave examples of how they sought consent from people before they supported them with care. They told us this was to ensure that people made their own decisions even if staff felt these were not wise decisions and they described best interests processes taking place for decision making including involving, family, GPs, social workers and anyone else that was relevant. One said, "I know people cannot always tell me exactly what they want so I have to help them express themselves and make their own choices or decisions. Sometimes this involves them pointing at something or some people, like [person] tell us using picture cards or we speak with their family." A second member of staff said, "We have to make sure people are fully informed in all the care we provide and they consent to anything we do for or with them."

Care records provided clear information on the decisions people were able to make, and those with which they required the involvement of others. Records identified people to involve in best interests decisions including their relatives or legal representatives and a range of multi-disciplinary health and social care professionals who were involved in the person's care.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards. For a few people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care or not leaving the home unescorted. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

A programme of supervision and appraisals was in place for all staff. Staff said they had supervisions and felt these were useful to raise concerns. They said they felt supported and knew they could talk to the registered manager at any time if they needed to. A clear program of induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their

needs.

Training records were held electronically and were monitored by an administrator and the registered provider's head office. These showed staff had access to a wide range of training which included: moving and handling, fire training, infection control, safeguarding, mental capacity and deprivation of liberty, challenging behaviour and awareness, dementia awareness, personalised care and health and safety. All staff had been encouraged to develop their skills through the use of external qualifications such as National Vocational Qualifications (NVQ) and Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

The registered provider had systems in place to support the development of skills for registered nurses. This ensured they were up to date with current practice and able to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

People spoke highly of the food and said this was excellent. One person told us, "The food here is excellent, the lady from the kitchen comes to see me every morning and asks what I wold like to eat at lunchtime and dinner." A relative told us, "I sometimes eat with [person] if I come to visit at lunchtime, and the food is just lovely." People were offered choice and if they did not want what was on the menu they could have something different. This was confirmed by the kitchen staff. Care plans identified specific dietary needs and kitchen staff were knowledgeable of these and had information about the type of diet people required, any allergies they might have and their likes and dislikes. All food was freshly prepared and staff had guidance about how to ensure the consistency of food and drinks were correct to meet people's needs. Staff described how they supported people with nutrition and hydration needs including, monitoring their food and fluid intake if there was a concern and monitoring their weight. They described how they fortified foods and drinks if people needed this and would liaise with the dietician if required.

Staff supported people to manage their meals in a calm and supportive manner, recognising people's needs as they changed according to their mood. For example, for one person who usually enjoyed their food but declined it on one day of our inspection, we saw staff encouraged them to try a little of their meal but they became agitated and left the dining room to walk around the home. Staff were patient and considerate of the person's feelings and allowed them time to settle and return to the dining area approximately ten minutes later when they enjoyed a newly plated meal. For another person who declined to eat their meal, staff offered other alternatives but the person chose not to have these and their choice was respected. Staff offered this person a milkshake later in the afternoon which they accepted. Staff were aware of the needs to ensure people were receiving adequate nutrition to maintain their health and welfare.

Records showed health and social care professionals visited the service as and when required. Care records held feedback from GPs, speech and language therapists, dieticians, social workers and occupational therapists. Staff identified people's needs and health and social care professionals told us they were involved appropriately in people's care.

Good

Is the service caring?

Our findings

People described staff as very kind and caring. They said they felt staff listened to and respected them. They felt they were given choices and staff respected their privacy and dignity. One said, "They [staff] are all just lovely and could not be kinder." Relatives spoke very highly of the caring way in which staff supported their loved ones. One told us, "[person] has dementia and [their] care needs are high. The staff are simply wonderful and treat [them] well, they are very kind." Another told us, "We think the home is wonderful, the staff are so good, they are kind and caring." Health and social care professionals told us they found staff caring and that they took time to support people with their care needs without rushing them.

The atmosphere in the home was warm, calm and very friendly. Staff interacted with people and each other in a calm and professional manner and took their time to ensure they had responded to people in a way which was appropriate to their needs.

For example, for one person who called out regularly in communal areas of the home to attract staff attention, staff remained calm, patient and supportive in their interactions with this person. For another person who became distressed and anxious when their environment was noisy or confusing for them, staff recognised their needs and sat with them or encouraged them to participate in activities to ease their concerns. For a third person who mobilised around the home for very long periods of time, particularly at night, staff recognised the need to observe the person and anticipate their needs to sit down and rest or sleep in different environments around the home. Staff were patient and spoke calmly and slowly with the person to support them as they grew tired, recognising the need to ensure their safety whilst maintaining their dignity and independence.

Relatives told us how welcome staff made them feel and that staff were always kind and responsive to the needs of their loved ones. One relative told us, "I am made to feel so welcome. It's wonderful to still be able to eat a meal together; I can't tell you how important that is to us." Another relative told us how kind and considerate staff had been when their relative had moved into the home from another care setting and had needed support to settle in the home.

Throughout the day staff spent time with people chatting and laughing whilst supporting them with their needs. They supported people to interact with each other. People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Doors remained closed when people were being supported with personal care or other activities and staff knocked and waited for a response before entering people's rooms. Staff had a good understanding of how to ensure people's dignity was maintained. For example, one person entered the communal area of the home in a state of undress and staff immediately moved to support them and ensure their dignity was maintained. People were able to personalise their rooms with their belongings and could access their rooms when they chose. Personalised door plates displayed pictures of activities or interests of the person. For example, two people had pictures relating to their favourite football team on their door whilst another had flowers or pictures of animals. People told us they chose what display was on their door.

Resident and relative meetings took place and actions from these meetings were responded to by the registered manager. For example, at a meeting in December 2016 relatives had requested more prompt response to the doorbell particularly at the weekend when there were no administrative staff working close to reception. We saw the registered manager had responded to this request by implementing a new entry system to ensure visitors received a prompt response to their call. Copies of the minutes from these meetings were displayed in the home.

The registered manager told us they operated an open door policy to encourage people and their relatives to discuss the care and support they received and raise any concerns they may have to improve their care. We saw people spoke with staff and the registered manager about things which were happening in the home and things they would like to do. People confirmed they could talk to the manager at any time. Relatives told us they were always able to speak with the registered manager or any member of staff about the care their loved one received at the home.

Good

Is the service responsive?

Our findings

Whilst people did not always know if they had a care plan or if they had been involved in planning care to meet their needs, they said that staff listened to them and knew what they needed. Relatives told us they and their loved one had been involved in the planning of their care and that should they feel any changes were required they would speak with the registered manager or nurse and these would be addressed. For example, two relatives told us how they had been involved in planning care for their loved ones and regularly spoke with staff and the registered manager about any changes in their care. They said staff responded to their loved ones changing needs in a positive and very sensitive way, ensuring they involved them as much as possible, even although their ability to understand and communicate their needs was limited. Health and social care professionals told us staff were very responsive to people's needs and were not afraid to support people with complex and challenging needs. They told us staff were confident and competent to respond to people's needs appropriately.

An assessment of people's needs was completed before they came to live at the home, this included ensuring a copy of the most recent information from the person's GP was available for the home. The registered manager told us they reviewed this information and would have no hesitation in declining a person's admission to the home if they felt their staff were unable to meet the needs of people. These assessments provided clear information to inform plans of care for the person and records showed people were encouraged with their relatives to inform this process. People's preferences, their personal history and any specific health or care needs they may have were clearly documented.

Staff had a very good awareness of people's needs and preferences. Care plans gave clear information for staff on how to meet the needs of people in a person centred and individualised way which ensured their safety and welfare. For example, one person chose not to wear their hearing aids as they disliked them. Staff were aware of this and care records showed they had discussed this with the person as they were concerned they would not hear staff knock at a door when they entered the room or if there was an emergency. The person had agreed that if they did not respond to any knock at their door then staff could put their head around the door to ensure their safety and welfare. Staff told us how they often had to just "pop their head around the door" as this person was not able to hear them and did not respond to their knock.

During our inspection we saw staff responded quickly and efficiently in an emergency situation. One person became very unwell and staff remained calm and sought appropriate support from the registered nurse and registered manager on duty. Whilst an emergency ambulance was required, staff continued to maintain calm and respond to the person's needs without causing undue anxiety or distress to others. On another occasion, one person was found to have moved themselves from the bed onto the floor and required assistance from staff. Staff responded promptly to the person's needs, reassuring them and explaining how they were going to support them to maintain their safety. Staff had a good understanding of how to respond to emergency situations and involve the appropriate staff without causing distress to others.

The system in place to review and update plans of care for people had been reviewed in October 2016 and a new format for these records had been implemented. Care plans were person centred and held clear

information and guidance for staff to ensure they could meet people's needs including specific health conditions such as diabetes and other long term conditions which would affect their abilities to maintain their independence. For example, for one person who had difficulties with the management of a complex neurological condition, care plans in place were clearly written to encourage the maximum independence for the person. Staff demonstrated a clear understanding of these needs and told us how they were updating care records to ensure they followed the new format of care records which had been implemented.

The registered manager told us they had recently introduced a key worker system to provide additional support for people although this work needed further embedding in the home. A key worker was a member of staff who took a key role in coordinating and promoting continuity of care for the person. One person told us, "I have a keyworker here at the home; we sat down when I first moved in and discussed my care needs. [They] put together a care plan for me and it's reviewed on a regular basis."

An activities coordinator worked in the home on five days per week to support the coordination and management of activities for people. They told us most morning activities were based around one to one interactions with people in their rooms and group sessions were held at different times during the week including music, art and crafts, jigsaws and games sessions. This was clearly displayed on an "Activities Rota" displayed around the home. Regular social activities such as celebration of birthdays and special events, garden parties and visiting musicians were held. For example, during the week following our inspection a party was planned for the anniversary of the home opening. Some people said they did not very often participate in activities and this was their choice as they were independent and liked to complete activities on their own in their rooms. One person told us how they always got a newspaper and enjoyed reading and doing puzzles independently. For people who were unable to engage in activities independently we saw staff encouraged them to join in with activities of their choice in the communal areas of the home.

We observed staff actively encouraging people to be involved in a range of activities in the communal lounge area of the home upstairs including jigsaw puzzle making and listening to music, watching a film or interacting with each other and dolls. The activities coordinator told us they were looking to introduce some more dementia friendly activities in the home once they had received further training in their role.

The registered provider's complaints policy was displayed in the home. We saw any concerns or complaints were investigated and actions from these were implemented. Records showed any concerns or complaints had been addressed in full. The registered provider monitored all complaints and concerns as they were reported through the manager's monthly report and worked with the registered manager to ensure all matters had been dealt with and reported appropriately.

We saw the registered manager and staff were very welcoming to visitors and encouraged them in a warm and friendly way to share their views on the service. Relatives felt able to express any concerns they might have and were confident the registered manager and their staff would address these promptly and efficiently. Health and social care professionals told us they felt the registered manager was very efficient and supportive of people, their relatives and staff and always responded promptly and efficiently to any matters which were brought to their attention.

Good

Is the service well-led?

Our findings

People, their relatives, staff and health and social care professionals felt the service was very well led by a registered manager who was experienced and very supportive of them all. One person told us, "The manager is wonderful, she is kind and caring and all the staff are happy." Another said, "All the staff are good, the manager is first class." A relative told us, "I have nothing but praise for the staff and the manager in particular. Her knowledge and care is wonderful." Another said, "The manager, well I can't fault her, her knowledge is amazing." Health and social care professionals said the service was well led and one told us the manager had their "finger on the pulse" of the service.

Staff felt supported in their roles through supervision and team meetings. They felt able to speak with the registered manager or registered nurses about any concerns they may have and felt these would be addressed promptly and effectively. Team meetings were used to provide information for staff on service developments and also any learning from incidents and accidents in the service. A staff survey completed in September 2016 showed staff were happy at the home and felt the standard of care was good in the home. A staff survey in March 2016 showed staff wanted more activities available for people and we saw actions had been taken to employ an activities coordinator.

The registered manager was supported by a group of managers at the registered provider's head office including the director of quality and the nominated individual. They also attended local meetings with other registered manager's from homes nearby to share experiences and learning.

The registered manager was very visible in the service and provided strong and effective leadership. They promoted an ethos of open and honest communication within the home. Staff felt respected and valued in the home and this was reflected in the way they supported each other and promoted person centred and efficient care for people.

There was a clear staffing structure in place at the home. An administrator in the home supported with all clerical duties, while registered nurses within the service supported the clinical day to day running and provision of care in the home. Shift coordinators were allocated to each floor of the home to support members of care staff in the daily work load. They worked with care staff to provide care and support for people and ensure monitoring charts were completed and routine checks were carried out in line with people's needs and plans of care. All staff felt supported in their roles and had a good understanding of their roles and responsibilities in the home.

Staff worked cohesively as a team and supported each other to meet the needs of people. They shared common values and visions in the service to provide excellent person centred care for each person. The registered manager and all staff we spoke with were very proud of the home and the care people received there. One member of staff told us, "We all work really well together, it's a team effort and we all need each other to be sure people get the care they need." Another said, "This is a great place to work, everyone just wants the very best for the residents and so we all work well together."

The registered provider had an "Internal Quality Assurance and Audit Schedule" which required the registered manager to complete a robust schedule of audits in the home to ensure the safety and welfare of people. This included audits for: medicines, infection control, staff training and recruitment, nutritional needs, environment, equipment checks and fire records. We saw the registered manager completed these and any actions from these audits informed an action plan for the home. The quality director was new in post and told us they planned to complete two full audits of each of the registered provider's homes each year. They were working to support the registered manager on the current action plan for the home. The registered manager also completed a monthly manager's report to the registered provider which identified the audits completed and any concerns or incidents in the home during the month such as complaints, incidents and accidents and safeguarding concerns raised.

People and their relatives were asked for their views of the service and the quality of the care delivered at the home. A survey of people's views was carried out in March and September 2016 and showed people were very happy with the care provided at the home. Feedback from these surveys was displayed in the home with the actions the registered provider planned to take to address any issues. For example, in March 2016 people had fed back the need for a more structured response to activities in the home. We saw this had been addressed. A survey of health and social care professional's views of the home was carried out in March and September 2016 and showed the home had developed good working relationships with external professionals.