Central England Healthcare Limited

Eversleigh Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Eversleigh Nursing Home on 23 November 2016. The inspection visit was unannounced.

Eversleigh Nursing Home is divided into three separate floors and provides personal and nursing care for up to 42 older people, including people living with dementia. There were 35 people living at the home when we inspected the service.

A requirement of the service's registration is that they have a registered manager. 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 and the associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection visit, however they were on extended leave from the service. An interim manager had been appointed to manage the service in their absence. We refer to the interim manager as the manager in the body of this report. During our inspection visit we also spoke with the development and delivery manager, who was assisting the interim manager three days each week at the home.

Staff received training in safeguarding adults and understood the correct procedure to follow if they had concerns. All necessary checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there. The manager and staff identified risks to people who used the service and took action to manage identified risks and keep people safe.

There were enough staff to care for people safely and effectively. People were supported by a staff team that knew them well. Staff received training and had their practice observed to ensure they had the necessary skills to support people.

People received their medicines as prescribed to maintain their health and wellbeing. People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

Care records were up to date and provided staff with the information they needed to support people responsively.

The provider, manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA requirements. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

Staff knew people well and could describe people's care and support needs. Staff treated people with

respect and dignity, and supported people to maintain their privacy and independence.

People were supported to take part in social activities and pursue their interests and hobbies. People made choices about who visited them at the home, which helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run, and action was taken in response.

Quality monitoring procedures identified where the service needed to make improvements. Where issues had been identified the manager took action to address them to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at Eversleigh. Staff had been recruited safely and there were enough staff available to meet people's needs. People were protected from the risk of harm as staff knew what to do if they suspected abuse. Staff identified risks to people and took appropriate action to manage risks and keep people safe. Medicines were administered to people safely.

Is the service effective?

Good

The service was effective.

Staff completed an induction and training so they had the skills they needed to effectively meet people's needs. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with people who were closest to them and health professionals. People received food and drink that met their preferences and supported them to maintain their health. People were supported to see healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff knew people well and respected people's privacy and dignity. Staff treated people with respect and kindness. There was end of life care planning in place to involve people in decisions that took into account their wishes and preferences.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in accordance with their interests and hobbies. People had an up to date record of their care needs and how these were being met to ensure they received consistent care from staff. People were able to raise complaints and provide feedback about the service.

Complaints were analysed to identify any trends and patterns, so that action could be taken to make improvements.

Is the service well-led?

Good

The service was well led.

The management team was approachable and there was a clear management structure to support staff. People were asked for their feedback on how the service should be run, and feedback was acted upon. Quality assurance procedures identified areas where the service could improve, and subsequent action was taken to improve the service.

Eversleigh 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 was 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 23 November 2016 and was unannounced. This inspection was conducted by two inspectors, an expert-by-experience and a specialist advisor. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with seven people who lived at the home and five people's visitors or relatives. We spoke several members of staff including two nurses, the deputy manager, three members of care staff, an activities co-ordinator and the gardener. We also spoke with the chef, the interim manager and the development and delivery manager who was also the provider's representative.

We reviewed the information we held about the service. We looked at information received from relatives of people who used the service, statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home. Prior to our visit we had received concerns about some aspects of the service, which we had shared with commissioners and were able to review on this inspection.

We also reviewed the information in the provider's information return (PIR). This is a form we asked the

provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they planned to make. We found the PIR reflected the service provided.

We looked at a range of records about people's care including five care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for two members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

There was a relaxed and calm atmosphere in the home and the relationship between people and the staff who cared for them was friendly. People did not hesitate to go to staff when they wanted support and assistance. This indicated they felt safe around staff members. All the people we spoke with told us they felt safe at the home. One person commented, "Yes, it is safe and comfortable here." Another person said, "I like it here, it's a very nice place. I feel safe here."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information on how staff could raise issues of concern with the provider. All the staff knew and understood their responsibilities to keep people safe and protect them from harm. Staff told us their training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were confident the manager would act appropriately to protect people.

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of candidates prior to them being recruited to work at the home. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce the identified risks. Risk assessments were detailed, reviewed regularly and gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, care staff were given information about people's mobility and how they should be moved to reduce the risk of harm when mobilising. Staff were also instructed how many staff were needed to move each person, and which equipment they should use to move the person safely. Staff we spoke with had a good understanding of the risks related to each person's care.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for, so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. This was to minimise the risk of people's support being provided inconsistently.

People and their relatives told us there were enough staff to care for people safely. We observed there were enough staff during our inspection visit to care for people effectively and safely. Staff were available to respond to people's requests for assistance. In addition to nursing and care staff, other members of staff such as domestic and auxiliary staff were available, so that care staff could concentrate on providing support to people.

Staff gave us mixed feedback about whether there were enough staff at the home. This was because one

member of staff said they would like more time to be able to sit and talk with people. Most staff told us there were enough staff with one saying, "We all work together as a team to cover all the shifts between us. This means we don't have to work every weekend." Another member of staff said, "Its great teamwork here, we all work together."

Staffing levels were determined by the number of people at the home, their needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. The manager used this information to determine the numbers of staff that were needed to care for people on each shift.

We asked the provider and manager about staff vacancies at the home. They told us they were in the process of recruiting more staff at the service to ensure staffing levels continued to be maintained, currently they had no vacancies at the home and were fully staffed. They explained they did not use agency staff often, as there were enough permanent staff to cover all the shifts. Agency staff were only used when staff were unexpectedly absent.

We observed medicines being administered. Staff who administered medicines were trained nurses and received specialised training in how to administer medicines safely. Nursing staff completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. This ensured staff continued to manage medicines to the required standards.

Medicines were stored safely and securely. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. MAR's contained an up to date photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use agency staff to administer medicines who might not know the people there. The MARs confirmed people received their medicines as prescribed.

Some people required medicines to be administered on an "as required" basis. There were detailed protocols (plans) for the administration of these medicines to make sure safe dosages were not exceeded and people received this consistently. Daily and monthly medicine checks were in place to ensure medicines were managed safely and people received their prescribed medicine.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. Staff received an induction to the home when they started work which included working alongside an experienced member of staff. They also completed training courses tailored to meet the needs of people who lived at the home. For example, staff received training in dementia care. A new induction training programme had recently been developed by the provider to make this more comprehensive and suited to staff needs. The new induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care staff in the UK. The provider employed a dedicated training manager to plan and arrange staff induction and training. This vacant post had recently been filled, and the provider told us the reason the 'Care Certificate' had not yet been fully implemented was because of this.

Staff told us the manager encouraged them to keep their training and skills up to date following their induction training programme. They maintained a record of the training attended to identify when staff needed to refresh their skills. One staff member said, "If you are due for training they inform you when it is needed. It keeps our skills up to date."

Staff told us that each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in medicine administration and managing people's health conditions, for example, how to operate and manage a syringe driver. One nurse said, "I am fully supported with training and I feel if I asked for additional training, they would arrange this for me." One member of staff described the training they received caring for people with dementia and explained this helped them to meet the needs of people at the home, as they understood the condition and how it affected people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with understood the basic principles of the MCA and knew they should assume people had the capacity to make their own decisions. Staff asked people for their consent and respected people's decisions to refuse care where they had the capacity to do so. For example, one person had been recommended to use a specialist mattress to prevent them from developing pressure sores. The person refused the use of the mattress. Staff had explained the risks to the person's health if the mattress was not used, however, the person had the capacity to make their own decisions and the mattress was not in use. Staff monitored the person's skin to make sure any damage to their skin was minimised and treated where required.

Where people could not make all their own decisions, a mental capacity assessment had been undertaken to determine which decisions they could make themselves, and which decisions needed to be made in their 'best interests'. Records confirmed following such assessments important decisions were made in people's 'best interests' in consultation with health professionals and people's representatives.

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 manager reviewed each person's care needs to assess whether people were being deprived of their liberties, or their care involved any restrictions. Only one person at the home had a DoLS in place. However, more than twenty applications for DoLS had been made to the local authority and were awaiting a decision. Some staff had difficulty in recalling the principles of DoLS when asked, however, we found care records clearly described any restrictions that were placed on people's care, so that staff had the information they needed to act in accordance with the MCA.

We observed a lunchtime meal during our inspection visit. The majority of people ate their lunch in their room, and were served their meal on a tray. We observed some people eating their meal in their room with the assistance and support of staff where they needed support. Staff told us this was according to each person's preference. One member of staff confirmed to us this happened each day, they said, "Most people enjoy eating in their room rather than the dining room."

We observed six people ate their lunch in the dining room, and one person ate in the lounge area with a tray whilst they watched television. The dining room was calm and was laid out with round tables where people could enjoy their meal with friends and relations. One relative who was eating their meal with the relation said, "It's always a nice meal when I come here." Tables were laid with table clothes, flowers, cutlery and condiments to enhance people's mealtime experience and make the mealtime a social event. There was a relaxed atmosphere in the dining room, which was attended by sufficient staff to assist people to eat their meal. Where people needed assistance to eat their meal, staff supported people at their own pace and waited for people to finish before offering them more food.

People told us they enjoyed the food on offer at the home, and could make choices each day about what they wanted to eat. One person said, "The food is good. Its Lancashire hot pot today, just what you need on a cold day!" A daily menu of the food on offer was displayed on the notice board at the home. Menus were located in people's rooms so that people could choose each day what they wanted to eat. People were able to choose from a range of options and staff asked people for their food choices before their meal was prepared. Where people were unable to make decisions themselves, staff made choices based on the individual's likes and dislikes. These were recorded in the care records we reviewed. We spoke to the chef at the home who told us, "We prepare food as ordered, however, people can ask for an alternative if they wish." We observed several people asking for an alternative to the standard meal option during the day, these were all accommodated by the kitchen who made them a different meal.

People were offered food and drinks that met their dietary needs. Kitchen staff knew the people's dietary needs and ensured they were given meals which met those. For example, some people were on a soft food diet or were vegetarian. Information on people's dietary needs was kept up to date and included people's likes and dislikes. The chef told us, "The staff here keep me up to date with people's dietary needs and if anything changes. We keep this information in the kitchen so it's readily available when we are preparing meals."

Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People and their relatives could help themselves to fruit, biscuits and drinks, which were readily

available in the communal areas of the home. People also had drinks taken to their room several times each day. We saw drinks in people's bedrooms were in easy reach.

Staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, dietician and dentist where a need had been identified. We found people were referred to see health professionals in a timely way to address their healthcare needs. The manager told us the doctor and other health professionals visited the home each week, for example, the doctor visited the home each Tuesday.

We found advice given by health professionals was being followed. For example, one person required support with a skin wound. Regular photographs and wound assessments were undertaken to manage the progress of the wound, and to check this was healing. Advice from healthcare professionals was followed and dressings were changed every few days.

Good

Is the service caring?

Our findings

People told us staff treated them with respect and kindness. One person told us, "I enjoy it (living here) and like them (staff) very much." A relative commented how the caring attitude at the home had impacted on their relation's care saying, "They have been calmer and more relaxed since coming here."

Staff told us they enjoyed working at the home because of the interaction they had with people who lived there. One member of staff said, "I get to know people really well." We observed staff interacting with people at the home in a respectful and caring way using people's preferred names. For example, where people needed assistance with putting on protective aprons and clothing, staff approached people to ask if they wanted their support, they waited for people to show signs that they agreed to wearing the clothing before assisting them.

One person told us, "I am very happy with the carers, they are very good and I'm looked after." A relative of another person commented, "[Name] came here after being in hospital, they are bed bound unfortunately but the staff have been very kind to them here."

Most staff communicated with people effectively using different techniques. We observed staff touching people lightly on their arms or hands to provide them with reassurance and comfort. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. People laughed and smiled at staff and we saw some people enjoyed these staff interactions. However, some of the time staff did not take the opportunity to speak with people when they could. For example, we saw one member of staff assisting one person to eat their meal. Although the staff member took their time, and gave the person time to eat, the staff member did not engage the person in any conversation.

People told us they made everyday choices about how they spent their time and lived their lives. They explained their decisions and wishes were respected by staff. One person told us about how they enjoyed having an alcoholic drink during the day, we saw the drink was available for them to help themselves to when they wanted a drink. Another person told us, "I like to spend time in my room." We saw that they did spend most of their time in their room. We saw most people at the home spent time in their room, rather than in the communal areas of the home. People had made choices about how their room was decorated and the personal possessions they had around them.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home and were supported to maintain links with friends and family. For example, one person often had their relatives visit them and eat with them in the dining room. We saw people and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome.

Staff promoted people's independence and encouraged them to do things for themselves where possible. For example, we observed staff encouraging one person to eat independently. The person was offered the food on a tray with a plate guard which is a device that assists people to gather food on cutlery without

assistance from staff. This was according to the person's wishes. We observed the person ate at their own pace, and staff checked on them frequently to ensure they did not require support to finish their meal.

People told us their dignity and privacy was respected by staff and we observed care staff respected people's privacy. Staff knocked on people's doors before entering and announced themselves. We saw where people chose to share a room with another person, the home had curtains and privacy screens available. A member of staff told us, "We are careful about people's privacy and dignity, we make sure doors or curtains are closed when supporting people."

People and their relatives were involved in care planning where possible and were involved in decision making. For example, information was sought about people's religious beliefs and their personal history, so that staff could support people in accordance with their wishes.

Some people at the home had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. People had up to date 'end of life' care plans which were comprehensive. Plans showed people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to. The deputy manager confirmed that people made these choices in consultation with health professionals, their relatives and staff, so that their wishes could be met.

Nursing staff had received specific training in caring for people at the end of their life, so that people could receive effective care that responded to their specific needs. Members of the nursing team had been trained in the National Gold Standards Framework (GSF) on 'end of life care'. GSF training uses a systematic, evidence based approach to optimising care for people approaching the end of their life to a recognised standard. The home had also received an accreditation from the GSF in sustained practice. One nurse told us, "We have been using the framework for around seven years now. The training was extensive and ran over a six month programme. Members of the nursing team attend monthly GSF meetings to keep up to date."

Good

Is the service responsive?

Our findings

People enjoyed the activities and events on offer at the home. The home employed a member of staff to support people with activities, hobbies and interests. One person told us how much they enjoyed spending time doing activities saying, "The staff help me with my crosswords now as my eyesight is getting worse, I do enjoy my crosswords."

Two people told us about a trip out into the town the previous evening where they were accompanied by the activities co-ordinator and a member of staff. Comments included; "We had a wonderful time seeing the Christmas Lights", "We enjoyed the pub where we had a drink".

We observed people sitting in the lounge areas at the home listening to the television. We observed one person enjoying a one-to-one activity with the activities co-ordinator where they were knitting together. Another person asked if they could knit as well, and the staff member encouraged them to join in. We saw other people chatting with their relatives and friends in their bedrooms which they enjoyed. We spoke with a member of staff who organised activities at the home. They said, "The people are lovely and I enjoy my role. Many people stay in their rooms, so we offer people one to one activity time in their room." We observed the activities co-ordinator spending time with people in their room, doing puzzles with people and talking with them.

A list of planned activities was on display in the communal areas of the home and in people's rooms for them to refer to. In addition posters were on display at the home advertising forthcoming events, such as the Christmas fayre at the home.

Care records were available for each person who lived at the home. Records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs and their personal preferences about how they wished their care to be provided. Records also identified information on people's life history, and activities and hobbies they might enjoy. Care reviews took place each year, or when people's needs changed. Yearly reviews were attended by the manager of the home, the person, their family or friends and commissioners of services. People told us they had been involved in planning their care and families also confirmed this. This helped to ensure care plans reflected people's individual needs.

Staff told us care records were kept up to date and provided them with the information they needed to support people effectively. Staff could describe to us people's individual support needs and information matched what people told us, which demonstrated staff knew people well.

Staff were able to respond to how people were feeling and to their changing health or care needs because they were kept updated about people's needs at a handover meeting at the start of each shift. The handover provided staff with information about any changes in people's needs since they were last on shift. Staff explained the handover was recorded so that staff who missed the meeting could review the records to update themselves. One member of staff told us, "The handover records are quite detailed. It gives you

information on people's heath, and if anything changes we would inform the nurse so the next shift is aware."

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. A typical response from people we spoke with was they had never needed to make a complaint. One relative told us, "I would certainly tell them if I needed to."

In the complaints log we saw that previous complaints had been investigated and responded to by the provider. For example, one relative had complained about their relation being moved to a single room after sharing a room with another resident. This has impacted on their emotional wellbeing. The provider had responded to the complaint and moved the resident back into a shared room. The person was now happier and seemed content with the new arrangement.

One relative we spoke with told us about a recent complaint. The family member had raised a number of concerns about their relative's care. They told us the issues had been resolved, they remained concerned only about their relation not being given enough support to eat their meal. The provider had investigated the concern and the person was now being supported by a member of staff at each mealtime.

Complaints were analysed to identify any trends and patterns, so that action could be taken to continuously improve the service provided. For example, the provider had recognised that they did not always get all the information they needed when people were admitted to the home. They were introducing a more robust assessment process to identify people's individual needs on admission.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. However, they were absent at the time of our inspection visit and were planning to leave the home. An interim manager had already been appointed and had been confirmed as being the new permanent manager the week of our inspection visit. The interim manager worked alongside the delivery and development manager (provider's representative) who was at the home three days per week. The interim manager was applying to become the registered manager at the home.

People and staff told us members of the management team were approachable. However, some staff commented they would have liked more communication from the management team in the registered manager's absence. One staff member said, "The delivery and development manager is approachable but isn't here all the time." They acknowledged that they had now been informed of the change in manager, although this had only happened the week of our visit. The provider explained they had not yet had an opportunity to fully discuss the changes in the management team with people, their relatives or staff as the change had just been made.

Some staff said morale had been low whilst the previous manager was away, as this posed some uncertainty for them. Due to the registered manager being away staff told us they had not had regularly arranged team meetings, the provider had not arranged these in the manger's absence. Although, staff had continued to meet within teams informally, to exchange information. Staff told us having no formally arranged staff meetings had affected their communication with managers. The last full team meeting was held in April 2016. One staff member said, "It's been difficult sometimes with the manager away, but we have now started to have conversations with the new manager, who has listened to my ideas." Another member of staff commented, "I was initially concerned, as were the residents, when the manager left but we now feel reassured. We are a strong team and experienced so we have continued as before."

The manager confirmed staff team meetings had now been re-introduced and staff appraisals and one to one meetings with their manager had continued to take place. These individual meetings gave staff an opportunity to discuss their performance and any training requirements. Staff team meetings gave staff an opportunity to provide feedback about the running of the home, and staff could be kept up to date with any changes or developments at the home.

The provider told us the management team operated an 'open door policy' and encouraged staff and visitors to approach them in their office. The interim manager explained they had only just begun working at the home, but planned to re-introduce a manager's daily walk around to improve management visibility at the home and staff communication.

The new manager was part of a management team which included a deputy manager on each shift, who was also a nurse. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was always an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to.

One staff member told us that despite the changes in management and the recent uncertainty, they enjoyed working at the home, and felt valued by the provider. They said, "I feel valued, I know I'm not just a number but a name."

People could provide feedback about how the service was run and their comments were acted on by the provider. The manager told us they encouraged feedback from people, visitors and relatives by holding regular meetings at the home. We saw in a recent meeting a relative had suggested the home started using a local charity to bring pets into the home. This has been implemented by the provider.

The provider also carried out bi-annual quality satisfaction surveys to gather feedback from people and relatives. Some survey results we reviewed showed people had a high level of satisfaction with the home, one person saying "I like all the attention from care and nursing staff. I am happy here." We noted another person had commented on how they would like more vegetarian food options to be added to the menu. We spoke with the chef who confirmed one person was vegetarian, they had meals prepared for them separately each day. On the day of our inspection visit we saw the person had a vegetable curry prepared especially for them.

There was a system of quality assurance and auditing procedures in place to ensure the quality of the service at Eversleigh was reviewed. For example, the manager conducted monthly checks on care records to identify where records needed improvement. In addition, the provider had developed a system where a person was selected each day, and their care and records were reviewed. The manager had also assigned keyworkers to each person who lived at Eversleigh. A keyworker was a designated member of staff who knew the person well and could review care records for the individual. They also closely monitored the person to identify any changes needed in their care.

The provider completed other regular checks on the quality of the service they provided. This was to highlight any issues and to drive forward improvements. For example, the provider directed the manager to conduct regular checks in medicine administration and infection control procedures. The management team produced quarterly reports into how the home was performing against business plans. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans were monitored for their completion by the provider. This demonstrated the provider took action to continuously improve the quality of the service provided at the home.

The provider had sent statutory notifications to us about important events and incidents that occurred at the home. They also shared information with local authorities and other regulators when required. They had kept us informed of the progress and the outcomes of investigations they carried out. For example investigations in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements to minimise the chance of them happening again.