Central England Healthcare Limited

Eversleigh Nursing Home

Inspection report

2-4 Clarendon Place
Leamington Spa
Warwickshire
CV32 5QN

Tel: 01926424431
Website: www.eversleighnursinghome.co.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Eversleigh Nursing Home on 22 December 2015. 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. We refer to the registered manager as the manager in the body of this report.

People did not always have social activities offered to them that supported their interests and hobbies and met their needs and their personal preferences. People's care records were not always kept up to date to reflect the care and support they required and received each day from staff. However, permanent staff knew people well and could describe people's care and support needs. Improvements were being made to the activities offered to people at the home.

People were protected against the risk of abuse as the provider took appropriate steps to recruit staff of good character, and staff knew how to protect people from harm. Concerns regarding people's care were investigated and responded to in a timely way to ensure people were supported safely. There were enough staff to care for people effectively and safely, and meet people's individual needs.

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.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This 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 fully 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. 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 the home. People were protected from the risk of abuse as staff knew how to safeguard people from abuse. The provider recruited staff of good character to support people at the home. Medicines were administered safely. There were enough staff available to care for people effectively and safely.

Is the service effective?

Good

The service was effective.

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

Is the service caring?

Good

The service was caring.

Staff treated people with respect and kindness. Staff knew people well and respected people's privacy and dignity. Staff supported people to maintain their independence. 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?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in social activities in accordance with their interests and hobbies. People did not always have 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. The manager was accessible to people who used the service, their relatives, and members of 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 the manager took action 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 22 December 2015 and was unannounced. This inspection was conducted by two inspectors, an inspection manager and a specialist advisor. 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.

We spoke with seven people who lived at the home and two people's visitors or relatives. We spoke with eight members of staff including two nurses (one of which was the deputy manager), two members of care staff and an activities co-ordinator. We also spoke with the chef, the registered manager and the 'Development and Delivery' manager. We also spoke with a health professional who regularly visited the service.

We reviewed the information we held about the service. We looked at information received from 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.

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 six 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 three 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

People gave us mixed feedback about whether there were enough staff available to care for people safely and meet people's care and support needs. One person told us, "I think there are enough staff and they are very good and helpful." Another person said, "I only have to ask and they help. I press my buzzer at night if I need them. You don't have to wait long." A third person told us, "There are people around at night." They added, "You feel there is someone there and this is very comforting."

However, one person told us they sometimes waited too long for staff to answer their call bell saying, "I don't think there are enough staff. If I press my bell, sometimes it can take up to an hour to answer it which is frustrating if it's important." Another person commented, "I don't think there are enough staff, there is too much for them to do."

We asked staff whether they felt there were enough staff at the home to meet people's needs safely. Staff told us they felt there were not enough permanent care staff employed at the service to cover all the shifts at the home. This had resulted in some temporary and agency staff being used. One staff member described the impact of agency staff usage at the home. They said, "I don't think there are enough staff, we have to use agency staff most days, sometimes there are two or three on the same shift." They added, "Staff are very stressed and struggling. Some agency staff don't seem to care as much about the residents, I know one resident who doesn't like agency staff to care for them. We do try to use the same agency staff though to keep continuity." Another staff member said, "When we have more than three agency staff on at the same time, we split them up across the shifts as permanent staff need to support them, this puts pressure on the permanent staff." They added, "We don't have time to talk to the residents then, because it's just too busy."

Other staff told us they felt there were enough staff on the shifts each day to care for people safely. They stated more permanent staff were needed to cover all the available shifts at the home, so that agency staff usage was reduced. One member of staff said, "Yes, there are enough staff on the shift. Care staff and nurses are supported by other members of staff such as domestic and auxiliary staff, so we can just concentrate on providing support for people."

We asked the provider and manager about the number of staff vacancies at the home, they told us they were in the process of recruiting more staff at the service. This included more care staff to cover night time shifts. Whilst recruitment was on-going, agency staff were being used to cover any gaps in staffing levels. They explained that recruitment had been difficult due to the level of employment in their local area. We asked them how they ensured there were enough staff to meet people's needs safely. They told us 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. The provider added, "We also ask current staff whether there are enough staff on the shift to care for people safely, and we listen to their feedback."

We observed there were enough staff during our inspection to care for people effectively and safely. Staff

were available at all times to respond to people's requests for assistance. We saw that in addition to the nurse and care staff, the manager who was a registered nurse was also available to cover care duties at the home when needed.

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 these. 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 undertook checks of people's skin where they were at risk of developing skin damage. Staff we spoke with had a good understanding of the risks related to each person's care.

Although risk assessments were up to date and regularly reviewed, we found one instance where a person's risk management plan was not being followed by staff, to minimise the risk to their health. The person was at risk of developing damage to their skin and was cared for using a specialist mattress. Instructions about the setting of the specialist mattress in the person's care records detailed a setting of 64 was appropriate. Records showed that a recording of 70 was made on the daily records on the day of our inspection. However, when we reviewed the settings on the mattress it was set at only 30. This meant the person would have been placed at risk, if the setting remained at 30. It also meant that the daily records were not correct. We brought this to the attention of the nurse during our inspection who rectified the setting of the mattress immediately. The nurse told us, "Care staff check the mattress settings." We were concerned that care staff may not be aware of the significance of the settings for the individual, if these were not maintained at the correct levels. We brought this to the attention of the manager during our inspection. We also checked the condition of the person and ascertained no damage to their skin had been recorded. We were confident that the person's health had not been affected by the incorrect setting of the mattress.

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 said, "If I was worried about anything I would tell staff, but I am not worried." Another person told us, "I do feel safe here. There's no reason not to."

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. One staff member said, "I would also make sure immediately that the person concerned was safe before doing anything else."

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 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.

We observed medicines being administered. Staff who administered medication were trained nurses, and had 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.

Nursing staff were following the latest recommended protocol to administer some types of medicines. Some people required their medicine before they were able to have a meal. For example, one person needed to have their medicine before their breakfast. This was so the medicine did not cause an adverse reaction. We observed people received their medicine before their meal on the day of our inspection. People told us they got their medicine when they needed it. One person said, "I get my tablets on time, there are no issues there."

Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. We reviewed the MAR for seven people at the home. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use temporary or agency staff to administer medicines who might not know the people there. Administration records confirmed people received their medicines as prescribed.

Medicines were stored safely and securely. Some people required medicines to be administered on an "as required" basis. There were detailed protocols for the administration of these medicines to make sure safe dosages were not exceeded. Daily medication 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. One person said, "Nurses are very good." Staff told us they 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. One staff member commented, "I think the induction could have been better for my role." However, 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. This demonstrated the provider was acting to continuously improve staff induction processes.

Staff told us the manager encouraged them to keep their training and skills up to date following their induction training programme. The provider employed a dedicated training manager to plan and arrange staff training. They maintained a record of the training staff attended, so they could identify when staff needed to refresh their skills. 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. One member of staff told us, "Yes, the training is good and we have the skills we need." Another member of staff told us, "Training is very good here, twice a year we have updates and we have trainers on site. We just have to ask if we want further training." Staff told us the provider also invested in their personal development and they were supported to achieve nationally recognised qualifications.

Staff used their skills effectively to assist people at the home. For example, care staff used their communication skills and their knowledge about caring for people with dementia to minimise people's distress or anxiety during our inspection. One person who became anxious was assisted by a staff member who provided them with reassurance and comfort. A member of staff told us, "Some people can become anxious, I always give them some time." They added, "Sometimes a different face or environment can also help the situation."

Staff told us they were supported with regular meetings with their manager to discuss their role and any training or staff development needs. One member of staff said, "I get supervisions every two months. It gives me a chance to talk about any concerns I have." They also had yearly performance appraisals to assess if they were carrying out their role to the standards expected by the provider.

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).

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 was able to explain to us the principles of MCA and DoLS, which demonstrated they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves.

Staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights. For example, they asked people for their consent and respected people's decisions to refuse care where they had the capacity to do so. One person told us, "Staff always ask before doing things; I think they are very respectful." Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with health professionals.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. One application for a DoLS had recently been made, and was awaiting a decision by the local authority. The manager was waiting to make further applications to the local authority in accordance with their guidance.

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 told us, "The food is good here, if I don't like something on the menu they will make something else for me." We observed people being served breakfast at the home. People were offered a choice of cooked breakfast, toast, and cereals. The majority of people ate their breakfast in their room, when they wanted. One member of staff confirmed to us that this happened each day, they said, "People can have what they want to eat at a time that suits them."

People were offered food and drinks that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes.

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 observed a lunchtime meal at the home. The dining room was calm, and there was a relaxed atmosphere. Where people needed assistance to eat their meal, staff assisted people at their own pace and waiting for people to finish before offering them more food. People were offered drinks and snacks throughout the day in accordance with their needs. Drinks were available in people's bedrooms and were in easy reach. One person said, "I enjoy my meals; they also get me drinks and snacks when I want them too." Another person told us, "The food is very good and I get regular drinks."

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 verbal handover meetings at the start of each shift. We observed a shift handover meeting during our inspection. This was attended by the nurse and care staff. 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.

Staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. One person told us, "They are good here, if I need a doctor they get one for me. They also sort out my optical and hearing needs." Another person told us, "If I need a doctor, one is called straight away." 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.

Good

Is the service caring?

Our findings

People told us staff treated them with respect and kindness. One person said, "This is a lovely place, I am happy here." Another person told us, "The staff are very kind." Relatives and visitors also told us staff were caring, and treated their loved ones with respect. One family member said, "The staff are very nice and explain everything to us, they are always welcoming."

Staff told us they enjoyed working at the home because of the interaction they had with people who lived there. One staff member said, "I love it, I have real job satisfaction working with the residents. It's not about the money." We observed staff interacting with people at the home in a respectful and caring way using people's preferred names. 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 people enjoyed these staff interactions. One person said, "I love it here, the place is very nice and the atmosphere is lovely."

People told us they made everyday choices about how they spent their time. One person told us, "I like to spend time in my room, which the staff respect." Another person said, "I am happy living here. I get up when I want." 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. One person told us, "It's not home but it's as near as they can get it."

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. One person told us, "Visitors can come in without any restrictions." 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 people to stand and move around with assistance rather than being hoisted or assisted to move fully by care staff. We also saw staff encourage people to dress and do everyday tasks themselves, where they could.

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 shared a room with another person, the home had curtains and privacy screens available. One person told us how staff used these to protect their privacy, saying, "Staff always draw the curtains when assisting me with care." One member of staff explained how they respected people's privacy and dignity. They said, "I knock on doors before entering and make sure people are covered up. I always ask permission before doing anything for someone."

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 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. We spoke with a health professional who worked with the service and reviewed end of life care. They told us, "Staff demonstrate flexibility and imagination in providing not just appropriate end of life care but individually tailored care throughout the home."

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded to their individual requests for support. One person told us, "Staff are lovely, they do so much for people. They are wonderful here; they make me feel very happy. If I want something they will get it for me." Another person said, "Although they are very busy, they put me first."

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. The 'Provider Information Return' we received from the service prior to our inspection visit stated that care reviews were attended by the manager of the home, the person, their family or friends and commissioners of services. We were able to confirm this happened. People told us they had been involved in planning their care and families also confirmed this. This ensured plans reflected people's individual needs. One person said, "Staff have discussed my care plans with me and I am always asked for consent before staff deliver any care."

We found that some people's care records were not always clear or up to date and did not provide staff with the information they needed to care for people effectively and responsively. For example, in one person's care records we saw the person had a visual impairment resulting in them not being able to see very well. There was no instruction to staff on how to support the person with any communication difficulties. In another person's records we saw they had recently lost weight and required help to eat. They had a reduced appetite and were at high risk of malnutrition. Their risk assessments and care plans had not been updated since September 2015 and their weight record within the care plan had not been updated to show this was being closely monitored.

In another person's records we saw there was differing information about their diet, in one record it stated the person was on a normal diet and in another place it stated they were on a 'diabetic diet'. In addition to this, the person was having their food monitored on a charting system used by staff. On three days we saw no meals had been recorded for the person. We were confident that kitchen staff understood the nutritional needs of the individual. However, the different information in their care records, and a lack of information about how much food they consumed, could have been confusing for staff.

Although care records were not always up to date, we found no impact to the care people received at the home. Staff could describe to us people's individual support needs and information matched what people told us, which demonstrated permanent staff knew people well. However, because the home used temporary staff, and new staff were being recruited, care records needed to be kept up to date to ensure all staff had the information they needed to support people.

Staff told us that generally care records were kept up to date and provided them with the information they needed to support people effectively. One staff member told us new staff were always introduced to people at the home to make sure they understood their individual needs. Agency staff always worked alongside existing permanent staff so that everyone knew what was expected of them. One staff member said, "The

staff work as a team. All new staff meet people, we tell them about people's likes and dislikes. The care plan is useful and we update the nurses if there are any changes."

We asked people whether they enjoyed the activities and events on offer at the home. People told us there were not enough activities on offer at the home to provide them with the stimulation and interaction they needed. This was because there were no activities organised during the weekends. In addition, there was only one member of staff employed at the home to organise events and activities for people to enjoy. This meant their time was limited. One person told us, "I read and do crosswords....I do get lonely because often it's only me in the lounge. I would like to mix more with people." Another person commented, "I don't see anyone from lunch to teatime sometimes and I only get to go out once every six months or so if I am lucky. I just watch TV really, there's not enough to do." One person's relative told us, "I think there needs to be more activities planned at the home. Staff aren't using the resources they have either." One relative commented, "I would like a member of staff or volunteer to spend time reading with my relative."

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. 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, "We offer a range of activities for people to take part in. This includes movement to music, singers and entertainers, and one to one sessions with people in their room." A list of planned activities was on display in the communal areas of the home for people to refer to.

We spoke with the manager and provider regarding the number of staff employed to offer people activities. They explained that until recently there had been a vacancy for an activities co-ordinator which had now been filled. This meant the activities person was relatively new to the home and had not yet established a programme of events and activities suited to people's individual needs. The manager explained they were continuing to expand staffing for activities at the home, and had recently employed a volunteer to assist the activities co-ordinator. The person was due to start following the relevant checks into their suitability and character.

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. One person told us, "I have no concerns, if I did I know who to tell." In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. Complaints were analysed to identify any trends and patterns, so that action could be taken to continuously improve the service provided.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. The manager had been appointed approximately five months before our inspection visit and had taken over the management of the home following a number of changes of management. People and staff told us the new manager was approachable. The manager operated an 'open door policy' and encouraged staff and visitors to approach them in their office. People told us they were confident in approaching them. One person told us, "I feel confident in approaching the manager or staff if I need to."

Staff told us the appointment of the new manager had improved the management of the home and staff morale. One staff member said, "The manager is a good nurse, and works alongside us doing a shift each week. They are really approachable." Another staff member told us, "You can talk to them, they are strict but fair. We had a lot of changes in managers before which had affected staff morale."

There was a clear management structure within Eversleigh nursing home to support staff. The registered manager was part of a management team which included a deputy manager who was also a nurse. Nurses were available to support staff on each shift. 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 member of staff said, "I think the manager is good. We have the support we need, the manager understands what's happening here because they are a trained nurse, they do a shift each week, and they do a daily walk around. We can also go and see them at any time."

The manager told us the provider was supportive and offered regular feedback and assistance to support them in their professional development. For example, the provider visited the service every week to hold meetings with the manager. They also discussed issues around quality assurance procedures and areas for improvement at the home. The manager said, "The provider is really supportive and will discuss anything I ask for to improve the home."

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. They also carried out bi-annual quality satisfaction surveys to gather feedback. For example, recent surveys had gathered people's views about refurbishment plans, and people's views had been taken into account. A consultation was held twice a year to get people's views on Summer and Winter menus and comments had resulted in changes to the menu. Some survey results we reviewed showed people had asked for activities to be improved at the home. Since this feedback the manager had employed a new member of staff to arrange activities at the home.

Staff had regular team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were held within teams. For example, nursing staff met to discuss clinical information. There was also a staff meeting held with all staff every three months. An agenda was drawn up before each meeting and staff were able to contribute their suggestions for discussion. One

staff member told us, "There are regular staff meetings and minutes are taken, copies are available for all staff to review." A recent meeting record showed staff had discussed the needs of people in their care, staff vacancies and handover arrangements. Staff told us they had an opportunity to raise any concerns they had, or provide feedback about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

We found that people's care records were not always up to date. We spoke with the manager regarding this. The manager explained they conducted frequent checks on care records to identify where records needed improvement; this included monthly audits of 25% of all personal care records at the home. In addition, the manager had developed a system where a person was picked each day, and their care and records were reviewed. The manager had also assigned keyworkers to each person who lived at Eversleigh nursing home. 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 manager 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.