Lancam Care Services Limited

Albany Park 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

Albany Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is a purpose-built house over three floors that accommodates up to 43 people. At the time of the inspection there were 40 people were living at the home.

This inspection took place on 23 and 24 January 2019 and was unannounced.

At our last inspection we rated the service as 'requires improvement' overall. However, safe was rated as 'inadequate'. At this inspection we found that identified issues had been addressed. The service is now rated 'good'.

At the last inspection in June 2018 we identified breaches of Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always having access to their call bells to ensure they would be able to call for help; easy access to staircases which resulted in an incident of a fall and a person absconding. There was a strong smell of urine in the communal area chairs and 11 people's bedrooms. We also found that some equipment and furniture was not in a good state of repair.

Due to the seriousness of the breaches found, we issued two warning notices to the registered provider Warning notices give the provider a specific time frame in which to improve in the areas identified at the inspection. At this inspection we found that these concerns had been addressed.

In addition, at our last inspection we also identified breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to a lack of structured activities and interaction, especially for those remaining in their rooms during the day and a lack of management oversight of the home and auditing processes. At this inspection we found that these concerns had been addressed.

There was a registered manager in post who was registered with CQC on 12 October 2018. 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.

New call bells had been installed in all rooms above people's beds which were accessible. There was also a call bell that was next to the person. People had two types of call bell to ensure they could summon help.

The home was clean and fresh throughout the inspection. There was a plan of works in place including replacing carpets and furniture.

Activities had improved at the home. The activities coordinator had received further training since the last inspection.

There were improved systems in place for the registered manager to ensure oversight of the home. This included, a better auditing system and daily walk rounds by the registered manager.

Staff and relatives were positive about the changes since the last inspection.

People's individual risks were well documented and there was detailed guidance for staff on how to minimise the risks.

Medicines were given safely and on time. There were systems in place to monitor medicines including regular audits.

Staff had received training in infection control and were aware of how to control and prevent infection.

Staff understood what safeguarding was and were aware if how to report any concerns if they had them.

Staff were recruited safely and appropriate checks conducted before commencing employment.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff received regular training supervision and appraisal to support them in their role.

We observed a warm friendly atmosphere throughout the home. There were good interactions between staff and people and staff knew people well.

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

There was good oversight and governance of the home including regular audits for various aspects of care and the environment.

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 and relatives told us that they felt safe living at the home.

People's personal risks were identified and guidance in place for staff to minimise risks.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

Medicines were well managed and given safely and on-time.

Staff understood how to protect people from the risk of infection.

Staff were safely recruited.

Is the service effective?

Good

The service was effective. Staff received induction, supervision and appraisal to support and monitor their performance.

Nursing staff received clinical supervision from a suitably qualified senior nurse.

Staff received on-going training in a variety of topics.

People received a choice of food. Specialist diets were catered for.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People and relatives told us that staff were kind and caring.

People were treated with dignity and respect.

Staff knew people well and understood their likes and dislikes.

People's cultural and faith needs were supported where identified.

Is the service responsive?

Good

The service was responsive. Care plans were detailed and person centred.

There had been an improvement in activities within the home.

People and relatives were aware of how to make a complaint.

End of life care was well documented and people's wishes noted.

Is the service well-led?

Good

The service was well-led. There were systems in place to ensure the quality of the service.

Staff were deployed well throughout the home.

There were regular staff meetings.

The home worked well in partnership with other healthcare professionals.

Albany Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 January 2019. The inspection was carried out by two adult social care inspectors, a CQC nurse specialist advisor and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One expert by experience attended the inspection and spoke with people to gain their views and opinions of the home. The second expert by experience supported this inspection by carrying out telephone calls to people's relatives.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the ratings for key questions of responsive and well-led to at least 'good'. The action plan included information around how they would address concerns related to activities and good governance of the home including effective auditing.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spoke with 11 staff including the registered manager, the clinical lead, three nurses, the nominated individual (who also owned the home) and five care staff. We also spoke with 16 people that

were living at the home and 13 relatives.

We looked at eight care records and risk assessments, 13 staff files including three nurses and 10 care staff, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. We also looked at four people's pressure relieving equipment and records and 10 people's medicines records.

Good

Is the service safe?

Our findings

At our last inspection we found that people did not always have access to call bells both at night and during the day for people that remained in bed. At this inspection we found that the registered manager had addressed this issue. On the first day of the inspection we arrived at 6.30am to check if people now had access to their call bells. We found that all people now had their call bells within easy reach. If people were in their rooms but out of bed, the call bell was attached to where they were sitting. We also saw that new call bells had been installed in all people's rooms above their beds. This meant that people had two call bells they were able to reach. We also saw that night staff completed a call bell audit each evening to ensure that call bells were within easy reach. Relatives that we spoke with told us that people had access to call bells and although some relatives felt that people would not always be able to use a call bell, they said that there were always enough staff around to provide help. Where people were unable to use a call bell, this had been risk assessed and hourly checks put in place.

At our last inspection we found that there was easy access for people on the first and second floor to staircases. This increased the possibility for accidents if people were confused or wandering and we found one incident where a person had fallen down the stairs. At this inspection we found that this had been addressed and there were now locks and alarms on doors that led to the staircases.

At our last inspection we found that parts of the communal lounge and 14 fabric chairs were malodorous of urine. We also found that 11 people's bedrooms were malodorous of urine. At this inspection we found that this had been partly addressed. Some of the chairs in the communal lounge had been replaced with easy clean armchairs. However, seven others had not been replaced and were still malodorous of urine. Following the inspection, the registered manager sent us confirmation that these seven chairs had been replaced. There was a plan of works in process where carpets were being replaced with laminate flooring in people's rooms to ensure ease of cleaning and some bedrooms were being redecorated. We found that no people's rooms were malodorous of urine and the home smelt clean and fresh throughout the inspection.

At our last inspection we also found that furniture and fixtures were not always in a good state of repair or clean. At this inspection we saw that this had been addressed. Furniture that had peeling veneer had been replaced and bed rails were new and in a good state of repair. Bathrooms were clean and drains clear. The registered manager conducted a daily walk round of the home to check if there was any maintenance needed. Where something was found this was addressed or added to the plan of works.

Relatives we spoke with were positive about the improvements in cleanliness and décor within the home. Comments included, "I think it is very clean, it is bright and warm", "Yes, I have not seen any dirty toilets. They could do with a little bit of paint in her bedroom" and" It is clean." Staff also told us that they had seen an improvement since the last inspection. One staff member said, "She [the registered manager] has brought in more improvements especially with the hygiene side of things. She has done well."

At out last inspection we found that staff were poorly deployed throughout the home, meaning that people did not always receive timely care. We saw that there were not always staff on floors where people were in

bed throughout the day and that staff were taking breaks at particularly busy periods such as meal times. At this inspection we found that the registered manager had addressed this. There was now a staff member allocated to each floor during the day to ensure that people who, either by choice or necessity stayed in their rooms, were appropriately supported. Staff were now not allowed to take their breaks during people's meal times which ensured that there were enough staff to serve the meals and support people that required help to eat. We observed a much better meal time experience for people with staff being able to take time with people who needed help. Relatives we spoke with were positive about the amount of staff that were available in the home. Relatives said, "They have lots of carers around" and "Yeah, there are plenty of staff."

The home used a 'dependency tool'. This was a tool used to calculate the care needs of people and ensure that there are enough staff to provide care and support. This helped the home manage staffing levels. The dependency tool was completed monthly by the registered manager and we saw that there were sufficient staff to provide care. The registered manager told us, "It gives an amount of how many staff I need and exactly who I need it for. It's a fantastic tool."

We asked people if they felt safe living at Albany Park. People told us, "Oh yeah [I feel safe], it is the surroundings", "Yes, yes, because of how the place is, difficult for anybody to do anything bad" and "Of course I do." Relatives were positive about safety in the home and said, "I am pleased with what they do, he is always nice and clean", "As far as I am concerned there are no concerns or problems" and "She does [feel safe], she is very comfortable."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member said about safeguarding, "Anybody can raise a safeguarding. Its making sure that if you feel that something is not right with the it needs to be investigated." Staff understood what whistleblowing was and knew how to report concerns if necessary.

People had risk assessments which were reviewed monthly and updated as the people's needs changed. People's individual risks included not being able to use the call bell, falls, moving and handling, pressure ulcers and choking. When risks had been identified, the care plans contained clear guidance for staff on how to manage these. Safe working systems had been clearly documented. For example, hoist and sling guidance and the use of a low-level bed for people with mobility risks. When people had been assessed as being at risk of falling out of bed, bed rails risk assessments had been completed and regular checks had been undertaken by staff to ensure the bed rails were being used safely.

The home regularly assessed people's risks of malnutrition and developing pressure ulcers. Where this was identified as a risk, appropriate referrals were made to address this. Where people were at risk of developing a pressure ulcer, we saw that pressure relieving equipment such as mattresses and cushions were in place where necessary.

Medicines were managed safely. People received their medicines from staff who were trained to do so and who had regular assessments to ensure they remained competent to administer medicines. Staff had access to information around medicines including a copy of the National Institute for Clinical Excellence (NICE) guidelines for administering medicines in care homes. This is considered to be best practice guidance for the administration of medicines.

People's medicines records were well organised, complete and up to date. They included important information such as allergies and an up to date photograph of each person. Where people were prescribed high risk medicines that required specific monitoring, for example, with regular blood tests, additional

information was available to staff which included warning signs to look out for. Guidance was in place for staff which described when, why and how often people could be given PRN or 'as and when required' medicines. 'As and when required' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they require pain relief or become anxious.

We found that Medicines Administration Records (MARs) had been accurately completed and there were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home. This helped staff check the numbers of medicines people had.

Covert administration of medication (without the person knowing) for people who lack capacity was in line with legislation and appropriate records were in place to support the process. Records showed that a best interest meeting had been held by the care home staff and all other relevant health professionals. Medicines were safely stored and appropriate arrangements in place to dispose of medicines if required.

The medicines system was audited by staff daily and the clinical lead completed full weekly and monthly audits, as well as spot checks. Controlled drugs were stock checked weekly and we saw that these had been completed with nothing adverse noted. This helped spot any errors or mistakes.

Staff understood infection control and how to protect people from infection. Staff had been trained in infection control and the service ensured adequate supplies of personal protective equipment (PPE) such as gloves and aprons. We observed staff using PPE throughout the inspection.

We saw that there had been a detailed recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue and what had been done. Staff meeting records showed that incidents and accidents were discussed at team meetings.

The home had up to date maintenance checks for gas, electrical installation, hoisting equipment, assisted baths, lifts and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Good

Is the service effective?

Our findings

Relatives told us that they thought that staff were suitably skilled at caring for their relative and commented, "Yeah, they are a good team I couldn't ask for a better nursing home, he is in a good position", "Yep, they are, they [staff] are friendly and chat with the residents", "Yeah, everyone I have come across, plus they know residents" and "I am more than happy, his health has improved since he has been there, he is always clean."

Staff received a comprehensive induction when they began working at the home. This included training in mandatory subjects such as manual handling, safeguarding and mental capacity. Nurses and care staff shadowed more experienced staff until they felt confident to work on their own and management were satisfied they were competent. The clinical lead told us, "Part of my role is to help new nursing staff go through the induction."

Staff told us and records confirmed they were supported through regular supervisions. A staff member said, "Yes I have them [supervision sessions]. They are useful, if I have any questions you can always bring your point of view across." We saw that nursing staff received regular clinical supervisions conducted by the clinical lead. All staff that had been working at the home for more than a year had received an annual appraisal.

We saw from looking at training records and talking to staff that training was on going. Training included the MCA, DoLS, first aid, food safety, medicines administration, and moving and handling, infection control, health and safety, safeguarding and fire awareness. Some staff had received further training in the care of people with dementia, diabetes, catheterisation, nutrition and behaviours that may challenge. Staff were encouraged to take a recognised course in health and social care. We saw that refresher and further training was planned for future dates. Nurses were supported by the clinical lead to complete their re-validation. Staff were sufficiently well trained to perform their roles.

Each person had a nutritional assessment and we saw that where necessary people had access to specialists such as dieticians or speech and language therapists (SALT). People's weights were recorded regularly to ensure they were not gaining or losing weight. People's food choices were recorded in care plans as were any special diets or pureed food. For people who were at risk of malnutrition we saw that fortified drinks were offered and full fat milk and cream used to provide more calories. We saw that the kitchen had a list of people's dietary requirements as well as their likes and dislikes.

We asked people if they thought the food was good, people told us, "It is not too bad" and one person rubbed their stomach and gave a thumbs up when we asked if their lunch was nice. Relatives said, "Yeah, he eats quite well, he can get a fried breakfast", "She eats all her meals. It is pureed. Drinking is her problem, but they watch that. The food is very good here, I say that as I have eaten it!" and "She is on soft food, they weigh her every week, her weight has gone up. They prompt her to eat and drink." Where people had specific cultural or religious requirements around food, this was provided. For example, a person that required Halal food was given this.

At our last inspection we found that people that were in their rooms during the day did not always have access to drinks. At this inspection we found that this had been addressed. People had jugs of water or juice in their rooms. The registered manager had also implemented a system in the mornings where kitchen staff completed the tea round so that care staff could concentrate of providing care.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. DoLS were well documented within the home. Where people required a DoLS, these had been applied for and there were records in place for when DoLS needed to be reviewed. Information on DoLS had been carried through into people's care plans and included information about what people were able to make decisions about and what they were unable to. This meant that people were being supported around their mental capacity in the least restrictive way.

Where people could make decisions about the care they received, staff encouraged and supported people to be independent and offered choice in the care they provided. Care records held clear information on how staff should support people to make decisions they were able to, such as selecting clothing, food choices and when to participate in activity. Decisions made in people's best interests were clearly recorded and showed where people had selected a legal representative such as a Lasting Power of Attorney or independent advocate to make decisions on their behalf were involved. For example, a person without family had been allocated an Independent Mental Capacity Advocate. This was good practice.

People had access to healthcare services. Records showed when the GP had been called to review people, the reasons why a review had been requested and the outcome of the GP visit. Records also showed when people were seen by other healthcare professionals such as the tissue viability nurse, community psychiatrist nurses, psychiatrists, Social Workers, SALT and the chiropodist. Relatives also told us that the home ensured people had routine healthcare appointments. Comments included, "Yeah, they call the GP when needed. The chiropodist comes in once a month" and "Yep, never an issue, dad had a cough, I spoke to [staff] and she got the doctor to come out and check him over."

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. We saw that the assessments had been fully completed for each person. This process helped to ensure that people's individual needs could be met at the home.

Good

Is the service caring?

Our findings

We asked people and relatives if they thought that staff were kind and caring. People said, "Yes, yes they [staff] are kind" and "They're nice to me. Yes, they are." Relatives told us, "Whenever I see, they speak to him nicely and smile", "They are kind and lovely people. The staff seem to be happy, there are no grumpy members of staff" and "Very caring."

Relatives told us that they felt that staff listened to people and responded in a kindly way. Comments included, "They do listen, they [staff] are lovely", "They [staff] are brilliant" and "Yeah, they look after him. They say hello darling. They had a nice Christmas for him, he does alright."

We observed staff during the inspection and how they interacted with people who used the service. Staff were professional, polite and had a good rapport with people. We did not see any breaches of privacy or witness anyone being treated in an undignified manner. We saw there was a good rapport between staff and people who used the service.

We observed an interaction between two staff and a person. One staff member had placed some biscuits in front of a person. Another staff member said that those biscuits were too hard and the persons favourite was Jaffa Cakes. The first staff member took the biscuits away whilst apologising and explaining that the other staff member would bring her favourite ones. A few minutes later the biscuits were replaced and the person gave a beaming smile. This showed that staff knew people and their needs well. Throughout the inspection we observed that staff knew people well and understood their likes and dislikes.

Staff were aware of the importance of talking to people whilst they were providing care to help people understand and feel comfortable with what was happening. Relatives commented, "They just say what they are doing, it takes two to lift him to the shower. He loves them", "They explain what they are doing, they jolly him along as he doesn't want to have a shower, they will distract him" and "They say we are going to change your pad now and tell her what is happening. To begin with she would shout. Now she is okay with it." A person told us, "Oh yes, they always talk to me." Staff told us that they always sought consent from people before giving care.

Staff were aware of how to ensure that people were treated with dignity and respect when receiving personal care. The home had notices that could be placed on the outside of the door to alert relatives and staff that the person was having personal care. People also had a choice of male or female care staff for personal care. Relatives commented, "They put a note on the door and lock it when doing personal care" and "When she came here I told them Mum does not like men for personal care. So, they put a sign up and she has always had female carers."

Throughout the inspection we observed relatives and friends visiting people. We saw that visitors spent time in people's rooms or communal areas and could chat and eat with them. There were no restrictions visiting and all relatives that we spoke with told us that they could visit whenever they wanted to. One relative said, "I take his brother to visit him, they have lunch together and watch films together, his brother stays all day."

People, where they were able, were involved in planning their care. Relatives commented, "Yeah, I go to meetings" and "Yeah, every six months we have a meeting and they check up." However, one relative told us, "Not as much as I would like to be. I have never been asked to contribute to his care plan."

People's faith was documented in their care plans. Where people required support to practise their faith, this was provided. We saw that the home had a vicar that visited every Friday. Other people were supported by relatives or friends with their faith.

Good

Is the service responsive?

Our findings

At our last inspection we found that there were not enough activities to ensure that people were stimulated. We also found that people in their rooms for the day often had little or no interaction throughout the day. At this inspection we found that this had improved. We observed greater interaction with people and staff taking part in delivering activities this included a bingo session. This was lively and people could be heard singing and laughing throughout home. There was an activities coordinator in post and since the last inspection she had received specialised training in activities. We observed that the activities coordinator was creating structured activities and successfully engaging people. Where people were in their rooms all day, staff allocated to the floor and the activities coordinator spent more time with people. People also had a choice of whether they joined in, we saw that some people liked to observe and others did not wish to engage. There were posters on the wall in the communal area that told people what activities were taking place and when. The registered manager told us and we saw that all rooms now had a television as part of the fixtures and fittings.

We asked relatives if they felt that activities had improved. Comments included, "The activities person comes to talk to him", "They do activities every afternoon, they had a BBQ and Christmas meal for relatives", "The Xmas party was lovely. We all had a dance" and "They have something going on every afternoon." However, another relative said, "They don't have enough trips, in 2018 they didn't go to the seaside, they did the year before. They went once only to a coffee morning at the Church."

The home had an electronic system that held all people's care records. All care staff had access to the system. Staff told us that care plans were easily accessible and updated yearly or when changes in people's care needs were identified. When there was a change, this information was provided to staff in handovers and an email sent to each staff member to make them aware.

Care plans were detailed and person centred. For people who lived with specific nursing or health care needs such as diabetes and dementia, plans of care clearly reflected these needs and how staff should support people. For example, two people who lived with diabetes, their care plan contained detailed information about the condition, how it specifically affected this person and what staff should do if they became unwell. Care plans also detailed people's likes and dislikes and how they wished for their care to be delivered. Where people may have been unable to have input, their legal representative or advocates were involved.

Care plans detailed background information about people including their personal history. We saw that each person also had a poster in their room that detailed, amongst other things, their likes and dislikes, what time they liked to get up and go to bed, how they liked their tea or coffee and their preferred name. Relative said, "They have a basic thing on the wall of his background" and "The night nurse phoned up wanting to know details of her family life, she has grandchildren and great children, I am going to write down the family history, so they know it." Staff had actively asked relatives about people's backgrounds and we observed that staff often talked to people about things they did in their younger years.

The home had also purchased two large fish tanks, one located in the main reception area and one in the communal lounge. We saw people spending time watching the fish. The registered manager told us that people said they really liked the fish and contributed to a homelier atmosphere.

The home regularly celebrated people's birthdays. The registered manager told us about a person that was about to celebrate their 100th birthday. Arrangements were being made with a family member and they were arranging who will do what such as bringing in an entertainer. The relative told the registered manager that the person liked the old songs and the registered manager said that she will be arranging a suitable entertainer.

The home had a complaints procedure and people and relatives were aware of how to make a complaint. We saw that complaints were logged and investigated. Relatives told us that they were always able to contact the home if they had any concerns. Comments included, "Yes I am [aware of how to make a complaint], we have no concerns" and "I talk to the nurse."

The home had also received compliments since the last inspection which were documented. Relatives wrote, 'Thank you for looking after [person] for the past 15 months' and 'His last few days were comfortable and he was well looked after. I would like to mention the entertainment organiser. She is very caring, kind and understanding'.

We saw from looking at people's care records that people had an end of life plan. This included details such as if a person had made a will and where it was kept, who the person wanted to be involved or informed, if they wanted their body to be donated for research, if they wanted burial or cremation, where they would like any ceremony to take place and if they had a preference for any particular undertaker. The plans showed that people and their relatives had been involved in making these decisions. This ensured people's last wishes could be respected at the end of their life.

Good

Is the service well-led?

Our findings

At our last inspection we found that systems and processes in place to check the quality of the service were not always effective. We found that call bell audits were being completed during the mornings when people were not in their rooms, the infection control audit failed to identify issues that we found during the inspection. We also saw that responses to a survey of people, relatives and healthcare professionals carried out in September 2017 had not adequately addressed issues that had been raised around food, activities and the environment. We also found that staff were not deployed well throughout the home. At this inspection we found that this had been addressed.

Call bell audits were now being completed at night to ensure that people had easy access to their call bells. A monthly infection control from December 2018 noted that the home had achieved 100% in the areas looked at. There were now allocated staff to each floor during the day and staff breaks were better managed around people's needs such as meal times. Issues identified in the survey were being addressed. This included, better choice for people at meal times, décor of the home and improved activities being provided.

We also saw that since the last inspection the home had an external company conduct a yearly health and safety audit. The audit had made a number of recommendations that we saw had been addressed or were in the process of being addressed. There were also audits to monitor the home and general maintenance, kitchen and catering, medicines, hand washing and care plans. There were quarterly home audits which noted actions around new uniforms, name badges and replacing carpets. Where any issues were identified on any audits viewed we saw that there was an action plan and information on how these were addressed.

Staff that we spoke with were also positive about changes in the home since the last inspection. Two staff said, "One thing is with the call bells, there used to be only one and now there is one above the bed in case they cannot reach the other one. Some rooms carpets have been changed. She's [the registered manager] employed more people as well, much has improved" and "The care home has improved since [the registered manager] came. There's more training we communicate with the management." All staff we spoke with were positive about the support they received and felt that they could raise any concerns and be listened to.

The registered manager had been in post one and a half weeks at the time of the last inspection and were now registered with CQC. The registered manager had worked with staff, the nominated individual and people to address the breaches of regulation found at the last inspection.

Relatives that we spoke with were positive about the registered manager and knew who she was. Relatives told us, "I do think the manager is good" and "The manager is approachable." Relatives also told us that they were confident with the communication with the home and that they would be contacted if there were any concerns with their relative.

There were regular staff meetings. This included meetings with night staff, day staff, kitchen staff and domestic staff. Staff told us that they had access to minutes if they were unable to attend.

There had been a 'residents and relatives' meeting held in October 2018. Topics discussed included staffing, call bells and décor. The registered manager told us that she planned to hold these meetings twice a year.

There were systems in place for the registered manger to ensure that training was booked and if staff had attended, that regular supervisions sessions for staff were taking place and maintenance issues were being addressed.

Where there were any learning points from accident or incidents or safeguarding concerns, we saw that this information was shared in staff meetings.

The home worked well with other agencies such as healthcare professionals and social services. We saw regular reviews and referrals in people's care files. The registered manager and clinical lead told us that working in partnership was important to help achieve good outcomes for people. A healthcare professional had complemented the home saying, 'Nursing home comes across as highly organised, clean and safe. Very caring and friendly caring team. The quality of care of residents has improved significantly and very prompt in responding to our queries and demand as well as managing medicines of our patients'.