Barchester Healthcare Homes Limited

Orchard House Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

About the service:
Orchard House Care Centre is a residential care home that provides personal and nursing care to 60 older and younger people. Orchard House Care Centre provides a service for people living with dementia or a physical disability who also require nursing care.

People's experience of using this service:
● People were happy living at Orchard House Care Centre. They told us their needs were met by staff who were competent, kind and caring. People were treated with dignity and respect.

● Most individual risks were managed appropriately, however we identified some concerns in how risks to people were being recorded and acted upon by staff.

● Medicines were managed safely and people received the personal care they required. They were involved in the development of their personalised care plans that were reviewed regularly. Staff worked with local health and social care professionals to ensure health care needs were known and met.

● People's rights and freedoms were upheld. People could make all their own choices and decisions. When people lacked the ability to make their own decisions, systems were in place to ensure these were made legally and in their best interests.

● There were sufficient numbers of staff who were well trained and worked well together. The registered manager continually considered ways to improve the service for the benefit people living there. Where we identified areas for improvement, they acted immediately.

The service met the characteristics of Good in most areas and is rated Good overall. More information is in the full report.
Rating at last inspection: At the last inspection the service was rated Good. (Report published 27 March 2017).

Why we inspected: This was a planned inspection based on the rating at the previous inspection.

For more details of this inspection, please see the full report which is on the CQC website at www.cqc.org.uk

Follow up: We will continue to monitor 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? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Orchard House Care Centre

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was undertaken by one inspector and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Orchard House Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single packages under one contractual arrangement. CQC regulates both the premises and the care provided, and both were looked at during the inspection. Orchard House Care Centre accommodates up to 60 people who require support with personal care. There were 59 people at the service at the time of the inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We considered information the provider sent us in the Provider Information Return (PIR). 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 also considered information sent to us by the registered manager shortly after the visit to the home.

During the inspection, we gathered information from:
• 16 people who used the service. We also observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
• Eight relatives or friends of people who used the service
• Three health and social care professionals who had regular contact with the service
• Eight people's care records
• Records of accidents, incidents and complaints
• Audits and quality assurance reports
• The registered manager and provider's area manager
• The deputy manager, four nurses and ten members of care staff
• Two housekeepers, the housekeeping manager, two administration staff members, two activities staff, maintenance staff and two kitchen staff

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management:

- Risks to people were assessed, recorded and updated when people's needs changed, however not all risks were managed safely.
- One person was at risk due to a piece of equipment they required to use on a regular basis. This was not being managed safely as essential cleaning of filters and changing of disposable tubing and face masks had not been completed as required to protect the person from the risk of infection. We identified this to the provider's clinical lead. They ensured that the equipment was cleaned and the person's risk assessment and care plan was rewritten to reflect the correct care required and to ensure the person received the necessary care to manage this risk.
- For one person, staff had failed to respond according to best practice guidance and the person's care plan, when the person had experienced an epileptic seizure. Emergency rescue medicines had not been administered within the stated time frame, placing the person at risk of a further deterioration in their health. The staff member in charge was unaware of where the emergency medicines for this person were kept and these had not been transferred to the person's in use medicines administration record. We informed the registered manager who told us they would take any necessary action.
- People's risk assessments included areas such mobility, bathing and other individual conditions. However, it was not evident from records of care provided that all necessary action was being taken to minimise identified risks. For example, a person was identified as being at high risk of malnutrition and dehydration. Their care plan stated they needed a supplemented diet and full support with all food and drinks. Staff were recording when they supported the person to receive food and drink however, there were gaps in the recording and it was not evident that the person was offered regular drinks or snacks especially during the evening and when awake overnight. It was therefore not possible to confirm that their risk of dehydration was being safely managed. Where people were identified at high risk of pressure injury and required regular changes in their position, records did not always evidence that this was occurring as per the risk management care plan. Records also failed to show that people were always receiving the personal care, including continence care, that was detailed in their care plans meaning that their skin integrity may be compromised.
- We discussed the gaps in the food and drink and repositioning records with the registered manager, who told us they were working with staff to improve recording of care provided.
- Environmental risks, including fire safety risks, were assessed, monitored and reviewed regularly. Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire.
- Lifting equipment was checked and maintained according to a schedule. In addition, gas and electrical appliances were checked and serviced regularly.

● Contractors working at the home confirmed they had been provided with information as to how they should manage risks associated with their work and equipment, taking into account the needs of people living in that section of the home.

Learning lessons when things go wrong:
● Accidents and incidents were recorded and investigated on a computerised monitoring system, in accordance with the provider's procedures. Permanent staff were following these procedures. However, we found that a non-permanent staff member had recorded injuries to a person on a body map but these had not been passed to the management team to investigate. The registered manager undertook to investigate this and take any necessary action to reduce the likelihood of further bruising or skin injuries.
● Otherwise when accidents had occurred, appropriate action had been taken where necessary. For example, medical advice was sought, risk assessments were reviewed and any lessons learnt were discussed with staff and further training offered if required.

Staffing and recruitment:
● On the first day of the inspection we attended the home during the early evening. We spent time in communal areas on the 'memory lane' unit, which provided a service for people living with dementia. We noted that when day staff left and night staff took over, there were periods of up to 15 minutes when neither of the two night staff were in communal areas, as they were providing care for people elsewhere. There were five people in the communal area. Two people were at high risk of falls and during the time where no night staff were present, they both stood from their chairs. They were assisted by an agency staff member, who was employed to provide individual care for another person. However, had the agency staff member not been in the communal area, both may have fallen. We discussed this with the registered manager, who acted promptly to change staff shift patterns to provide an additional staff member in this area during the early part of the night.
● Otherwise people were supported by appropriate numbers of staff. However, there was a high turnover of staff. Prior to the inspection, the registered manager completed the Provider Information Return (PIR). This included information about staff turnover and stated that 56 staff had left the home's employment in the year prior to the inspection. We discussed this with the registered manager who said they were trying to understand the reasons for this and felt it may be due to the "high expectations/workload". The registered manager told us they had adjusted their recruitment interviews to try to make this clearer to potential staff. When we spoke with people, some commented on the frequent changes of staff and that they preferred staff they had got to know.
● People also told us they felt that, day to day, there were enough staff. One person said, "You ring [the call bell] and someone comes, usually quite quickly."
● Nursing, care and ancillary staff told us they felt there were sufficient staff available and we saw people were supported without being rushed.
● The registered manager told us they kept staffing levels under constant review using the provider's dependency based staffing assessment tool.
● The provider had clear recruitment procedures in place. Records confirmed these were followed and had helped ensure that only suitable staff were employed.

Systems and processes to safeguard people from the risk of abuse:
● Appropriate systems were in place to protect people from the risk of abuse.
● People said they felt safe at the home. A person said, "It took me a while to get settled here, but now I feel like it's my home." One visitor said, "I've no worries, I can go home and not worry about [person's name]."
● Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse.

● Safeguarding incidents had been reported and investigated thoroughly, in liaison with the local safeguarding team.

Using medicines safely

● People told us they received their medicines as prescribed. They also told us they could receive ad hoc pain relief such as for a headache, if required.

● Arrangements were in place for obtaining, storing, administering and disposing of medicines in accordance with best practice guidance. Records of medicine administration confirmed people had received their medicines as prescribed. There were systems in place to audit medicines systems including the application of prescribed topical creams.

● Nursing staff and care practitioners had been trained to administer medicines safely and this was reassessed annually as part of a formal competency assessment. We observed staff administering medicines in an appropriate and safe manner.

Preventing and controlling infection

● People and visitors said they felt the home was clean. One person told us "They [housekeeping staff] come in and give it [my bedroom] a very good clean every day."

● The registered manager was unaware of the need to complete an annual infection control statement. This is a annual review of infection risks and actions taken which is required to be in place. They did however complete this promptly once the need to do so was identified to them.

● The home was clean and staff completed regular cleaning in accordance with set schedules. The lead housekeeper undertook spot checks and audits to make sure cleaning was completed as required. The laundry was well organised to help ensure clean items did not come into contact with those waiting to be washed. Potentially contaminated laundry was managed safely.

● Staff had been trained in infection control techniques and had access to personal protective equipment, including disposable gloves and aprons, which we saw they used whenever needed.

● The registered manager was aware of the action they should take if there was an infection risk at the home.

● The local environmental health team had awarded the home five stars (the maximum) for food hygiene.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● Prior to admission to the home, the registered or deputy manager undertook an assessment of people's individual needs to ensure these could be met, including any specific equipment that may be required. A request was also made to the person's GP for medical information and copies of this and any hospital discharge documents were kept within care files. This would help ensure all needs were known and met following admission.
● Care planning and risk assessments followed best practice guidance. For example, they used nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition.
● Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed; pressure-activated floor and chair mats were used to alert staff when people moved to unsafe positions. Systems were in place to ensure pressure relieving equipment for beds was used safely and in accordance with the person's needs.

Staff support: induction, training, skills and experience:
● People were supported by staff who had completed a range of training to meet their needs. Training was refreshed and updated regularly. When asked if they felt staff knew how to look after them, one person said, "Yes, they have very good staff."
● Staff told us they received plenty of training and felt supported in their roles by the registered manager and the provider. There was a clear plan to ensure all new staff received any necessary training as part of their induction. Staff were supported to obtain recognised care qualifications and provided with training to further develop their knowledge and skills. Nursing staff confirmed they received appropriate training to keep their nursing knowledge and skills updated and to meet the requirements of their professional registration. Ancillary staff such as maintenance, chefs and housekeepers also confirmed they received a range of relevant training.
● Staff received regular one-to-one sessions of supervision. These provided an opportunity for the members of the management team to meet with staff, discuss their training needs, identify any concerns, and offer support. In addition, staff received an annual appraisal to assess their performance.

Supporting people to eat and drink enough to maintain a balanced diet:
● People's dietary needs were assessed and met consistently.
● People were offered a choice of food and drink, including regular snacks. One person said, "The meals are good and there is a choice or you can ask for something else. The chef comes around sometimes and asks us if we are happy or want anything else." Another person confirmed they could get snacks and drinks when they asked for these. They said, "If you ask they [staff] will always get you something." Where people required their meals in a softer format we saw these were pleasantly presented. We also saw that soft snacks

were provided. The chef described how they made cake and biscuits into a suitable format which we saw were provided for people who required these.
● People's weight was regularly monitored and the registered manager described the action they would take should a person lose weight. This information was also part of the monthly audit completed by the registered manager. Records viewed showed that where people had lost weight this had been investigated and action taken to provide a fortified high calorie diet and discuss the weight loss with visiting medical staff.
● We saw, where needed, people received appropriate support to eat and were encouraged to drink often although some records did not reflect this.

Staff working with other agencies to provide consistent, effective, timely care:
● People were supported to access external healthcare services when needed. Care records confirmed people were regularly seen by doctors, opticians, specialist nurses and chiropodists. A visiting health professional told us, "Staff contact us when needed and will follow up if they are unsure."
● When people transferred to hospital or to another care setting, staff ensured all key information about the person's needs was passed on. This would help ensure appropriate information was available to the hospital team. These arrangements helped ensure continuity of care for the person.
● Following issues with receiving prescriptions correctly and when required, the registered manager had met with the local GP surgery to discuss ways to improve communication between the two services. This had resulted in improvements with prescriptions.

Supporting people to live healthier lives, access healthcare services and support:
● People told us they received healthcare support when they needed it. One person said, "They [staff] will call the doctor if needed and I have seen the optician who came here."
● Care records showed specific healthcare needs were being appropriately met. For example, we saw where people had wounds, records showed these were appropriately managed and healing. Nursing staff were clear about how they supported a person with a urinary catheter and there were systems in place to ensure dressings and catheters were changed when required. Where people had a specific known medical need such as diabetes, records showed routine monitoring was undertaken appropriately.

Ensuring consent to care and treatment in line with law and guidance:
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.

● People and relatives told us they were always asked before care was provided. Where necessary, care plans provided appropriate guidance for staff as to the actions they should take if a person refused care. Staff were clear they would ask people before providing care and if people declined care, they would return later to offer support.

● Some people living at Orchard House Care Centre lacked the ability to give informed consent to all aspects of their care. Staff protected people's human rights by following the Mental Capacity Act, 2005 (MCA). Where people did not have capacity to make decisions, best interests decisions were made in consultation with family members and other relevant people.
● We checked whether the service was working within the principles of the MCA and found that they were. Some DoLS authorisations had been made and others were awaiting assessment by the local authority. The registered manager was aware of when additional conditions had been applied to some approved DoLS and these had been complied with by the home.

Adapting service, design, decoration to meet people's needs:
● The home was suitable to meet the needs of the people who lived there. Orchard House Care Centre was a modern building on two floors. The first floor could be accessed via a passenger lift if required. At the time of the inspection, the home was being extensively refurbished. Work completed showed this was being done to a high standard and the improvements would enhance the lifestyles and environment for people. Fixtures and fittings had been designed with the needs of people living with dementia or visual impairment in mind. Where necessary, signs and colour schemes supported people. For example, hand rails were a contrasting colour to the walls, making them more readily noticeable to people and suitable signage was displayed to support those moving around independently to find their way.
● All bedrooms were for one-person use, had ensuite facilities and were personalised to the individual. Should they wish to do so, people could have their own furniture and personal fixtures and fittings.
● From the ground floor, there was level access to various flat enclosed garden areas which people told us they had enjoyed using the previous summer. The home had won some provider awards for the interesting designs of garden areas.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
● People told us they liked living at Orchard House Care Centre and were treated with consideration. One person said, "The staff are kind, they are nice to us, no worries there." A visitor told us this was the second care home their relative had lived in and that they [the relative] seemed more relaxed at Orchard House Care Centre.
• We observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. When a person living with dementia was distressed, care staff spent time talking with them and distracted them with the suggestion of a cup of tea.
• People's protected characteristics under the Equalities Act 2010 were explored as part of their needs assessments before they moved to the home. The registered manager explained how they met people's individual needs following admission.
• People's diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Staff had received equality and diversity training.

Supporting people to express their views and be involved in making decisions about their care:
● Records and conversations confirmed that people, or their relatives where appropriate, were involved in meetings to discuss their views and make decisions about the care provided. One visitor told us, "Before [my relative] moved here the [registered] manager came to talk with us. We had a meeting recently and talked about the care plan then."
● Staff had access to some picture cards to help people make decisions when either English was not their first language or where this would help people living with dementia or communication needs to express a preference. At meal times we saw sample plates of both options were shown to people, enabling them to make a more informed choice or to express themselves by pointing to their preferred option.
● Family members were kept up to date with any changes to their relative's health needs. When asked about this, one family member told us, "We are always kept informed, such as if the doctor has been to see them."
● Family members were welcomed at any time. The registered manager told us that families could join people for meals should they wish to do so. Important events were celebrated and relatives had been invited to celebrate Christmas with their family members. When we visited in the evening, we saw some relatives were visiting and remained later into the evening as was their wish. The registered manager told us how they sought to maintain family contact and had supported a person to visit family members living in another part of the island who were unable to visit the home.

Respecting and promoting people's privacy, dignity and independence:

● People were encouraged to do as much as they could for themselves. For example, staff described how some people completed parts of their personal care. At lunch time we saw adapted crockery and cutlery was available when required and staff encouraged rather than took over when people were slow to eat.
• Staff described how they supported people's privacy and dignity. This included listening to people, respecting their choices, closing doors and curtains and keeping people covered as much as possible when providing personal care. People confirmed staff always closed the curtains and ensured their dignity and privacy was maintained. All bedrooms were for single occupancy and equipped with ensuite facilities meaning personal care could be provided in private.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● staff responded to people's changing needs. For example, we heard care staff saying that a person had had a disturbed night, so they would leave them in bed longer before seeing if they were ready for morning personal care to be provided.
● People told us their needs were met in a personalised way and this was confirmed by family members. Staff showed a good awareness of people's individual needs, preferences and interests. For example, we heard staff talking in one part of the home. They spoke about a person's preference as how their breakfast should be served, such that the baked beans were not in direct contact with the bread. Care files included information about people's life histories and their preferences. This showed staff considered people individually and acted to meet their needs in a person-centred way.
● Care plans had been developed for each person using the provider's formalised and comprehensive system. We identified some minor inconsistencies with care plans. The deputy manager audited a sample of care plans each month. Audits from preceding months showed that there was a general improvement in the consistency and completeness of care plans. Where actions were required, the deputy manager checked that these had been completed.
● People could make their own decisions and choices. People told us they could choose when they got up and went to bed, where they took their meals and how they spent their day.
● People were happy with the activities provided. A person said, "They [activities staff] come and tell me what is going on to see if I want to join them." We saw staff within one part of the home encouraging people to join those in another section for activities.
● The home employed two activities organisers who worked across all days of the week and at the weekend. They provided activities directly and external activity providers also attended the home regularly. Records showed there was a good variety of activities providing physical and mental stimulation for people with varying needs. People who remained in their bedrooms by choice or due to medical need were visited by activities staff and offered suitable activities or interaction.
● Activities staff were working with individual people to identify any special wishes they may have, such as places to visit or things they would like to do. They then worked to organise this and to fulfil the person's 'wish'.
● The home shared a minibus with a nearby home owned by the same provider. We saw this was used for individual and small group outings to places of interest around the island. For example, on the third day of the inspection a person was taken out for lunch and to visit a favourite part of the island where they had spent a lot of time as a child. This outing had been arranged to meet a request made by the person.

End of life care and support:
● No-one was imminently approaching the end of their life at the time of this inspection. The registered manager spoke positively about their desire to provide people with high quality care at the end of their lives,

to help ensure they experienced a comfortable, dignified and pain free death. There were good links with the nearby hospice, which the registered manager said they could approach for additional support or advice, such as managing people's pain symptoms. This would help ensure people remained comfortable, dignified and pain free at the end of their lives.

● Nursing and care staff had completed additional training to help meet people's needs towards the end of their lives. For nursing staff, this had included using equipment to help provide regular and effective pain relief.

Improving care quality in response to complaints or concerns:

● People and visitors told us they knew how to make a complaint. Everyone said they would speak to the registered manager or the nurse if they had a concern or complaint. One person told us, "I know the [registered] manager, I would speak with her." A relative told us that when they had raised a concern previously, this had been dealt with to their satisfaction.

● The provider had a complaints policy. Information about how to complain was available for people and relatives in the entrance area of the home. Where formal complaints had been received, records showed these had been investigated by the registered manager and a written response provided to the person raising the complaint. There were no common themes within the complaints which had been received. The registered manager said that if themes emerged, action would be taken to address the underlying issues.

● The registered manager stated they aimed to make themselves as available as possible to people and visitors, meaning any issues could be addressed promptly before people felt the need to make a formal complaint.

● There was a suggestions box located in a communal area of the home meaning people, staff or visitors could make any comments or complaints anonymously should they wish to do so. The registered manager said the suggestions box was very rarely used but they would act if anything was received.

● The service had received compliments about individual staff and thankyou cards which the registered manager said they ensured were passed on to staff.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- There was a clear management structure in place, consisting of the registered manager, the deputy manager and various heads of department, such as catering and housekeeping. The provider's area manager attended the home several times per month. People were aware of who the registered and deputy managers were. They each had clearly defined roles, however they could cover for each other should one be unavailable. Both were registered nurses and able to oversee the management of the clinical needs of people. The home's management team were supported by various clinical and lead staff within the provider's organisation.
- The registered manager made decisions in relation to the home. For example, the provider allocated the registered manager a garden allowance which they had decided how it was spent. In 2018, the home had won awards from the provider for the gardens and outdoor spaces.
- Staff understood their roles and communicated well between themselves to help ensure people's needs were met. Staff told us they worked well as a team. For example, we saw a member of the housekeeping team support a person to use their call bell to seek care staff assistance for a personal care need.
- The registered manager was aware of when they needed to notify CQC about incidents in the home and had done so when required.

Continuous learning and improving care:

- When we identified areas for improvement during the inspection (detailed in previous sections of this report) the registered manager, the deputy manager and the area manager were receptive to our findings and acted to investigate and make improvements. Information provided following the inspection confirmed that this had occurred
- A range of audits and quality monitoring procedures were in place. These included audits completed by the registered manager, the deputy manager, the area manager and by specific teams employed by the provider, such as the health and safety team. Where these had identified improvements were required, subsequent audits and reports showed appropriate action had been taken.
- The registered manager told us they were committed to ensuring a high quality of service was provided at the home. In November 2018 the provider had sent surveys seeking the views of people, their relatives and other stakeholders. The registered manager had not yet received feedback from these, but stated they would act on any areas identified for improvement by survey responses.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

● The registered manager told us they would cover nursing shifts when required and we saw this had included working at weekends and at night. They said this gave them the opportunity to better understand the issues affecting staff at these times and to monitor the way staff worked across the whole day and week.
● The provider's quality monitoring systems required the registered manager to submit monthly reports to the provider's senior management and lead teams. This enabled senior managers to monitor the service and identify any trends or themes for review.
● The registered manager demonstrated an open approach and encouraged staff to do the same. They understood their responsibilities in this respect. Where people had come to harm, relevant people were informed in writing, in line with the duty of candour requirements.
● The previous performance rating was displayed in a communal area of the home and on the provider's website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● A variety of meetings were held including resident and relative meetings, staff meetings and various departmental meetings. Minutes were kept and showed that where issues were raised action was taken. Meetings were also used to provided information, such as about the improvements to the environment which were ongoing at the time of the inspection.
● There was a 'you said, we did' board in the reception area. This was used to provide feedback to staff, people and visitors about actions the management team had taken because of suggestions and comments received.
● Each month staff, visitors or people could vote for an employee of the month with nomination forms on display in the reception area. Winning staff received various gifts as a thank you for their performance.
● The majority of staff told us they felt valued and able to contribute their ideas to the running of the service. They were positive about the management team.

Working in partnership with others:
● The registered manager was proactive in ensuring the home was part of the local community. As many people living at the home were unable to readily access community events and groups, they were providing a venue for these, meaning people or relatives could join in should they wish to do so. This included a local dementia support group, an action for hearing loss group, and social events including a poetry reading group. One day a week, local older people were invited to the home to enjoy a hot cooked meal with people living there. Links were also being developed with other community groups including schools.
● The registered manager said their goal was for the service to be an integral part of the local community and had joined a local nursing homes forum.
● Health professionals said they felt staff and the home's management team worked well with them for the benefit of people living there.