Wells House Limited

The Manor Nursing and Residential Care

Inspection report

Fore street
Yealmpton
Devon
PL8 2JN
Tel: 01752 880510
Website:

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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

Overall summary

This inspection took place on the 20 and 23 July 2015, and the first day was unannounced.

The Manor Nursing and Residential Home is a care home with nursing, situated in the village of Yealmpton. The home is registered to provide accommodation for nursing and personal care for up to 22 older people: 18 people were living at the home at the time of our inspection.

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

Summary of findings

People told us they felt safe in the home, comments included "yes I feel safe here." The relatives we spoke with confirmed their confidence that their loved ones were safe. Staff had received training in safeguarding vulnerable adults and had a good understanding of how to keep people safe.

Risks to people's safety and well-being had been assessed prior to their admission to the home, regularly reviewed and were well managed. Advice was sought when necessary from health care specialists, such as dieticians or the community mental health team. People's medication was managed safely. People had prompt access to their GP, or other specialists such as occupational or physiotherapists, when needed and the outcomes of these referrals were recorded in people's care files. One community nurse told us the care at the home was very good, and they and their colleagues had no concerns over the ability of the staff to care for the people living at the home..

People spoke highly of the care they received. They told us the staff were always caring and friendly: comments included "they are such kind girls", "I'm very happy here, I'm well looked after" and "the staff are very nice." For those people who were unable to share their experiences of living in the home, we saw during our periods of observation, people were treated kindly and with patience. Relatives told us they were happy with the care their loved ones received, one relative said "(name) loves it here, they get on really well with the staff" and another said "she's very well cared for."

People were supported by sufficient numbers of safely recruited and well trained staff. The registered manager confirmed staffing levels were arranged in accordance with people's care needs which were regularly assessed in consultation with the staff. People told us there were enough staff on duty to support them. One person told us "yes, there seems to be enough staff". We saw people being assisted unhurriedly and call bells were answered promptly. People told us they had confidence in the staff and spoke positively about the care they received. Staff were knowledgeable about people's care needs and had the skills and knowledge to support them. Staff received regular supervision and appraisal of their work performance as well as their training and development needs. Staff told us they enjoyed working at the home, they said "I love working here", "there is a great deal of satisfaction from caring for people" and "I'm proud of the care we give."

People and their relatives where appropriate, were involved in planning their care. The care plans recorded what people were able to do for themselves, their preferences in how they wished to be supported and provided staff with clear guidance. The home uses a "key worker" system, where people have a named carer responsible for reviewing their care and support needs, arranging appointments and ensuring people have items such as toiletries, or any equipment they need.

People's wishes regarding how and where they wished to be cared for at the end of their lives was described in the care plans. The home had received training and guidance from the local hospice in providing end of life care and had it's practice acknowledged by the hospice as providing a high level of care to people: the registered manager and one of the nurses were "End of Life Champions." Between the two days of our inspection, the home had held a meeting to encourage people and their families to think about how they wished to be cared for at the end of their lives and if there was anything they wished to achieve before they died.

Staff had a varied understanding of the Mental Capacity Act 2005, (MCA) some staff understood the principle that people were presumed to have the capacity to make decisions, while others weren't sure. We discussed this with the registered manager and they agreed to provide additional training and information for staff.

People told us they liked the food and had a good choice available to them. Comments included, "I love the food" and "the food is excellent and nutritious." We saw people enjoying their lunchtime meal: people were offered choices and the mealtime was pleasant and unhurried. We saw people were supported to eat in a manner that respected their dignity and at an appropriate pace.

The results of the recent quality assurance survey (May 2015) showed people identified "more activities" as an area for improvement. The registered manager said this was a priority and confirmed the registered provider had recently increased the leisure budget to enable this to happen. One staff member took the lead in planning activities but the staff said they were all involved in

Summary of findings

providing activities at some time during the day, usually in the afternoons. A "Wishing Tree" meeting had identified people's wishes in relation to activities they would like to take part in and staff used this to plan events.

People and their relatives as well as the staff told us the home was well managed. There was a policy in place for dealing with any concerns or complaints and this was made available to people and their families in the entrance hallway. People said they would speak with the registered manager, or any of the staff, if they had any concerns or wanted to make a complaint, but they had not needed to do. The registered manager said they had an "open door" policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. The registered manager was a member of the "Outstanding Manager's Group" run by a training provider in association with Skills for Care, (the employer-led workforce development body for adult social care in England). This management group shares good practice and keeps abreast of new initiatives in caring for older people.

The registered manager used a number of methods to gain people's, relatives' and staff's views of the care and support provided at the home, including individual and group meetings and using surveys. The results of the survey in May 2015 showed a high level of satisfaction with the way the home was managed. In response to the question about making improvements to the home, the comments received included, "I wouldn't change anything" and "everything is satisfactory."

The registered provider met regularly with the registered manager and records of these meetings were made available. We saw actions had been identified and met, and included providing equipment people needed such as new beds or air mattresses, and making improvements to the environment. For example, one person had requested the doorway from the conservatory to the patio be levelled so they could access the patio without the assistance of staff, and we saw this had been done.

Health and safety audits ensured medication practices were safe, equipment was safely maintained and accidents reviewed to identify any trends and prevent them re-occurring.

Summary of findings

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 home was safe.

People told us they felt safe in the home.

Staff had received training in safeguarding vulnerable adults and had a good understanding of how to keep people safe.

Risks to people's safety and well-being had been assessed prior to their admission to the home, regularly reviewed and were well managed.

People were supported by sufficient numbers of safely recruited staff.

Medicines were stored and administered safely.

Is the service effective?

Good

The home was effective.

Staff had a varied understanding of the Mental Capacity Act 2005, (MCA) some staff understood the principle that people were presumed to have the capacity to make decisions, while others weren't sure.

Staff received regular training in issues relating to people's care needs as well as health and safety topics. They were knowledgeable about people's care needs and had the skills and knowledge to support them.

People told us they liked the food and had a good choice available to them.

Nutritional risk assessments and people were supported to maintain a healthy diet.

Is the service caring?

Good

The home was caring.

People spoke highly of the care they received. They told us the staff were always caring and friendly. For those people who were unable to share their experiences of living in the home, we saw during our periods of observation people were treated kindly and with patience.

Staff told us they enjoyed working at the home.

People were supported to discuss and share their wishes regarding how and where they wished to be cared for at the end of their lives. The home was accredited with the local hospice in providing end of life care and all staff had received "end of life" training.

Is the service responsive?

Good

The home was responsive.

People and their relatives where appropriate, were involved in planning their care. Care plans detailed people's specific care needs.

Summary of findings

The home uses a “key worker” system, where people have a named carer responsible for reviewing their care and support needs.

People had identified more leisure activities was an area for improvement and the registered manager confirmed this was being addressed.

The registered manager had an “open door” policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. A policy was in place for dealing with any concerns or complaints in a timely manner.

Is the service well-led?

Good

The home was well-led.

People and their relatives as well as the staff told us the home was well managed.

The registered provider and registered manager were aware of their responsibilities relating to their duty of candour saying, “we are open and honest if anything untoward happens.”

Quality assurance systems ensured the registered provider and registered manager reviewed care practices as well as health and safety issues, and were alert for any issues that might place people’s health and safety at risk.

The Manor Nursing and Residential Care

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 20 and 23 July 2015 and was unannounced. The inspection was carried out by one adult social care inspector. Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 11 people who used the service, Some of these people were not able, due to complex care needs, to tell us about their experiences of the home. We therefore 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 comment directly on the care they experienced. We also spoke with five relatives, the registered manager and one registered nurse, six members of care staff, and two members of the housekeeping team. Following the inspection we contacted local community teams who supported or commissioned people's placements at The Manor Nursing and Residential Home for their views on the service.

We looked around the premises and observed how staff interacted with people throughout the day. We also looked at four sets of records related to people's individual care needs; three staff recruitment files and records associated with the management of the home including quality audits, training records and policies and procedures. We looked at the way in which medication was stored and administered to people. We observed people being supported to eat their lunchtime meal. We sat in on a staff handover meeting to see how information was communicated between staff.

Good

Is the service safe?

Our findings

During our visit we spoke with people who lived at the home and asked if they felt safe. One person said "yes I feel safe here" and another said they felt safe living at the home and could talk to any of the staff or the registered manager if they had any concerns. For people who were not able to tell us, we used our observations to help inform us of their experience: we saw people smiling and talking freely to staff indicating they felt safe in the staff's company. The relatives we spoke with confirmed their confidence that their loved ones were safe.

We spoke with seven staff members, including one nurse, who told us they had received training in safeguarding vulnerable adults and certificates held in their training files confirmed this had been recent. They demonstrated a good understanding of how to keep people safe and how they would report their concerns. One staff member said they would "without doubt" report any concerns over people's safety and welfare. The policy and procedure to follow if staff suspected someone was at risk of abuse were available in the office and telephone numbers for the local authority and the Care Quality Commission were clearly available for staff.

There were robust recruitment practices in place that included completed application forms, previous employment history and references as well as Disclosure and Barring checks, to ensure as far as possible only suitable staff were employed at the home. Records showed the registered nurses had their registration with the Nursing and Midwifery Council checked prior to their employment and then annually.

There were sufficient staff on duty to keep people safe and meet their needs. At the time of our inspection, in addition to the registered manager, there was a nurse, four care staff, two housekeeping staff, and a cook as well as maintenance staff on duty. The registered manager confirmed staff levels were arranged in accordance with people's care needs. People's care needs were regularly assessed in consultation with staff to identify changes in their dependency and their possible need for more assistance from staff: we saw records of these dependency assessments in people's care files. Those people who were able to tell us their views told us there were enough staff on duty to support them. One person told us "yes, there seems to be enough staff". We saw people being assisted unhurriedly and call bells were answered promptly.

Risks to people's safety and well-being had been assessed prior to their admission to the home and regularly reviewed to identify any changes. Risk assessments in people's files included the risk of skin breakdown and the development of pressure ulcers, poor nutrition, the risk of falls as well as the risks associated with health conditions such as diabetes. Staff were also guided to be observant for signs of infection and identified people were at risk. Where risks had been identified, people were consulted over how they wished to be supported to manage these. For example, due to a change in their health, one person's mobility needs had changed and staff had consulted them about how they now wished to receive their personal care, and it was agreed a shower was safer for them than a bath.

Where necessary staff had sought advice from health care specialists to assist in managing people's risks. For example, one person had been assessed as at risk from not eating enough to maintain their health. Records showed staff had consulted with a dietician and their advice was clearly recorded in the person's care plan and staff were closely monitoring this person's nutritional intake. Records showed risk assessments had been reviewed monthly or more frequently if people's needs had changed.

People's medication was managed safely. We observed some medicines being administered and this was done unhurriedly. Medicines were administered by the registered nurses on duty.

Medicine administration records were clearly signed with no gaps in the recordings. The medicine administration records included information which protected people, such as any allergies recorded. It was also clear when a medicine was to be administered and in what dose. Where medicines were prescribed with a varying dose, such as warfarin, this was managed safely, with staff receiving written confirmation from the GP of the forthcoming week's doses. Medicines were stored safely and only the nurses and the registered manager had responsibility for checking stocks, reordering and returning medicines to the pharmacy. The registered manager and the nurses undertook regular audits, either weekly or monthly, depending on the medicine, to ensure medicines received in to the home and administered could be accounted for. We checked the

Good

Is the service safe?

quantities of a sample of medicines available against the amounts recorded as received and the amounts recorded as administered: all were correct. We saw medicine that required refrigeration was kept securely at the appropriate temperatures.

Good

Is the service effective?

Our findings

Staff were knowledgeable about people's care needs and had the skills and knowledge to support them. People told us they had confidence in the staff and spoke positively about the care they received. One person said "they (the staff) are looking after me well" and a relative said "the staff are very kind and considerate, they have a good understanding of (their relative's name) needs." In the summary of the survey asking people their views of the home in May 2015, we saw people and their relatives had been asked to comment on what they liked about the home. The responses were very positive and comments included "the friendliness of the staff" and "the nurses are very good."

Staff received regular training in issues relating to people's care needs such as skin care and the prevention of pressure ulcers, health conditions such as Parkinson and Huntington Diseases and diabetes, as well as caring for people with dementia. Training was also provided in health and safety topics such as safe moving and handling, fire safety, food hygiene and infection control, and certificates were seen in staff files. The registered manager was the home's trainer for manual handling and received annual updates to ensure their practice reflected current legislation: a certificate was seen of their recent update in April 2015. A staff training matrix identified the training each member of staff had undertaken and when updates were due. The registered nurses were provided with additional training to maintain their professional registration and also to ensure their specialist skills were kept up to date such as administering medicine through a syringe driver, taking blood samples and catheterisation. An annual staff development plan detailed the training the registered manager and individual staff had identified as being required or which had been requested. This included planned training events for conditions such as stroke care, motor neuron disease and Huntington's disease, as well as end of life care.

Newly employed staff were provided with an individually planned induction dependent upon their previous experience. Staff were provided with a Code of Conduct detailing the values of the home and the standards expected from staff regarding treating people with respect and protecting their dignity. Two staff told us they had worked alongside experienced staff and undertaken training prior to being assessed by the registered manager as competent to work unsupervised. Newly employed staff were also enrolled to undertake the Care Certificate, a training and development course designed to provide staff with information necessary to care for people well and, for which, staff were required to provide evidence of their knowledge, skills and competences. The registered manager confirmed they were undertaking the Care Certificate assessor's course. They had also introduced elements of the Care Certificate to existing staff to help them improve their knowledge and practice.

Staff received one to one supervision every two months from the registered manager. Staff were encouraged at these meetings to share their views on the running of the home and their personal development and training needs. We saw staff had been encouraged to identify personal objectives for the coming year and actions were detailed as to how these objectives would be supported and met. For example, one staff member told us that they had been encouraged to undertake an apprenticeship in health and social care at level three, which is a senior level, and would be able to develop this further if they wished. Staff said they found these meetings useful and felt listened to. Staff also received an annual appraisal where their work performance was formally assessed.

People told us they saw their GP promptly if they needed to do so. Care files contained records of referrals to GPs, community nurses and other health care specialists such as occupational therapists or the community mental health team. The outcomes of these referrals were documented with changes to care needs transferred to the care plans. Not all of the people living in the home required nursing care, and for those who did not, the community nursing service provided advice and support for staff. One community nurse told us the care at the home was very good, and they and their colleagues had no concerns over the ability of the staff to care for the people living at the home. They said they were contacted promptly should the staff require advice over someone's care needs. During the morning on the first day of our inspection we sat in on the staff handover meeting between the care staff and nurse on duty. Staff were able to share information about people, such as whether someone was eating and drinking well, or who appeared to be unwell.

Staff had a varied understanding of the Mental Capacity Act 2005, (MCA) some staff understood the principle that

Good

Is the service effective?

people were presumed to have the capacity to make decisions, while others weren't sure. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. However, all staff told us they supported people to remain as independent as possible and involved people in decisions about their care. For example, they told us some people were limited in the decisions they were able to make due to living with dementia but where they could make decisions, they were offered choices, such as what clothes they wished to wear, where they would like to spend their time and what they would like to eat and drink. We discussed staff's varying understanding of the MCA with the registered manager and they agreed to provide additional training and information for staff.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and the registered manager was aware of the implications of this legislation. Where it had been identified someone was being deprived of their liberty to maintain their safety, applications to the local authority for authorisations for DoLS had been applied for, and we saw this in their care file. Where people had made choices to have their liberty restricted, staff were aware of their responsibility to ask the person's consent each time the restriction was put in place. For example, one person had requested the use of bedrails at night. The person's care plan guided staff to ask the person each evening if they wished to have the rails in place, and if they chose not to we saw this had been documented in their care notes.

People told us they liked the food and had a good choice available to them. Comments included, "I love the food" and "the food is excellent and nutritious." One person told us they have their food "mushed up" as they had "a problem with my swallowing" and confirmed it as always "very nice". We saw this person's care plan gave clear guidance to staff in how to support them to eat and drink safely following the advice of the specialist Speech and Language team. The cook confirmed menus were planned around people's likes, dislikes and dietary needs, and that the menus had recently been revised after consultation with people. The home did not have a formal dining room, although there was a dining table in the conservatory. People were able to take their meals where they chose and we saw staff asking people where they would like to eat. Some people chose the conservatory and others chose to stay in the lounge. We saw people enjoying their lunchtime meal: people were offered choices and the mealtime was pleasant and unhurried. We saw people were supported to eat in a manner that respected their dignity and at an appropriate pace.

Care plans included nutritional risk assessments and people's weight was monitored regularly, weekly for some people, to assess for any changes that might indicate further support and advice was required.

Good

Is the service caring?

Our findings

Those people who were able to share their experiences with us spoke highly of the care they received. They told us the staff were always caring and friendly: comments included “they are such kind girls”, “I’m very happy here, I’m well looked after” and “the staff are very nice.” For those people who were unable to share their experiences of living in the home, we saw during our periods of observation people were treated kindly and with patience. We heard one member of staff talking to a person who was being nursed in their room. They were assisting them to have a drink and we heard them in conversation and laughter together. This person later told us the staff were “very kind” to them and “nothing was too much trouble”. We saw staff in pleasant conversations with people and it was obvious staff had genuine affection for people. Relatives told us they were happy with the care their loved ones received, one relative said “(name) loves it here, they get on really well with the staff” and another said “she’s very well cared for.” They confirmed they also have a good relationship with the staff, one said, the staff “are friendly and always laughing.”

Staff knew people well and, when asked about the care needs of the people whose care files we looked at, were able to describe these and how they wished to be supported. Staff told us they enjoyed working at the home, they said “I love working here”, “there is a great deal of satisfaction from caring for people” and “I’m proud of the care we give.” They told us their caring role was about “treating people as if they were my family” and “providing holistic care, paying attention to people’s emotional needs as well as their physical needs. I love to see people smile.”

People’s wishes regarding how and where they wished to be cared for at the end of their lives was described in the care plans. The home had received training and guidance from the local hospice in providing end of life care and had it’s practice acknowledged by the hospice as providing a high level of care to people. The registered manager and one of the nurses were “End of Life Champions” having completed the hospice’s Six Steps Programme of enhanced training. They regularly attended End of Life Forums to keep up to date with the latest advice. An end of life care plan, devised by the registered manager and approved by a member of the education team at the hospice, focused on people’s needs, including pain management and nausea, diet and fluids, their spiritual needs as well as the needs of their relatives and friends. The registered manager said relatives were supported to spend as much time as they wished with their loved one, to be involved in their care if appropriate, and “to say goodbye.” They were provided with meals and could also stay overnight if wished. Between the two days of our inspection, the home had held a meeting to encourage people and their families to think about how they wished to be cared for at the end of their lives and if there was anything they wished to achieve before they died. A 'yellow brick road” was used to record people’s wishes. The registered manager said if at all possible staff would try to help people fulfil their wish. For example, one person wanted to write his autobiography and the home had provided them with a dictaphone to record their memories. Another person, who was being nursed in bed due to their frailty, said they “just wanted to sit in the garden, in the sunshine with a glass of real lemonade” and this was being arranged for them.

Where people had made decisions about whether they wished to receive emergency treatment such as cardio-pulmonary resuscitation, or had made advanced directives, these were clearly recorded in their care files. Staff worked with the local GP service to ensure advanced decisions were well documented and understood. Anticipatory medicines were requested when a person was identified as nearing the end of their life. Anticipatory drugs are medicines that are used to manage people’s symptoms during their end of life. These medicines help people to experience a pain free and dignified death. The provision of anticipatory drugs ensured that medicines and pain relief were available to people at the right time to enable them to receive their end of life care in their preferred place.

People’s privacy and dignity were respected. For example, we heard staff spoke quietly and discreetly to people about using the toilet before having their lunch. We saw staff had received information on confidentiality of information and personal or sensitive information recorded about people in their files was treated respectfully.

Good

Is the service responsive?

Our findings

People and their relatives where appropriate, were involved in planning their care both prior to their admission to the home and throughout their stay, and we saw their involvement recorded in their care plan reviews. Care plans recorded what people were able to do for themselves, their preferences in how they wished to be supported and provided staff with clear guidance. For example, one person's care plan indicated they were able to "wash their hands and face and comb their hair" and their night time routine was described as "likes to have tea and a piece of chocolate before settling. To have the small bedside light left on." Another person's indicated the caution required when assisting them to mobilise to keep them and the staff safe. These plans and associated documents such as risk assessments were reviewed each month and care plans were amended to reflect the changes in people's care needs.

A further document, entitled "This is me", was held in each person's room giving a summary of their care needs as well as "what you need to know about me." It included information about people's sensory abilities, whether they were living with dementia and if so how it affected them and how to communicate well with people. Their past social history was also recorded to enable staff to initiate conversations with people. A "complete care chart" provided evidence of when and how staff had supported each person and included their pressure area, continence care and diet and fluid intake.

The home used a "key worker" system, where people had a named carer responsible for reviewing their care and support needs, arranging appointments and ensuring people have items such as toiletries, or any equipment they need.

Some people we spoke with were unable to recall how they spent their time, while others said they either entertained themselves or joined in with the activities arranged by the staff. The results of the recent quality assurance survey (May 2015) showed people identified "more activities" as an area for improvement. The registered manager said providing more meaningful activities for people was a priority and confirmed the registered provider had recently increased the leisure budget to enable this to happen. The home planned activities each week and these were either provided by the staff or people coming into the home, and included games, musicians and animal petting. One staff member took the lead in planning activities but the staff said they were all involved in providing activities at some time during the day, usually in the afternoons. One staff member said "we don't want people to become bored." A timetable for events was on the notice board in the lounge. Staff said they spent time with people who were being nursed in their rooms due to their frail health, either in conversation, looking at their photographs or reading to them or doing word games. Staff had recently consulted with the community mental health team for advice in encouraging people at risk of isolation to become involved in activities and this advice was recorded in the relevant people's care plans. A "Wishing Tree" meeting had identified people's wishes in relation to activities they would like to take part in and staff used this to plan events.

There was a policy in place for dealing with any concerns or complaints and this was made available to people and their families in the entrance hallway. People said they would speak with the registered manager, or any of the staff, if they had any concerns or wished make a complaint, but they had not needed to do so as they were happy with the care and support they received. One person said, "everything is good, I have no problems whatsoever." The registered manager confirmed they and the registered provider, who visits the home every two weeks, speak to people in private to ascertain their views and whether they are happy with the care and support provided by the home. Relatives told us they felt confident if they had any concerns these would be listened to and dealt with promptly. The registered manager confirmed the home had not received any complaints.

Good

Is the service well-led?

Our findings

People and their relatives as well as the staff told us the home was well managed. The Staff understood their roles and said the communication between themselves, the nurses and the registered manager was good. Staff said duties were allocated well and they knew what was expected of them during their shift.

The registered provider and registered manager were aware of their responsibilities relating to their duty of candour. In the provider information return (PIR), the registered provider said "we are open and honest if anything untoward happens." The duty of candour places requirements on providers to act in an open and transparent way in relation to providing care and treatment to people. The registered manager said they had an "open door" policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. The registered manager was a member of the "Outstanding Manager's Group" run by a training provider in association with Skills for Care, (the employer-led workforce development body for adult social care in England). This management group shares good practice and keeps abreast of new initiatives in caring for older people.

The registered provider identified in the PIR they were in the process of registering for the Social Care Commitment which is a Department of Health initiative. Registering requires making a promise to provide people who need care and support with high quality services. It is a commitment to seven statements which cover activities such as recruiting the right staff, having a thorough induction, ensuring a strong culture that values dignity and respect and effective communication.

The registered manager used a number of methods to gain people's views of the care and support provided at the home. They said they regularly met with people and their relatives individually to discuss in private their views and how well they felt they were being cared for. An annual survey was sent to people, their relatives as well as the staff. The results of the survey in May 2015 showed a high level of satisfaction with the way the home was managed. In response to the question about making improvements to the home, the comments received included, "I wouldn't change anything" and "everything is satisfactory." A monthly newsletter gave information about developments in the home, planned events and updates on staffing issues. We saw copies of the newsletter, a summary of the May 2015 survey and also surveys for people to complete at any time, were available in the entrance way.

Regular staff meetings, held separately for registered nurses and care staff, allowed staff to discuss as a group how well the home was meeting people's needs. The registered manager confirmed improvements had been identified through these meetings such as the way in which medicine stocks were checked. The registered provider met regularly with the registered manager and records of these meetings were made available. We saw actions had been identified and met, and included providing equipment people needed such as new beds or air mattresses, and making improvements to the environment. For example, one person had requested the doorway from the conservatory to the patio be levelled so they could access the patio without the assistance of staff, and we saw this had been done.

Monthly audits were carried out to review health and safety practices such as fire safety, equipment checks, and analysis of incidents such as falls to try to identify any trends and prevent them re-occurring. Any incidents such as skin tears were investigated and an action plan or additional support put in place where needed.

Equipment such as lifts and hoists were on a service and maintenance contract so that any issues could be remedied. Clinical waste arrangements were managed by an external contractor. The home employs maintenance staff to ensure minor repairs could be dealt with quickly and staff were clear about how to report maintenance. There was a business continuity plan in place to ensure the home continued to function safely in unusual circumstances, such as power cuts.