Court Healthcare Limited

Bay Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 21 July 2016.

Bay Court Nursing Home is registered to provide accommodation with nursing care for up to 29 older people. There were 27 people using the service on the day of our inspection which included one person receiving respite support.

We had previously carried out a comprehensive inspection of this service in May 2015. Two breaches of legal requirements regarding staff levels and recording keeping were found.

There was a registered manager at the service who had been in post since January 2016. They had been successfully registered with the Care Quality Commission (CQC) the week before our visit. A registered manager is a person who has registered with CQC 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. The registered manager was very visible at the service and undertook an active role. They were committed to providing a good service for people in their care and demonstrated a strong supportive approach to people, their relatives and staff. They were supported by the providers who visited regularly.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. The registered manager had increased the staff levels at the service. They regularly completed a dependency tool to assess people's needs. They adjusted the staff levels as required. Staff undertook additional shifts when necessary to ensure these were maintained. When gaps were not able to be covered, agency care workers were used.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. They understood where people lacked capacity, a mental capacity assessment needed to be completed with best interest decisions made in line with the MCA. They had submitted nine applications to the local authority Deprivation of Liberties Safeguarding team (DoLS) to deprive some people of their liberties. One of these applications had been authorised with the others waiting to be reviewed. Staff had a good understanding about giving people choice on a day to day basis. Staff had received MCA training to help them understand their responsibilities.

People were supported by staff who had the required recruitment checks in place. Staff had received an induction. The registered manager had put in place a programme of training to ensure all staff had completed the provider's mandatory training.

Staff had completed safeguarding training and were knowledgeable about signs of abuse and how to report concerns. Staff felt confident any concerns they raised would be investigated and actions taken to keep people safe.

People were supported to eat and drink sufficient amounts and receive a balanced diet. Improvements had been made to the recording and monitoring of people's diet and fluid intake which was being checked daily by the nurses at the service. People were positive about the food at the service.

Staff treated them with dignity and respect at all times and in a caring and compassionate way. People received their medicines in a safe way because they were administered appropriately by the nurses at the home.

People had access to activities at the service. People were encouraged and supported to be independent and to avoid social isolation.

People's needs and risks were assessed before and on admission to the home. Risk assessments were undertaken for people to ensure their care needs were identified. Care plans reflected people's routines and wishes and were updated with people's changing needs. They gave staff guidance about how to support people safely. People were involved in making decisions and planning their own care on a day to day basis. People were referred to health care services when required and received on-going healthcare support.

The home had a homely atmosphere with no unpleasant odours. The premises were well managed to keep people safe. The provider had a continued programme of redecoration for the service.

The provider had a quality assurance and monitoring system in place. This included regular audits with this year's annual surveys ready to be sent out for the provider to assess the effectiveness of the service provided.

The registered manager actively sought the views of people and staff through regular meetings. There was a complaints procedure in place. There had been no complaints at the home in 2016. The registered manager had a clear understanding of how to respond to concerns and tried to deal with grumbles before they became complaints.

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.

The premises and equipment were managed to keep people safe.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

Improvements had been made to ensure people's medicines were being managed safely.

The registered manager ensured staff levels were adequate to meet people's individual needs.

There were effective recruitment and selection processes in place.

Is the service effective?

Good

The service was effective.

The registered manager had a programme of staff training underway to ensure all staff had received the provider's mandatory training.

Staff were seen to be confident in meeting people's needs.

Staff had received an induction. They had all had supervision with the registered manager and had regular supervisions with their line managers. The registered manager had scheduled staff appraisals.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Visitors were encouraged and always given a warm welcome.

Is the service responsive?

Good

The service was responsive to people's needs.

Care plans were person centred about people's wishes and social needs. They reflected people's changing health needs and guided staff how to appropriately meet those needs.

There were two designated activity staff who supported people to undertake a range of activities.

There were regular opportunities for people and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the improvements at the service and how the registered manager and owners worked well with them.

The registered manager at the service had recognised there were areas that had required improvement. They had taken action to address these concerns.

People's views and suggestions were taken into account to improve the service.

There were audits and surveys in place to assess the quality and safety of the service people received.

Bay Court Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 21 July 2016 and was undertaken by one adult social care inspector.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in June 2016. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

The local authority Quality Assurance and Improvement Team (QAIT) had been contacted by the Community Health and Social Care manager in 2015 requesting they provide some support to the service. QAIT had carried out three visits between October 2015 and finished working with the service in April 2016. Their work had included support with documentation such as care plans, daily recording, daily charts and risk assessments.

We met and observed most of the people who lived at the service and received feedback from seven people who were able to tell us about their experiences. We spent time in communal areas and observed staff interactions with people, along with the care and support delivered to them. We also spoke with two visitors and a visiting health care professional to ask their views about the service.

We spoke and sought feedback from fifteen staff, including the registered manager, deputy manager, registered nurses, care staff, the cook, a kitchen assistant, two housekeepers and two kitchen assistants. We also spoke with two of the providers.

We reviewed information about people's care and looked at three people's care records and four people's

medicine records. We also looked at records relating to the management of the service. These included staff training records, support and employment records, quality assurance audits, and minutes of team meetings. We contacted health and social care professionals and commissioners of the service for their views. We received a response from two of them.

We also spoke with a 'paid representative under the Mental Capacity Act Deprivation of liberty safeguards' who had been appointed to represent a person at the service and a member of the QAIT team who had been providing support.

Good

Is the service safe?

Our findings

People said they felt safe and were happy at the home. Comments included, "I am quite happy here. They know what I like and what I don't."

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff had time to meet people's individual needs. Comments from one visitor included, "Generally enough staff, occasionally there is a pinch point," this referred to times when there was an increased demand at peak times. Comments from staff included, "The staff levels are quite good, bells are being answered a lot quicker, and there are more staff. Staff now take their breaks separately which is much better" and "It is much better here, at the moment it is alright."

The Provider's Information Return stated "staffing levels have increased in line with resident dependency, this is reviewed daily." This was demonstrated when a twilight shift was introduced between 3pm and 9pm, when people's needs had increased to support people with their evening meal and to go to bed.

The registered manager said they almost had a full complement of staff which would minimise the use of agency staff where ever possible. The staff schedule showed there were two nurses and six care workers on duty in the morning, with one or two nurses and five or six care workers in the afternoon. This ensured staff numbers remained consistent. At night there was a nurse and two care workers on duty. Also working at the home during the day was the registered manager, a cook, kitchen assistants, housekeeping staff, a part time administrator and an activity person. Staff undertook additional duties when necessary to cover gaps. If required the provider used the services of local care agencies to cover gaps.

People were protected because risks for people were identified and managed. Records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin damage, safety, nutrition and manual handling. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. For example, people assessed as being at risk of weight loss were given fortified fruit smoothies and mousses to increase their calorie intake. The people whose records we looked at had all gained weight at the service. People assessed as at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs.

People received their medicines safely and on time. All medicines were administered by the registered nurses who had received training. The registered manager was implementing a competency framework to ensure they continued to have good practice. They had a good understanding of the medicines they were giving out. Nurses were seen administering medicines in a safe way. They were very patient and did not rush people.

There was a system in place to monitor the receipt and disposal of people's medicines. Medicines were stored at the recommended temperature. The medicine fridge, nurse's office where medicines were stored and people's individual medicine cabinets had their temperatures monitored. Medicines at the service were

locked away in accordance with the relevant legislation.

Where people had medicines prescribed as needed, (known as PRN), protocols had been put into place by the registered manager about when and how they should be used. New prescribed topical cream charts had been put in place for staff to record when they had administered creams. The nurses undertook a daily check as part of their role to check the charts to ensure people's creams had been administered as prescribed.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures. The registered manager had undertaken a check of all staff recruitment files since arriving at the service to assure themselves all staff had a DBS in place.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. These were stored in the fire folder and easily accessible in the event of a fire.

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. They were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the registered manager about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary.

The environment was safe and secure for people who used the service and staff. The provider used the services of a local contractor who visited the service each week to carry out work identified in the maintenance log and undertake maintenance projects as directed. Staff were able to record repairs and faulty equipment in a maintenance book. External contractors undertook regular servicing and testing of moving and handling equipment, gas and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. A recent visit by the fire officer identified no significant concerns.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry was small but tidy. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Good

Is the service effective?

Our findings

People's needs were met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service. Staff were able to tell us how they cared for people to ensure they received effective care and support. They demonstrated through their conversations with people and their discussions with us that they knew the people they cared for well.

People were supported by staff who were knowledgeable about their health needs. When staff first came to work at the home, they undertook a period of induction which had given them the skills to carry out their roles and responsibilities effectively. This included working alongside a designated experienced mentor to get to know people and their individual care and support needs. They had completed a checklist with the registered manager and designated mentor. The registered manager said they had not needed to use the new Care Certificate which had been introduced in April 2015 as national training in best practice. This was because all staff they had employed had previous experience of working in care and had a care qualification. They said, however, they had identified staff had not completed the care certificate and were in the process of implementing the training for them.

The registered manager had identified not all staff had completed the provider's mandatory training. Mandatory training at the home included, manual handling, first aid, the Mental Capacity Act 2005 (MCA),Deprivation of Liberty Safeguards (DoLS), safeguarding vulnerable adults, infection control, health and safety, food hygiene, fire safety and duty of candour. Staff were just completing the programme of mandatory training which the registered manager had put in place to ensure all staff had received the required training. The registered manager used the services of an external trainer who visited the home to deliver training. Staff were positive about the training they had received. One care worker commented, "He is excellent, it is better when we can have discussions better than the booklets."

Ten staff were scheduled to undertake a 'train the trainer' course in fire safety. This meant they could take on the role of delivering fire training every month to ensure staff remained updated. Care workers were being supported to undertake extended training in their roles. For example, this included testing people's urine, blood sugar levels and blood pressure. There were plans for care staff to undertake medicine administration training and undertake competency checks. The registered manager said this was because care staff were often asked to check medicines with the nurses and needed to have knowledge of the procedures.

The nurses at the service undertook additional training to ensure they had the knowledge and competence to undertake their role. This included, chronic illness training, venepuncture (taking bloods), understanding Huntington's disease, epilepsy, diet and nutrition and peg feed training (artificial means of feeding for people who have difficulty swallowing). Care staff had attended some of these training sessions also. Training had been scheduled for syringe driver training (a small, portable pump that can be used to give people a continuous dose of painkillers and other medicines through a syringe).

Checks were made by the registered manager to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. The registered manager was also supporting nurses through the NMC revalidation process to retain their nurse registration status.

Staff had all received one supervision with the registered manager so they could have an opportunity to get to know each other. Staff had been designated a line manager to undertake further supervisions. Staff said they were listened to and could discuss training needs. The registered manager had scheduled staff appraisals. Staff said they felt supported by the registered manager. One staff member commented, "I feel supported, I know a lot more with (Registered manager's) guidance."

The 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. Best interest decisions had been made at the service. The staff had included relevant health professionals and families as appropriate in the decision making process.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The registered manager had submitted nine applications to the local authority DoLS to deprive people of their liberties. One of these had been approved. Records showed that the majority of staff had undertaken training on the MCA, with other staff scheduled to undertake it.

People confirmed they were always asked for their consent before care and support was provided. Staff involved people in decisions about the care they received. Staff had considered people's capacity to make particular decisions and knew what they needed to do to ensure decisions were made in people's best interests. Professionals and relatives had been involved in the decision making process where appropriate. There was supporting evidence of a best interest meeting which was scheduled to take place.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP and had regular health appointments such as with the visiting optician, and chiropodist. Records showed when health concerns were identified, people were visited by health care professionals, and staff took action and followed their advice. One health professional said, "I have no concerns they follow our advice here. I have been a couple of times, everyone looks well cared for and they (staff) are dealing with their needs."

People were supported to eat and drink enough and maintain a balanced diet. There was a four week menu with a single choice of main meal with alternatives available if required. The kitchen staff were given a nutritional profile when people came into the service. The cook said one of the kitchen team would meet with new people to ask them their food preferences. People were complimentary about the meals at the

home. Their comments included, "Good homely food" and "The food is alright, not too bad really."

During the lunchtime period there was a happy atmosphere in the dining room. Staff were attentive to people's needs and went around offering a choice of drinks and support. People who needed additional support to eat their food had their meals served half an hour earlier. This was so care staff could support them with their meals unrushed. People who required a special diet were catered for. The cook had clear guidance about people's needs and who required a special diet. They could differentiate between the recommended consistencies given by the Speech and Language Team (SALT). For example, pureed and fork mashable consistencies. The SALT team provide treatment and support for people who have difficulties with communication, or with eating, drinking and swallowing. This meant people who required a specialist diet recommended by SALT had the appropriate meal consistency to meet their needs safely.

Good

Is the service caring?

Our findings

People said staff were kind and friendly towards them. Comments included, "Nice atmosphere here", "Staff chat and joke, spend time with us" and "I couldn't be happier. They look after me very well." A visitor's comments included, "Very respectful, they (staff) slip in quietly or sit and have a chat with them not just look after them, see them as friends."

Staff were seen positively interacting with people chatting, laughing and joking. They talked with us about individuals in the home in a compassionate and caring way. They had spent time getting to know people and demonstrated a good knowledge of their needs likes and dislikes. Care plans were focused on the person and their individual choices and preferences. Staff were completing people's personal histories documents. This would enable staff to have a greater knowledge of people's past and people and events special to them.

Staff were considerate and caring in their manner with people and knew people's needs well. They were friendly and supportive when assisting people. They treated them with dignity and respect when helping with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people appropriately and gained consent before providing care. We observed care staff support a person to move positions using a hoist. They were very attentive, gave reassurance and explained what they were doing throughout the process. The registered manager had approached 'Dignity in Care network' which is led by the national dignity council to put dignity and respect at the heart of care services. This was regarding having a designated dignity champion at the home.

People's formal consent for care and treatment at the home and consent for day to day care and treatment was sought. Staff gained people's consent before they assisted people to move and they explained what they were doing and involved the person. They listened to people's opinions and acted upon them. People were offered choices and staff asked people their preferred preference. For example, if they wanted to go to the lounge, stay in their room, would like to watch television or listen to the radio. In one person's room there was a prompt reminding staff to offer these choices daily and record the person's response.

Staff supported people to be as independent as they wanted to be. People were active around the communal areas. One person said they liked to work in the garden which included painting a fence. They were very proud of the work they had achieved. An external call bell had been purchased and a staff member was allocated the alerter so they could respond if people called. This was so people could be independent in the garden and call for assistance if they required it.

The service offered end of life care, although no one was receiving this care during our visit. People had access to support from specialist palliative care professionals. The registered manager had signed up to the Hospice Care End of Life Initiative (end of life best practice) to improve staff knowledge and skills. This involved a worker from the local hospice team working alongside staff at the home for eight weeks. Their role was to support staff, giving them knowledge of how to support people at the end of their lives to have a

dignified death. Then some staff had the opportunity to spend time working at the local hospice to get more experience. End of life training had also been scheduled for staff provided by the hospice worker.

People's rooms were personalised with photographs, items of furniture, ornaments and technology for people to access the media as they chose. People's relatives and friends were able to visit when they liked. People and a relative said they were made to feel welcome when they visited the home. One visitor said, "I have been very impressed by everyone I met in Bay Court and do thank you for your kindness and help (and cups of tea) when I visited." Another said, "I get offered a cup of tea… well greeted."

Good

Is the service responsive?

Our findings

People received personalised care that aimed to meet their individual needs. People confirmed the daily routines were flexible and they were able to make decisions about the times they got up and went to bed; how and where they spent their day and what activities they participated in.

Before people came into the service the registered manager or senior nurse would undertake a pre-admission assessment and dependency assessment to ensure the service could meet their needs. A care plan was developed where staff had identified a need when people arrived at the service. The registered manager had been working with the nurses to improve the care plans. The registered manager said, "The new documentation is now risk based and person centred." They went on to explain that they had set an action that all of the people's care plans would be in the new style by the end of July 2016. They were well on their way to achieving this." The new care plans assessed people's needs, the goal they wanted to achieve and the interaction and support they required to meet that goal. People's care plans included, continence needs, washing and dressing, mood and behaviours, communication, sleeping, pain, social and spiritual needs. Where people's needs changed, care plans were updated to reflect the changes. Short term care plans had been put into place for unexpected changes to people's health. For example, one person had conjunctivitis and the care plan recorded the actions needed.

People's care plans and risk assessments were reviewed monthly by the nurses and more regularly if people had a change in their needs. There was a formal review carried out six monthly by the designated named nurse which included people and their nominated relatives and friends as appropriate. However, individual arrangements had also been made that where appropriate relatives had a monthly telephone call to keep them informed.

The registered manager had needed to make some difficult decisions about whether the service could some meet people's needs. Where they had identified they were not able to meet these needs, they were working with people and their families to find more appropriate placements for them.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the registered manager or nurses. One person said, "I don't have a problem raising anything here." The provider had a written complaints policy and procedure. Written information was given to people when they came to live at the home, which included how to raise a complaint.

The registered manager had not received any formal complaints. They had recorded 'grumbles' or issues that people or relatives had raised. They had taken action to ensure these grumbles were resolved before they became a complaint.

Activities formed an important part of people's lives. The registered manager had increased the provision of activity staff. There were two designated activity staff who worked at the service over six days a week. A weekly activity programme was on display on the notice board in the main entrance and given to everybody

at the home to make them aware of the activities on offer. The registered manager was working closely with the activity staff to develop people's life histories to have more detail about their likes and dislikes, interests and hobbies.

Activity plans were in place to identify what the objectives were for the activities undertaken and what resources were needed and general information. For example, if the activity was exercises the resources included a parachute and small balls. Records demonstrated that every person in the home had at least a weekly session of meaningful activities. This was either by joining in group activities or, where people chose not to leave their rooms, an activity person would undertake a one to one visit. There were also external entertainers and enablers from age concern and privately arranged who visited the home. On the day of our visit people were enjoying a game of skittles. Everyone who was taking part was engaged in the activity and were happily joining in. One visitor said how their relative particularly enjoyed the sing along sessions.

The service had joined the National Association for Providers of Activities for Older People (NAPA). This is an organisation dedicated to increasing the profile and understanding of the activity needs for older people. The home would benefit because they would get newsletters and up to date guidance which would further improve activities at the home.

The registered manager said they wanted to develop the activities at the home to have more outings and be more involved with the local area. People had already been on an outing to the Exmouth seafront and had ice-creams and cream teas. A visit to the garden centre was scheduled the week of our visit. One member of staff said, "Activities are a lot better, more going out on trips."

Good

Is the service well-led?

Our findings

Staff spoke positively about the registered manager and said they had made significant changes and improvements at the home. The registered manager was in day to day control at the service and said their priority had been to ensure that people were safe and well cared for. They were supported by a deputy manager and nurses who worked alongside staff.

People were positive about the registered manager. Comments included, "Very good, I see her most days when I go up for lunch" and "Nice and chatty, down to earth and approachable. You know where you stand with her." One person gave an example where the registered manager had been very thoughtful and without hesitation had gone and helped their spouse at a difficult time, which they were extremely grateful for." There had been several cards sent to the staff thanking them for arranging a celebration of the Queen's birthday. Two relatives had taken the opportunity to congratulate the registered manager on the changes they had made. Their comments included, "You are making such a difference" and "You make such a difference here keep up the excellent work."

Staff were complimentary about the registered manager and the changes they were making at the home. Comments included, "(The registered manager) is doing ok, made a lot of improvements, changed the paperwork and lots of training but still more to do", "Matron is very good", "Has brought in discipline, up to speed with training, things that hadn't previously been done are now being done. We are all on the same page, so know what is happening" and "(The registered manager) has changed things for the better…never quibbles about anything I request." A professional said they had seen improvements at the home, "Improved documentation, delivery of care and personalisation."

The registered manager was supported by the owners who visited the home at least once a week and held a management meeting to ascertain how things were going. The registered manager said they were supportive and had backed the changes they were making. The provider's said, "All areas are being addressed."

The changes at the service included the location of the daily hand over. One care worker said they found it a lot better as they could hear what was being said and felt included. Their comments included, "Where they do report now is much better. It is a really good report they don't just tell you what happened yesterday."

The registered manager was working with the new house keeping supervisor to put in place a cleaning schedule. A protocol was already in place to guide housekeeping staff what tasks they needed to undertake if there was only one staff member on duty. Housekeeping staff were very positive about the changes being made to their roles. One commented, "There are lots of records but you know what you are doing because you are kept up to date."

Changes had been made to staff roles and responsibilities. The deputy manager had changed their role and had additional time to undertake administration duties which included audits and monitoring records were being completed correctly.

Improvements had been made regarding the completion of people's monitoring charts. New food diaries and fluid charts, cream charts and repositioning charts had been introduced at the home. The registered manager had put in place a checklist in each person's bedroom file for the nurses to check each day. This was to ensure people had received the appropriate care. This included, adequate fluids, adequate diet, been repositioned as required and had topical creams applied as prescribed. The registered manager made us aware at the beginning of the inspection that they and the deputy manager were still working with staff on the completion of people's new monitoring charts. We identified there were still a few gaps on the monitoring charts but were satisfied this was being managed.

People's views and suggestions were taken into account to improve the service. The registered manager recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. They held a well-attended residents and families meeting in June 2016 which was followed by a cream tea where family, friends and relatives were also invited. Meetings were scheduled to be held every three months. At the meeting people were made aware of new staff, updated on changes being made and changes to activities at the home. They were also made aware of plans to look at the meal experience at the home. The registered manager was going to develop a 'food forum group' to meet and look at the menu choices. The registered manager was in the process of sending out questionnaires to people, relatives and stake holders in the service to ascertain their views.

Staff were consulted and involved in decisions making about the service through regular staff meetings. Staff said they felt informed and listened to. The last meeting held in June 2016 discussed uniforms policy, training and reminded staff about people's personal care needs. All staff had a copy of the minutes of the meetings so they were informed. The registered manager had also had a meeting with the nurses at the service. They had discussed supervisions, documentation and the results of medicine audits.

A range of quality monitoring systems were in use which were used to continually review and improve the service. The registered manager had implemented a range of audits to assess service. These included medicines, infection control and fire risk assessments. For example, the registered manager said they had recognised the medicine management at the home had previously not been safe. They had worked with the deputy manager and completed an audit to identify the concerns. They had taken action and addressed the concerns. Audits completed since had demonstrated a significant improvement. They had also arranged for the local pharmacist to visit at the beginning of August 2016 to undertake a full pharmacy audit to ensure they had not missed any areas of concern.

The service worked with other health and social care professionals in line with people's specific needs. The nurses commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP's, speech and language therapist, district nurses, dieticians, community psychiatric nurse and occupational therapists.

Staff had access to a range of policies and procedures to guide their practice which the registered manager had reviewed and updated.

There were accident and incident reporting systems in place at the service. The registered manager reviewed all of the incident and accident forms. They looked to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they took action to find ways further issues could be avoided.

The provider was meeting their legal obligations, such as submitting statutory notifications when required.

For example, when a death or injury to a person occurred. They notified the Care Quality Commission (CQC) as required and provided additional information promptly when requested and working in line with their registration.

The rating was displayed in the main entrance and by the end of the inspection had been added to the provider's website.