Mrs Carol Shutt and Mr Winston Shutt

Milton House Nursing and Residential Home

Inspection report

Marton Road
Gargrave
Skipton
North Yorkshire
BD23 3NN

Tel: 01756748141

Date of inspection visit:
09 May 2017

Date of publication:
18 July 2017

Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 9 May 2017 and was unannounced. We previously visited the service on 19 March 2015 and found that the registered provider met the regulations that we assessed.

Milton House is registered to provide personal and nursing care for up to twenty-two older people. The main part of the house is over 200 years old and this provides the lounges and a small number of bedrooms. There is additional purpose built accommodation providing further bedrooms, dining room and a conservatory lounge. Many areas of the home have views of the surrounding countryside and the river, which runs alongside the property. It is a short drive away from the village centre.

The home had a registered manager in post, as required. A registered manager is a person who has registered with the Care Quality Commission (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.

A system of audits and quality assurance checks were in place. However, these did not always identify areas where improvements were needed, such as when to implement the use of food and fluid monitoring for people at risk of being under nourished. We made a recommendation about this.

People who used the service were not protected against the risks associated with the appropriate administration, use and management of medicines. We identified deficiencies with a significant number of medicine administration records and the way medicines were being managed.

People were supported to maintain good health. Care plans identified people's daily and nightly care needs and information was personalised.

People usually consented to care and support from care workers by verbally agreeing to it. Records included provision for people or their representative to sign their agreement to the care and support they received. Records concerned with people, care workers and the running of the home were maintained and kept securely.

Care workers and nurses received support in their role from the registered provider, registered manager and senior staff team. There was a process for completing and recording supervisions and annual appraisals and we saw this was being reviewed and updated.

Systems and processes were in place that ensured sufficient numbers of suitably trained and competent care workers, including nurses, were on duty to meet and respond to people's needs. Pre-employment checks on employees were completed that helped to minimise the risk of unsuitable people from working with adults who may be at risk.

Care workers confirmed they received induction training when they were new in post and told us that they were happy with the training provided for them. Training for care workers and nurses was organised by the registered manager and a training programme was in place.

We found that people were protected from the risk of avoidable harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Care workers and nurses received training on safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

The registered provider had systems and processes to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence. Systems and processes were in place that helped identify risks associated with the home environment and when providing care and support for people.

Care workers and nurses had received training and understood the requirements of The Mental Capacity Act 2005 and the registered provider and registered manager were following this legislation.

People were supported with a choice of food at meal times and any special food requirements were accommodated. Snacks and hot and cold drinks were available for people throughout the day and this was confirmed to us by people we spoke with.

All staff demonstrated a clear understanding of people's individual needs and preferences. They were caring and treated everyone with dignity and respect. We saw staff clearly communicated with the people they were providing care and support to and gave people the opportunity to comment and agree before providing that support. Staff took a pride in their work and told us they were proud to work at the home.

A programme of activities was on offer to meet both people's individual requests and as a group. People spoke with enthusiasm about what they did with their spare time and it was clear that people could opt in or out of any of the activities as they wished.

People told us they felt well supported and were able to raise any issues with the management team, including the registered provider. We observed a warm and friendly atmosphere throughout the visit. We received very positive comments from everyone we spoke with about the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. You can see what action we have asked the registered provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were sufficient numbers of skilled staff employed that ensured people received the care and attention they needed.

Care workers and nurses received training on safeguarding adults from abuse and understood their responsibilities to report any incidents of abuse to the relevant people.

Risk management plans were in place for the home and enabled people to receive safe care and support without undue restrictions in place.

People were not protected against the risks associated with the unsafe management of medicines.

Is the service effective?

Good

The service was effective.

People were supported to remain healthy and choices of food were available at all meal times. Drinks and snacks were available throughout the day.

Care workers and nurses received appropriate support and training that gave them the skills and knowledge to carry out their roles and meet people's individual needs.

The staff team received supervisions and appraisals on a regular basis.

The registered manager and staff team understood their responsibilities in respect of the Mental Capacity Act 2005 (MCA). People were supported to make choices and decisions.

Is the service caring?

Good

The service was caring.

The feedback we received and our observations confirmed that the staff team cared about the people they were supporting.

People's individual care and support needs were understood by the staff team, and people were encouraged to maintain their independence as much as possible.

People's privacy and dignity was respected by care workers and nurses.

Care records were being reviewed to ensure people who may have had any protected characteristics, under the Equality Act 2010, contained the required information.

Is the service responsive?

Good

The service was responsive.

People were very happy with the care they received and confirmed care workers and nurses were responsive to their individual needs.

People's care plans recorded information about each person's preferences and staff had sufficient detail to know individual needs.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or a complaint.

People were encouraged to participate in activities of their choosing either in groups or on their own.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were shortfalls with regard to the medicines management although in all other areas the service was well-led.

People told us the registered provider and registered manager had a visible presence in the home and were available to them when needed.

The registered provider sought the views of people and acted upon any suggestions where necessary.

Milton House Nursing and Residential 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 April 2017 and was unannounced. This meant that the registered provider and staff did not know we would be visiting.

Two Adult Social Care inspectors carried out the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home and any information that was shared by the local safeguarding authority. We used all of this information to plan the inspection.

On the day of the inspection we spoke with eight people who lived at the home. We spoke with five relatives, two care workers, a nurse, the cook and the registered provider. We spoke briefly to the registered manager, who was on her day off on the day of the inspection, but called in to introduce herself to the inspection team. We also spoke with a visiting district nurse.

We looked at bedrooms (with people's permission) and communal areas of the home and also spent time looking at records. This included the care records for five people who lived at the home, staff recruitment, medicine records, training records and records relating to the management of the home.

We 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 or who preferred not to. We also made general observations throughout the visit of staff interactions, which included, the dining experience, medicines administration process, an activity session in the lounge area and care interactions in the communal lounges and dining area.

Requires Improvement

Is the service safe?

Our findings

As part of this inspection we checked how medicines were managed, stored and given and whether people received their prescribed medicines on time. We saw people's tablets were supplied in blister packs. Blister packs are made up by pharmacies and contain the tablets each individual is prescribed at set times of the day.

Medicine Administration Record (MAR) sheets were used to document the medicines given, and in some cases the times of administration, where these were time critical. All MAR sheets had a photo of the resident to ensure medicines were not given to the wrong person, as well as known allergies and other personal information such as their date of birth recorded. Policies were in place for medicines management.

The provider's medicines policy was not being followed correctly. We looked at the MAR charts. We found omitted signatures where creams, eye drops and medicines had been given but not signed for and hand written MAR charts which had not been verified by two staff to guard against errors.

One medicine had been altered because the frequency of dosage had been increased by the prescribing doctor, by telephone. However, the change in frequency should have been confirmed by the doctor at the next available opportunity, in writing. The standards for medicines management provided by the Nursing and Midwifery Council states, "A verbal order is not acceptable on its own. The fax or email prescription or direction to administer must be stapled to the patient's existing medication chart. This should be followed up by a new prescription signed by the prescriber who sent the fax or email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). In any event, the changes must have been authorised (via text, email or fax) by a registered prescriber before the new dosage is administered. The registered nurse should request the prescriber to confirm and sign changes on the patient's individual medicines administration record (MAR) chart or care plan." The evidence seen during the inspection showed that this had not happened appropriately as per the best practice guidance.

It was also unclear, from the MAR charts at what times time critical medicines were being given. The entries included 'breakfast, lunch, tea and bed' but not the times. Where there should have been a pre-determined gap, the times the medicines were given should be recorded.

The manager confirmed that audits for medicines were completed monthly by the deputy manager. We looked at the audits with the most recent report completed on the 8th April 2017. This indicated and confirmed that all medicines were recorded at the time of administration and that all as required medicine directions were clear and detailed. This did not reflect what had been recorded on the MARS charts that we reviewed. Therefore the audit tool being used and completed was inaccurate and had not picked up the issues we found during our inspection.

We concluded the registered person was not managing medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment .

We reviewed medicine storage. Controlled drugs (medicines which are more liable to misuse and therefore need closer monitoring) were stored securely and appropriately managed.

People we spoke with who lived at the home told us they felt safe at Milton House. One person who used the service said "I feel very safe and comfortable. I know if I need help someone will come when I press my buzzer". Another person told us, "I feel safe because it is a small home, the more personalised the care the safer you feel. We are in safe hands here."

Care workers had received safeguarding training and understood the types of abuse to look out for and how they would escalate their concerns. A care worker said, "Yes, I have had training in safeguarding. We are always discussing people's needs and write up what they have been like after each shift. If I have any concerns I would report them to the manager or owner. I know I can speak to you at CQC (Care Quality Commission) as well."

We saw that people had risk assessments in place for any identified risks. This included risks associated with the use of bed rails, falls, nutrition and moving and handling. However, we noted that one person, who was at risk of being undernourished was not being weighed often enough for the staff to monitor this closely. We discussed this with the registered provider who immediately put this in place.

The registered provider had a health and safety file which included fire safety checks and information on the safe control of substances hazardous to health (COSHH). We saw evidence of portable appliance testing (PAT), gas and electric test certificates, equipment for the moving and handling of people, test certificates and maintenance of water outlets. All of these checks were up to date. People had a personal emergency evacuation plan (PEEP). PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation taking place.

The registered provider had systems to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence. This ensured people were kept safe and any health and safety risks were identified and actioned as needed.

The registered provider and registered manager kept an oversight on staffing numbers and although they did not use a formal dependency tool. Staffing levels were adjusted when people needs increased. Records showed there were sufficient numbers of care workers, and that staffing levels were regularly reviewed. The registered manager told us, "We have enough nurses and carers to meet people's needs and to support them." A care worker told us, "We work as a team and that helps. We have enough staff and morale between staff is really good." Another care worker told us, "Some staff have worked here a lot of years. Some go and come back. It can be busy and hard work but we get it all done between us." People we spoke with told us they thought there were enough skilled staff to deal with their needs. One person said, "I never have to wait if I use my buzzer. They [care workers] will come quickly and then if I can wait they come back a few minutes later. They might already be seeing to someone and I understand that."

The registered provider had a robust recruitment process. Checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These checks help employers make safer recruiting decisions and help to minimise the risk of unsuitable people from working with children and vulnerable adults. We saw nursing staff registration checks were maintained.

Good

Is the service effective?

Our findings

People and relatives we spoke with told us they were more than happy with the staff employed at the home. One relative told us, "The staff are amazing. The whole set up couldn't be better." Another relative told us, "You are made to feel welcome. The staff are very patient. I have never felt they weren't caring." One person commented on the care they received and that staff were, "courteous and can't do enough for you." Another person told us, "We are very lucky here. We are treated like family, you can't ask for more than that."

People usually consented to care and support by verbally agreeing to it. Staff told us they discussed care and support with people on a daily basis and always checked they understood and were happy with the intervention. We found people had been involved in their care plans and where necessary relatives had assisted with the process.

Some of the care plans we looked at included a 'Do Not Attempt Cardiopulmonary Resuscitation, (DNACPR). We saw these were available at the front of peoples care plans with the rationale for this decision. DNACPR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wished to be resuscitated.

Staff told us they were supported in their role. We saw that supervision and appraisals were being carried out and were scheduled for the remainder of the year. This process was also confirmed from our discussions with staff. A care worker told us, "We have one to one meetings with one of the managers. I usually have [name of manager] but when she was off the deputy did it. It's okay, we talk about timekeeping, the job and we are given feedback." We gained the impression that the supervision sessions were beneficial and gave people an opportunity to discuss any issues in a private and confidential way. We were provided with a timetable showing which supervisions had been completed and ones planned for during the year.

All new care workers completed an induction period when they started work at the home. The registered manager had systems in place to make sure all designations of staff received the appropriate training they needed to carry out their roles. We were provided with the records for completed staff training and saw training was planned for the remainder of the year. This included areas of learning the registered provider considered to be compulsory such as moving and handling, safeguarding, dementia awareness and infection control. A care worker told us, "The training is good. The dementia training provides an insight into how people living with dementia feel, which helps us to provide better support to meet their needs." We noted that nurses did not attend refresher training with regard to medicines management. We discussed the benefits of this with the registered provider.

Care workers had received training and understood the principles of The Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked and found the registered provider was working within the principles of the MCA and any conditions on authorisations to deprive a person of their liberty were being met. One person was deprived of their liberty and this had been approved by the authorising body and was recorded correctly.

At lunch time we observed the dining experience. The tables in the dining room were set, including a tablecloth, paper napkins, cutlery, condiments and drinking glasses. We also saw a range of adapted specialist cutlery on some tables. People were seated a short time before the meal was served, meaning they did not have to wait long for their meal as they were served promptly. People could be overheard saying how nice the meal looked and that it was hot. People were each offered a choice of drink and were given plenty of time to finish their first course before the dessert was served. We heard people chatting to each other and discussing their morning, including the activities they had been involved in. People who needed extra support with their meal were provided with appropriate levels of prompting and where necessary staff sat with people to assist. The majority of people attended the dining room for their meal. However, for the few who were in their rooms, they were provided with a tray service. People were asked what they wanted for lunch, if they did not want the main option. We could see different dishes were provided where people had chosen an alternative.

We also observed the tea time service. The home again provided a hot snack, sandwiches and sweet at tea time. People ate their food at their own pace and were not rushed. Staffs, including the cook, were aware of people's likes and dislikes.

We spoke to the cook about the food provision. We were told that all food was home cooked and the cook clearly knew peoples individual likes and dislikes and how to cater for different diets, including enriched foods for people who may have been at risk of being malnourished. When asked about the food they received, people made positive comments. One person said, "The food is very good. They provide traditional cooking and there are lots of choices available." Another person told us, "The food is as good as you would get in a hotel restaurant." People told us there were lots of opportunities to get a hot or cold drink and snacks in between meals.

The kitchen had a food hygiene rating [FHRS] award of 5 by the Local Authority. The rating was awarded in February 2017. Ratings were based on how hygienic and well-managed food preparation areas were on the premises. A food preparation facility is given "FHRS" rating from 0 to 5, 0 being the worst and 5 being the best.

People were supported to maintain good health. Care plans contained detailed information with regard to those people who were at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST'). These were completed monthly and where risks were identified, we saw the person's care and support plan had been updated. This included referrals to the district nursing team or dietician where necessary. The registered provider told us that food and fluid charts had been used in the past for some people where there had been concerns about weight loss or reluctance to eat. However, these had bee reviewed by the GP with staff and they were no longer considered necessary. It was clear that staff handed over information of dietary needs at each shift changes, so that they knew what each person had had to eat and drink. However, we recommended that where people frequently refused food and drinks or thickener was used in drinks that a record is kept of what they have eaten and drunk. The record should also include details of what has been offered, refused or tried.

People were clear about how they could get access to their own GP and that staff in the home would arrange appointments for them.

There were signs on rooms such as the toilets and bathrooms and some minimal directional signage around the home which helped people to move around independently; especially people living with dementia.

The communal areas and rooms were clean and there were no unpleasant odours.

Good

Is the service caring?

Our findings

People we spoke with told us they were extremely well cared for. Comments included; "It is 100% here. It is very, very good." One person told us, "I am kept very comfortable, the staff are keen to keep us happy at all costs. They take an interest in how we are and that means a lot. They make sure our clothes are well washed and ironed and we have our hair done every week" and "The carers and nurses are marvellous. They look after me very well."

We observed the registered provider and staff team interacting with people throughout the day. We saw they were all polite, friendly and sensitive to people's needs. We saw staff knocked on people's doors and asked if people were happy for them to enter. A care worker told us how they respected people's privacy and dignity whilst providing personal care. This was confirmed by one of the people we spoke with. They told us, "I can do most of my own bathing but the carer dries where I can't. I am kept covered and feel staff are sensitive to making sure I don't feel exposed unnecessarily." Relatives told us they thought the staff team encouraged people to be as independent as possible and treated their relatives with dignity and respect.

All the staff during our inspection showed patience and empathy as they supported people with activities and daily living. It was clear that staff, including the registered provider, knew people extremely well. We overheard them talking about recent family events and referring to relatives by name. Care plans also included this information. People were comfortable in the presence of staff and we saw many examples of effective care and support including staff providing support and reassurance appropriately. A care worker told us, "We treat everyone as we would our own families. It is small enough for us to do that easily." Another care worker talked about how important it was to make people feel cherished and valued, they told us, and "I don't like it when someone dies, when we lose one of the service users. But I know we have provided good care. I enjoy getting to know everyone, we have a laugh."

Protected characteristics as defined under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation) were being provided for.

Where people were unable to effectively communicate their needs, we saw the registered provider had included family members in the decision making process. No one at the service was using an advocacy service. However, staff knew who to contact should people require this level of support.
People were supported to make their preferences for end of life care known and these were recorded where they had agreed. We looked at the arrangements in place should people spend the end of their life at Milton House. Arrangements were well planned and suitable equipment was made available. In some instances anticipatory drugs were also made available so that should the person be experiencing pain, for example, staff had the necessary prescribed medicines to use to keep the person pain free and comfortable.

Good

Is the service responsive?

Our findings

The people we spoke with were happy that staff understood their care and support needs and were able to meet them fully. Everyone who lived at the home had a detailed care plan in place. We saw regular reviews were being carried out and people using the service and their relatives were generally involved in these. People who used the service confirmed they knew about their care plans and some confirmed they had been involved in review of the information. This helped to ensure that the care was consistent and met people's changing needs.

We looked at three care plans. The information included details of people's communication, mobility, wound management, social interactions and activities people enjoyed. The information provided good levels of detail so that staff knew and could deal with people's individual preferences and conditions. One example included a care plan regarding communication for a person living with dementia. It outlined that short frequent activities and conversation worked well due to the person losing attention quickly. Another care plan identified how many staff should be assisting when using hoist equipment or supporting a person to stand. A third care plan described how staff should ask the person how they were feeling and if they were confident to weight bear before attempting to stand. Care plans were reviewed regularly, were up to date and signed. External health care providers, such as tissue viability nurses and dieticians were also consulted when necessary to make sure people were receiving the right care at the right time.

One member of staff and one person we spoke with commented on the increasing needs of people moving into the home. One person thought assessments should be more thorough and not done by telephone before people moved in. They thought this resulted in people not being right for the service. Another person thought that demands on staff were increasing and that this impacted on people who were more able. We discussed this with the registered provider. However, we did not see any evidence of this during our visit and this was not the view of relatives we spoke with.

We saw consistent daily entries which showed good communication with other agencies including liaisons with district nurses, GP's and psychiatric teams. The district nurses completed initial nursing assessment, Malnutrition Universal Screening Tool (MUST) assessments, catheter plans, wound management and wrote notes following visits.

A visiting district nurse we spoke with told us they visited most days and always when a request was made by the home. They confirmed they were involved in treatments such as catheter changes, blood tests, nursing assessments and end of life advanced care planning. They told us, "The home is very good and up to date with everything. They pick up on things quickly and ring me straight away."

Staff and people we spoke with confirmed that the GP attended the home regularly and completed reviews.

We saw people were supported to follow their interests and take part in social activities without unnecessary restrictions in place. Some people were able to access the local community independently and continued to do so. Staff and external agencies undertook activities with people and people were

encouraged to join in if they wished. On the morning of the inspection we observed a knitting session and an embroidery group. People were also seen reading books, papers or chatting in small groups. People spoke to us about the activities provided and one person told us they particularly enjoyed the cream teas every month. Other activities included singing entertainers, armchair games and craft workshops.

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. Friends and relatives were encouraged to visit at any time. Relatives said they always felt welcome and had a good relationship with the staff, the registered provider and registered manager. They told us they felt involved in decisions about the health and welfare of their relatives and that communication between the home and themselves was good. A relative told us, "I feel involved and I have never had to ask for anything twice. Staff are on the ball and take action when needed."

Staff told us they encouraged people to raise any concerns or complaints, no matter how small, so that they could deal with it immediately. People who used the service told us they would speak with the provider or registered manager if they wanted to complain. A care worker told us, "If anyone raises a concern with me. I ask them if they want me to report it to the manager. I can sometimes sort something out straight away. If we know about something we can act on it so we make sure people know they can talk to us." The registered provider had a complaints policy and we saw this was available in the statement of purpose folder in the entrance hall. The file included guidance on how to complain and what to expect as a result. There had been no complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

Despite the poor management of the medicines and the lack of up to date monitoring when people were at risk of being malnourished, we judged overall that the service was generally well-led in all other areas. We discussed this shortfall with the registered provider and we were assured that the management of medicines would be closely monitored with immediate effect and safeguards put in place to make sure the records were maintained properly. We recommend the registered provider improve the way medicines are audited and further develop the audits in place.

The service had a registered manager. They were registered as a 'registered manager' by the Care Quality Commission in 2014. The registered manager was supported by a deputy manager.

When we asked staff and people who used the service about management and leadership, everyone told us they thought the home was well managed. People emphasised the fact the registered provider and management team were a visible presence in the home, and that this was a huge positive. They told us, "The bosses are on hand if anything needs sorting out. You don't have to ring a head office somewhere and wait for a response."

A care worker told us, "We can be really busy but it's a nice place to work. The manager is more like a friend. She can be strict but at the right time, when it is needed." They went on to say that the home was well run and that the registered provider was keen to get it right, "because it matters, because she cares." Another member of staff told us, "We all like to get it right, we want the people here to feel valued and loved." Another member of staff said, "It's definitely got better, they are trying to get everybody on board with the paperwork. I think it is working."

We were provided with the audits and quality assurance checks the registered provider and registered manager completed to monitor and improve the way the service was delivered. Audits included care planning, environmental checks, training attendance and views of relatives and people who used the service.

People told us they felt well supported and able to raise issues with the management team. We observed a warm and friendly atmosphere and it was evident that the registered manager, registered provider and deputy manager were keen to review all aspects of the service to see where improvements could be made.

The registered provider had a good understanding of their role and responsibilities. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. Important events include deaths, accidents, incidents or allegations of abuse. We had received all the necessary notifications.

Everybody we spoke with, spoke highly of the registered manager and registered provider. One care worker told us, "The management is very good, I can talk to them about anything, we have meetings and can raise issues. Things get done". Relatives and people who we spoke with told us they felt they could approach the

registered manager and registered provider with any problems they had.

The registered provider had employed a deputy manager and along with the nurses and staff team ensured there was a staffing structure at the home. All care workers we spoke with confirmed they had a clear understanding of their roles and responsibilities and understood when they needed to escalate any concerns or issues.

Despite staff meetings not being held regularly, staff told us they met as a group at training events and as a smaller group at each handover where important information was shared and discussed. Staff told us they thought this was sufficient and that they had enough opportunities to discuss the running of the home and contribute to the introduction of new ideas.

We saw that people's care was person centred and people were empowered to make choices and encouraged to maintain their independence in a safe, managed way. Care workers told us they were supported and kept up to date with changes, not just for people but also in best practice and organisational changes. One care worker told us, "We receive updates about people's needs at our daily hand overs and we record things in the notes in people's files." A nurse told us she was able to keep up to date with her clinical practice and had sight of clinical periodicals and was a member of a professional organisation which provided up to date research and information.

We saw from care plans that the registered provider and staff team worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people.

The quality assurance tool used by the home included sending surveys out to relatives and other people associated with the home, for example health care professionals. This had been done in 2016 and was due to be repeated in 2017.

We saw many thank you cards and letters sent to the home commending staff for the care and attention relatives had received. Some comments included: "They were tended to with such compassion." "They felt safe here and loved." "Can't imagine a nicer place for him to have spent the last couple of years."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not have systems for the proper and safe management of medicines. Regulation 12(2)(g)