Crosscrown Limited

Clifton Court Nursing Home

Inspection report

Lilbourne Road
Clifton-upon-Dunsmore
Rugby
Warwickshire
CV23 0BB

Tel: 01788577032

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20 November 2015

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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 inspected this service on 17 and 20 November 2015. The inspection was unannounced.
The service provides accommodation and personal care for up to 40 older people, some of whom lived with dementia. There were 40 people were living at the home on the day of our inspection.

There was 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.

The provider's policies and procedures minimised risks to people's safety. Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's health care and social needs. The registered manager checked staff's suitability to work in social care during the recruitment process. The registered manager regularly checked the premises and equipment were suitable and maintained to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. People's needs were met effectively because staff received appropriate training and support. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and ensured people or an appropriate representative consented to care and treatment. No one was subject to a DoLS at the time of our inspection.

People were offered meals that were suitable for their individual dietary needs and met their preferences, which minimised risks to their nutrition. People were supported to eat and drink according to their needs and staff understood the importance of helping people to maintain a balanced diet.

People were cared for by kind and compassionate staff who understood them. Staff knew about people's individual preferences for care and their likes and dislikes. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health or when their needs changed.

People and their representatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs, abilities and preferences and care plans

were regularly reviewed.

The provider's vision and values were understood and shared by all staff. The management team demonstrated the skills and quality of leadership to inspire and support staff effectively.

The provider's quality monitoring system included consulting with people, their relatives and other health professionals to ensure planned improvements were focussed on people's experience.

The registered manager made regular quality checks of people's care and health, medicines management, meals and suitability and management of the premises. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence.

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. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. Staff recruitment included checking staff's suitability for the role and there were enough staff to support people's safety. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for by staff who had relevant training, skills and management support. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were supported to maintain good health and to access other healthcare services when they needed them.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by supporting them to lead their lives in the way they wanted.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning and reviewing how they were cared for and supported. Staff understood people's preferences, likes and dislikes. Staff supported and encouraged people to take an interest in their surroundings and their community. The provider's complaints policy and procedure were accessible and made known to people and relatives.

Is the service well-led?

Good

The service was well led. People, their relatives and staff were encouraged to share their opinions about the quality of the service which ensured planned improvements focused on

people's experiences. The provider and registered manager operated an open culture that empowered and inspired staff. The provider's quality monitoring system included checking people received an effective, good quality service that met their needs

Clifton 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 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 17 and 20 November 2015 and was unannounced. The inspection was undertaken by an inspector and a specialist advisor. Our specialist advisor was a person who is a professionally qualified and works as a registered nurse.

We had not asked the provider to complete a provider information return (PIR), because they had already supplied a PIR when we completed our first ratings inspection in November 2014. However, the registered manager was able to give us all the information we requested during the inspection. The PIR 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.

We reviewed the information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 12 people who lived at the home, one relative and an external health professional from the local clinical commissioning group. We spoke with the provider, the registered manager, two nurses, five care staff and one cook. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff. One person said, "I like it here. I feel safe." We saw people were relaxed with staff and spoke confidently with them.

Staff knew and understood their responsibilities to keep people safe and protect them from harm. Care staff told us they had trained in safeguarding and felt encouraged by the whistleblowing policy to raise any concerns. A member of care staff told us, "I have seen all the staff in practice and I have never had any concerns." Staff knew the signs of abuse, and were confident the registered manager would refer any concerns to the safeguarding authority. A member of care staff told us, "We have been trained in safeguarding but we all really care about these people and nobody would let anything happen to them and not take action." Another member of staff said, "Abuse might be neglect or saying something hurtful. I would report to the senior or team leader and I know where to find the contact number for the safeguarding team." The manager had not needed to make any referrals to the local safeguarding team.

The provider's policy for managing risks included assessments of people's individual risks. The manager assessed risks to people's health and wellbeing. Where risks were identified, the care plans described how staff should minimise the identified risks. For example, the manager checked risks to people's mobility, nutrition, skin and communication. The care plans described the equipment needed and the actions staff should take to support people safely. A member of care staff told us, "We are all trained in risk assessment and we know how important this is to ensure that people are safe."

A member of care staff told us, "People have a choice. If their choice is a risk, we negotiate and remind them of the risks." One person's care plan identified they were prone to skin damage because they could not move independently. To reduce this risk, the care plan instructed staff to apply creams to the identified areas of skin and to support the person to change position every two hours. Staff signed a daily record to show they had taken the prescribed actions.

The provider completed risk assessments for the premises and equipment and took action to minimise the risks. Risk assessments included identifying potential hazards and the severity and likelihood of the hazards causing harm. The provider engaged professional experts to check and maintain the safety of essential supplies, such as water, gas, fire safety and the lift. All staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency.

Staff understood the actions they needed to take in an emergency. The registered manager told us everyone who lived at the home had a personal emergency evacuation plan and a staff had been trained in the use of a 'stair slide' so they knew how to support people to evacuate the building in an emergency. Staff fire training included new staff observing the weekly fire checks undertaken by the maintenance person to identify alarms, exits and fire safety measures. A member of staff told us, "We test the fire bell weekly. We practice the fire drill with people who are mobile. If there was a real fire we couldn't use the lift." The member of staff demonstrated they had understood their training by pointing towards the fire exits while they were talking to us about the actions they would take in an emergency.,

Staff told us they were trained in safe moving and handling techniques as soon as they started working at the home and the equipment they needed was always available. Records showed equipment was regularly checked and repairs and replacements were obtained promptly when needed. A member of care staff told us, "If I see something is broken, the bed or anything, I tell [Name] and write it down. He fixes it quickly and the book is checked by the manager."

Staff recorded incidents, accidents and falls in people's daily records and kept an on-going log for analysis. Records showed the manager analysed each person's falls, the location, time, and outcome to identify patterns or trends. Records showed actions had been taken to minimise the risks of a re-occurrence for each individual and there were no identifiable patterns across the home in the previous six months. This gave the registered manager assurance the individual and premises risk assessments were effective.

There were enough staff on duty to meet people's needs. The registered manager had identified people's needs and abilities and given them a dependency 'score', which was used to calculate the total number of hours of care needed. The registered manager planned the staff rota to ensure there were enough staff on duty to meet all the identified needs. People who spent time in their own rooms told us staff always responded promptly when they rang the call bell, whatever time of day or day of the week. One person said, "Staff come straight away when you ring the bell to see what you want." During our inspection we saw there were enough staff to meet people's health and social care needs. Staff told us agency staff were rarely used and staff turnover was low, which ensured people received care consistently from staff they were familiar with.

The registered manager checked staff were of good character before they started working at the home. They showed us records of the checks they made of staff's suitability for the role. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. A member of staff told us they had been asked to supply this information when they started working at the home. The registered manager that checked newly recruited nurses' were registered with the Nursing and Midwifery Council, for assurance they maintained their professional skills and knowledge. When agency nurses were needed to cover unplanned absences, the agency sent a personal profile for the nurse in advance, which included confirmation they had made all the appropriate checks.

People's medicines were managed and administered safely. Staff rotas showed there were always at least two staff trained in medicines administration for each shift. Medicines were delivered by the pharmacy with a medicines administration record (MAR). This record was marked with the name of the person, the dosage, the frequency and the time of day they should be administered, and were kept in a locked cabinet. Senior staff regularly audited the medicines to make sure they were managed safely. They checked the amount of medicine available matched the amount received and administered, and that only trained staff administered them.

The nurse understood the importance of good communication with people when they administered their medicines. When people exercised their right to decline to take medicine, the nurse respected their decisions and recorded this appropriately. The three MARs we looked at were signed and up to date and showed people's medicines were administered in accordance with their prescriptions and decisions. One person told us they managed their own medicines. They told us, "The manager agreed I am capable and it saves me waiting. The nurse checks and records what I take." Records showed a risk assessment had been completed for the risks associated with the person self-administering their medicines, which the person had signed.

Good

Is the service effective?

Our findings

People told us the staff supported them according to their needs and abilities. People told us, "They are great with me" and "They know what they are about when they come to help you." We heard one person say to a member of care staff, "You are looking after me very well, so don't worry."

People told us they received care from staff who had the skills and knowledge to meet their needs effectively. Care staff told us they felt well prepared and confident in their role, because they had shadowed experienced staff, read the care plans and received training which enabled them to meet people's needs training. A member of care staff told us, "You have to read the care plans to get to know about them, their illnesses and preferences. You have to sign to show you have read them." Another member of staff said, "New staff need to watch and follow to learn about people. You couldn't know about the needs of people (otherwise)."

Care staff told us their training was effective. One member of care staff told us they understood how people might feel about being supported to move because their training included being, "Sat in a sling and hoist." Staff understood that people might feel a loss of control and anxiety about being lifted into the air. The registered manager told us that all staff had nationally recognised qualifications in health and social care and new staff were enrolled on the training programme within two weeks of starting work.

The training provider, who was on site during our inspection, told us they offered courses that staff completed over eight weeks, which included written assessments, in, for example, equality and diversity, healthy eating and food hygiene, safeguarding and understanding dementia care. Staff told us they could choose to train in any of the subjects available as well as completing the provider's programme of training. One experienced member of care staff had chosen to complete the Care Certificate as a refresher course.

The registered manager ensured staff were supported to be effective in practice with regular one to one supervision meetings and by observing their practice. Care staff told us they felt supported by the senior care staff and manager. A member of care staff told us, "[Manager's name] is really good. She makes loads of time for one-to-one sessions and you can contact her anytime to discuss anything that worries you or you need help with. She is really good."

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 whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were

being met.

The registered manager explained their responsibilities under the Act. These included making an assessment of the person's capacity to understand and consent to restrictions to their liberty for their safety, and, if the person did not have capacity to understand and consent, then they needed to apply to a Supervisory Body. The Supervisory Body provides the authority to deprive the person of their liberty. No one was being deprived of their liberty at the time of our inspection, so no DoLS applications had been made.

Care staff understood the principles of the MCA meant people should be supported to make their own decisions. We saw staff asked people how they wanted to be cared for and supported before they provided care. People told us staff encouraged and supported them to make their own decisions about what time they got up and went to bed and how they spent their day. Staff understood that decisions might need to be taken in the person's best interests if the person did not understand the risks relating to their decision.

A nurse told us one person declined to take their medicines, and their GP had been involved in making a 'best interest' decision about their use of medicines. Records showed the manager held best interest meetings when needed. One person was supported by an advocate and the mental health team for decision making. An advocate is an independent person who is appointed to support a person to make and communicate their decisions. Another person's care plan contained a consent form signed by their family representative after a best interest meeting with the manager, which showed the manager worked within the requirements of the Act.

People were supported to eat and drink according to their needs and preferences. People told us the food was very good and they always had a choice. They told us, "The food is always lovely here they do very well considering how many people they have to feed" and "The food is very nice here and the choice is good too." During the morning we saw a member of care staff took the day's menu around and asked everyone individually what they would like for lunch. One person told us, "You get a choice and staff remember what you like." The cook showed us the week's menu plan, which offered nutritionally balanced meals based on people's preferences. They told us, "I am planning to have a meeting with people to refresh the winter menu" and "There is no budget. You buy want you like, but there is little wastage."

At lunch time we saw people were supported to move to the dining room to eat together and make lunch a sociable event. The dining tables were laid with cloths, cutlery, napkins and condiments and everyone sat down together. The meal was unhurried and staff gave people time to savour and enjoy their meals, and the meals looked and smelled appetising. People who ate in their own rooms, either by choice or because they were too unwell to leave their room, told us the food was just as good as when they ate in the dining room. One person told us, "I usually go down for meals, but I didn't want to while I was ill. Staff bring food up. It is hot when they bring it" and "They did soup for me when I was ill."

The registered manager assessed risks to people's nutrition. People's care plans included the identified risks, actions to minimise risks and people's food likes, dislikes and preferences. The cook understood people's dietary needs, which were recorded on a noticeboard in the kitchen. The cook told us the nurse updated the board when they assessed people's dietary needs and risks. The board listed people's allergies and specific dietary requirements, such as sugar free, vegetarian or soft or pureed meals. At lunch time we saw people who needed specialist diets, for example, soft foods or diabetic meals, were offered appropriate meals. For people who were identified as at risk of poor nutrition, care staff recorded how much they ate and drank, to ensure they knew when to seek specialist nutritional advice and to monitor the impact of following the advice.

People told us they were supported to maintain their health. People told us, "I see the chiropodist" and "I have to go to the GP surgery again and [Name of manager] said staff will take me this time." People's daily records showed other professionals, such as GPs, speech and language therapists, dieticians and tissue viability nurses were involved in people's care when needed. People's treatment records included regular weight and blood pressure checks and detailed treatment plans. The clinical commissioning group lead nurse told us that nurses were good at asking for guidance and taking advice, which resulted in improvements in people's health.

The shift lead nurse shared information about people's health during the handover meeting at the beginning of each shift to ensure all staff knew signs to look out for if people's health declined. The nurse talked about each person in turn and shared information about their appetites and food supplements, damaged skin, treatment and repositioning timings, illnesses, GP visits and advice and any planned hospital visits. A member of care staff told us, "The handover meeting is in depth and there is enough information to know what is going on. It is written down too so we can refer to it."

Good

Is the service caring?

Our findings

People told us they were happy living at the home. They told us the staff were kind and thoughtful. People said, "The staff are all very nice. I know most of them" and "They are always polite and listen to us. They are very nice we like all of them really."

People told us when they first moved in to the home, they were involved in discussing and agreeing how they were cared for and supported. People's care plans included their life history, religion, culture, family relationships and significant events. Care staff told us this helped them to understand the person and to get to know them as an individual and to understand their anxieties and behaviours. Care staff told us, "People's hobbies and interests are in their care plans, but that depends on being told" and "We have time in the evenings to share stories."

Care plans included a dementia assessment which recorded the person's current values, beliefs and feelings. This ensured that people were cared for and supported according to how they felt currently, rather than how they had felt at an earlier time in their life. Care staff told us, "It's about getting to know them. Some people can tell you" and "We chat while giving personal care – that's why it takes so long." Staff understood people who were not always able to explain their needs and supported them with kindness and compassion. Staff knew one person who was too unwell to get up, missed seeing the cat who lived downstairs at the home. The person showed us an imitation cat on their bed and told us staff made sure it was always within reach, because, "The cat is for me to keep calm." The person knew it was an imitation cat, but they told us they liked stroking the fur.

The registered manager promoted people's independence by identifying the level of involvement they wanted in their care and in running the home. Care plans included 'factors to maximise contentment.' One person told us attending meetings made them feel involved in how their home was run and people's suggestions were acted on. Records showed people were invited to attend meetings to talk about things that were important to them. People discussed the meals, maintenance of the home, staff's responsibilities for laundry and actions to be taken in the event of an emergency. People had made suggestions for changes to the meals and for events and activities they would like organised. We heard a member of care staff remind one person about the 'gentlemen's afternoon', which was an event that was suggested at the most recent meeting.

Staff were observant and proactive in supporting people to maintain their dignity. For example, when a member of staff noticed one person spilled their drink on their clothes they encouraged and supported them to return to their bedroom to change their clothes straight away. A member of care staff told us, "Dignity and respect means keep it private. We shut doors and close the curtains." Care staff checked that people wanted to speak with us before we were invited into their rooms to speak privately with them. One person told us, "They all respect me. They are great with me." Staff kept people's personal information and records in the office where only staff could access them.

We saw relatives were welcome to visit whenever they liked. There was a continuous flow of visitors during

our two day inspection. Two people told us they liked sitting in the reception area because they liked to see 'what was going on', just as they would know what was going on in their own home.

Good

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted. They told us care staff understood them and knew what they liked and disliked. People told us, "They know me. They understand my preferences" and, "I have made friends here." We saw staff were proactive and anticipated people's needs. For example, a member of care staff had already found a foot stool for one person before they had finished asking.

One person told us they appreciated staff's support because, "Staff encourage us to do things which we sometimes can't always be bothered with" and "They will help us change our bed and things which we probably would not do ourselves." People told us they were supported to do the things they enjoyed such as reading quietly in their own room, listening to the radio, playing dominoes and joining in quizzes. One person told us staff understood they liked to do different things at different times of day, such as being in the lounge in the morning, but spending time in their own room in the afternoon, because they could choose which programme to watch without worrying about what other people wanted.

One person told us there was something to do every day if they wanted to join in, such as flower arranging, bingo, exercise sessions and arts and crafts on Thursday and Saturday. The provider employed two support staff whose sole purpose was to ensure there were opportunities for people to engage in hobbies and pastimes that interested them, either as a group or individually. During our inspection we saw people engaged in number bingo, art therapy and a group game, which caused lots of smiles and some laughter.

People's craft work was arranged along the window sill in the dining room which encouraged them to take pride in their achievements. Photos of people engaged in various events and activities were displayed in the hallway, which reminded people of enjoyable events and reassured relatives that their relations lived a full and satisfying life at the home.

People had a meeting with their nominated member of care staff, described as a keyworker, every week to discuss their care and support and future needs. Care staff told us they shared information at the shift handover, which was detailed enough to let them know whether there were any changes in their needs and abilities. Records showed people's care plans were regularly reviewed and changed when people's needs changed.

The provider's complaints policy and procedure was explained in a poster in the hallway for anyone to read and in the service user guide in each bedroom. People told us they did not have any complaints about the service. One person told us, "There is nothing to complain about here in my view." The registered manager showed us the one complaint they had received in the previous 12 months. They had followed the provider's policy and procedure in responding to the complaint and undertaken a full investigation. The registered manager's letter in response to the complaint addressed each issue in full, but did not substantiate the complaint. The detailed care records that staff kept supported the registered manager's response.

Good

Is the service well-led?

Our findings

The people we spoke with were happy with the quality of the service. People told us, "They do very well for us" and "It's like living in a hotel, washing done, cleaning done, cooking done for you. You just put your clothes out if they want washing." The registered manager had displayed thank you cards from people's relatives in the hallway where anyone could read them, and which ensured staff were aware they were appreciated.

The provider's quality assurance system included an annual survey of people who lived at the home, their relatives and visiting health professionals. The results of the most recent survey, which showed 94% of respondents were satisfied with the service, were posted in the front hall where everyone could read them. An accompanying letter included the positive and negative comments people made, which demonstrated the open culture of the service. People had commented, "The number of staff has noticeably improved" and "You are doing a brilliant job." Two health professionals had commented positively on the quality of the service. The registered manager told us actions they had taken to improve people's satisfaction included installing a wireless free internet connection and additional television capability for two people who had specifically asked for that facility.

The registered manager understood the responsibilities of their registration and notified us of the important events as required by the Regulations. They were proactive at keeping us informed of issues or concerns raised by relatives and other health professionals, in accordance with the provider's policy of openness and transparency. A copy of our previous inspection report and the ratings were displayed in the reception area for all to see. The previous rating was Requires improvements in Responsive, but overall Good.

Staff told us they appreciated the provider's open culture of management and felt empowered by it. They told us the manager led by example and championed improvements within the home. Staff told us, "[Name of manager] is always available day or night she will never turn you away even when she is really busy" and "I love [Name of manager], she really cares about this place and she really cares about us too."

A member of staff told us, "It is a nice environment and nice people to work with." Staff understood their responsibilities and were supported to improve their practice and professional development through regular meetings with the registered manager. One member of staff told us, "It feels like everyone is pulling in the same direction, it feels nice. The manager has spoken to me about making my role bigger and taking more responsibility and that makes me feel as though I am wanted here."

Staff told us everyone who worked at the home had the same goal, which was to support people to live the lives they wanted. One member of staff told us, "The company puts the people first it's not all about the money with them." All the staff understood the provider's vision and values, "Respect privacy, dignity, care, love ... as for our own family." We saw staff upheld these values in their interactions with people by delivering care centred on the individual. One member of care staff told us, "I watch and think about how my own grandmother might feel." Another member of care staff said, "My work is the most important thing in my life at the moment I absolutely love it here, I love my job and I love the people."

The provider's quality monitoring system included regular checks of staff's practice, people's care plans, medicines administration, the premises and equipment. Checks of staff's practice involved observing how they carried out their duties and how they engaged with people and with each other. The registered manager shared their observations at team meetings to make sure staff understood how they could improve the quality of the service. Records of the most recent meeting showed they discussed changes to shift patterns and rotas, confirmation of roles and responsibilities in newly issued job descriptions and reminders about fire safety measures.

The registered manager told us the lead nurse for the local clinical commissioning group (CCG) had been supporting them to monitor the quality of the nurses' practice while they had been recruiting additional nurses. The lead nurse for the CCG told us they had visited the home every month and the quality of nursing care was good. The lead nurse for the CCG was confident people received the treatment they needed to improve their specific medical conditions.

The registered manager told us they proposed appointing nurses to lead on different specialities, instead of appointing one lead nurse. This would ensure shared responsibility for overall nursing care, rather than being reliant on one person, and would enable nurses to develop a specialism. The registered manager told us they would discuss the plan with the nurses once all the newly recruited nurses had completed their induction to the home.

Staff knew about and understood the purpose of the quality checks. Care staff told us the nurse, senior care staff and team leader checked the daily records, reviewed care plans and made changes to them when needed. The manager checked all the relevant information was included and that the care plans were regularly reviewed and updated when people's needs changed. One member of care staff told us, "[Name of manager] checks everything. She checks how quickly we answer the bell and she checks the (maintenance) book." Records showed maintenance and equipment issues were resolved promptly, frequently on the same day they were reported.

The registered manager told us recent challenges had been in recruiting appropriate staff. They told us they had recently recruited three nurses and two care staff, which would give them a larger pool of experience and increased resources to cover unplanned staff absences. They told us, "I supervise nurses and hold nurse meetings. We talk about each person's needs and end of life care. Now we are accredited with Gold Standards framework, we can fast track admissions for end of life care. We have to prepare an advanced care plan, which the health commission reviews every six months."

The registered manager told us their plans to improve the quality of the service included a plan to introduce dementia care mapping (DCM). DCM is an observational tool that looks at the care of people living with dementia from the viewpoint of the person with dementia. The results of the observations assist with developing person-centred care from the person's point of view to improve the person's sense of wellbeing. Two nurses had already attended a specialist course in dementia care to ensure successful implementation of this plan.