Pine View Care Homes Ltd

Royal Manor Nursing Home

Inspection report

346 Uttoxeter New Road
Derby
DE22 3HS
Tel: 0133 234 0100
Website:

Date of inspection visit: 13 April 2015
Date of publication: 03/09/2015

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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 13 April 2015 and was unannounced.

Royal Manor Nursing Home is a care home that provides residential and nursing care for up to 25 people. The home specialises in caring for older people including those with physical disabilities, people living with dementia or those who require end of life care. At the time of our inspection there were 24 people in residence.

A registered manager was 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 registered provider was also the registered manager at this service.

People's care and support needs had been assessed and were used in the development of their plan of care. Staff had a good understanding of people's care and support needs. People told us they were satisfied with the care provided and that this was delivered in the ways that they preferred, in order to meet their needs. However, some

Summary of findings

care plans did not reflect the care being provided. Staff understood the importance of enabling people to do as much for themselves as possible to maintain their skills and promote their independence.

People were involved in making decisions about their care and we saw that good relationships had built between people and the staff team. Staff were caring and attentive and people were treated with dignity and respect.

Staff had a good understanding of how to keep people safe. Most people told us that they felt safe and for the small number of people who told us that they did not always feel safe, the provider was taking actions to address the issues raised. Risks associated with people's care had been assessed and we saw that care was provided in a safe way.

There were sufficient numbers of staff available to support people at the times they needed them. The provider had safe staff recruitment procedures and staff received relevant training and support so they could meet people's needs.

Most people received their medicines as prescribed. Medicines were ordered, stored and disposed of safely. However improvements in record keeping were needed in relation to the management of people's medicines, including 'as required' medicines.

People were provided with a choice of what to eat and drink and people's individual nutritional needs were well supported. People enjoyed the food provided. Where changes in people's health were identified, they were referred promptly to other healthcare professionals.

The provider had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) so that people who lacked capacity to make decisions could be appropriately supported. Staff understood that they needed to gain people's consent before delivering care.

People were supported to take part in social activities. The provider has accessed training which is planned for staff to ensure that the range of activities provided meet people's individual interests, needs and preferences.

People told us that the provider was approachable and that they had opportunities to make suggestions and raise concerns. People told us they felt enabled to raise a complaint that they would be listened to and it would be acted on. However a system for recording other issues people may raise was not in place.

The management team were supportive to staff and worked with them to provide good standards of care. There were effective management systems to monitor and improve the quality of service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff knew how to protect and safeguard people from abuse and other risks relating to their care and treatment needs.

Staffing levels ensured that staff were available at the time that people needed them. Staff recruitment practices reduced the risk of unsuitable staff being employed at the service.

Most people told us that they received their medicines as prescribed however improvements in record keeping were needed in relation to the management of people's medicines.

Is the service effective?

Good

The service was effective.

People were cared for by staff that had received on-going training and support in order to meet their individual needs.

Staff gave people choices and understood people's rights in relation to the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

People received a choice of food and drink according to their needs and had access to health and social care professionals when required.

Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring. People were treated with kindness, compassion and their dignity was respected. People were involved in making decisions about their care.

We saw positive interactions and relationships between people using the service and staff and visitors were welcomed to the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People told us that they received care and support that met their individual needs and preferences. Staff had a good understanding of this, however people's care plans did not always reflect the care provided by staff.

People had opportunities to share their experiences about the service and knew how to make a complaint if needed. However a system for recording other issues people may raise was not in place.

Summary of findings

People were supported to take part in social activities. The provider has accessed training which is planned for staff to ensure that the range of activities provided meet people's individual interests, needs and preferences.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who was accessible and responsive to requests and concerns. They provided good support to their staff team, and staff provided good support to people

People had opportunities to put forward suggestions about the service they received and actions were taken in response to feedback received.

There were effective systems in place to assess and monitor the quality and safety of care provided.

Royal Manor 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.

This inspection took place on 13 April 2015 and was unannounced.

The inspection team consisted of two inspectors, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.' The expert-by-experience has experience in care of the elderly and dementia care. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had returned the PIR.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information received sent to us from people who used the service or the relatives of people who used the service and health and social care professionals.

We contacted health care professionals and commissioners for health and social care, responsible for funding some of the people that live at the home and asked them for their views about the service.

During the inspection visit we spoke with 12 people who used the service. We spoke with three relatives who were visiting their family member. 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.

We spoke with the provider [who is also the registered manager], one nurse, four care staff and the cook.

We looked in detail at the care and support four people received, which included looking at their plans of care.

Requires improvement

Is the service safe?

Our findings

Most of the people we spoke with told us that they felt safe at the service and that staff cared for them safely. One person told us "The staff are caring, I get on well with them," another told us "I've not been here very long but I do feel safe here. If I was worried I would be happy to talk to the staff about my worries." However another person said "I don't feel safe here. One of the residents walks round at night and they come in my room – they frighten me a bit." We informed the provider and staff team about this, and the staff confirmed the person did not want their bedroom door locked at night. They also said they would speak to the person concerned to see if there was anything else they could do to make them feel safer at night. Another person said, "There is a man who walks around during the day, he swears and puts his fists up to me; he scares me." Though we did not observe this behaviour during our inspection, we spoke with staff who were aware that, on occasions this person exhibited this type of behaviour. Later in the day we saw that staff used effective techniques to engage the person in conversation and other practices to deflect this behaviour. Information for staff about how to manage the risks associated with this person's behaviour was also accurately detailed in the person's care plan.

We spoke with four relatives who felt their family members' were safe and well cared for.

Staff we spoke with had a good understanding of the types of abuse, and their responsibilities to act on any concerns about people's safety. One member of staff said, "If I saw any abuse I wouldn't hesitate to report it. I have not had to make a safeguarding referral here but I'm more than capable to." Staff were also aware about the provider's whistle blowing policy and were confident to use it if their concerns were not acted on. Staff told us that they had received training in recognising abuse and safeguarding procedures. We viewed the training matrix which confirmed this.

People using the service and their relatives confirmed they were involved in discussions and decisions about how risks were managed. We noted that a number of specialist beds had been provided for people's comfort. These were a hospital type 'profiling bed', which meant they could be raised or lowered to assist the person being able to get in and out of bed, to promote their independence whilst maintaining their safety. The beds were also an appropriate type for use with bed rails, which, following assessment, protected people from falling out of bed. We saw people were enabled to move around the service safely using walking aids, fixed handrails and support from staff as needed.

People could be assured that steps had been taken to maintain their safety. All the bedrooms had an appropriate door lock and had secure storage to keep their valuables safe.

We saw a range of equipment used to maintain people's independence and safety such as walking aids, hoists and wheelchairs which were stored safely and were accessible when required. Staff were aware of how to use this equipment safely. We saw people being safely hoisted in the lounge before being transferred to other areas of the home. We saw staff using the footrests on wheelchairs appropriately, which meant that people were transferred safely.

We looked at people's care plans which showed that staff had considered the potential risks associated with their care and support needs. Plans had been put in place to manage these risks. We saw a variety of risk assessments had been undertaken and were available within care plans. For example these covered risks of falls, use of bed rails, moving and handling and pressure sore risk assessments. We also saw that care plans and risk assessments were reviewed on a monthly basis to ensure that care provided met people's individual needs.

Staff were able to describe how they supported people safely. This was consistent with individual plans of care, as well as staff being able to explain safety in general terms. Records showed that advice was sought from health care professionals in relation to risks associated with people's care and risk management plans were reviewed regularly.

Regular fire safety checks were carried out, and each person had an evacuation plan that detailed how to support the person in the event of an emergency. Staff used the provider's procedures for reporting incidents, accidents and injuries. The provider notified us of incidents and significant events that affected people's health and safety, which included the actions taken. The provider was aware of other relevant authorities that require to be informed if a health and safety issue came to light.

People told us that there was enough staff on duty to meet their individual needs. One person told us, "There are

Requires improvement

Is the service safe?

plenty of staff." Another said, "There are enough staff here." A member of staff told us that if they needed to contact the provider and he was not at the home, they would just call him. The member of staff added, "If we need [The provider] at any other times we just pick up the phone." We also noted a staffing tool was in place, this meant that the staffing levels were set in accordance with the dependency levels of people using the service at that time. The provider confirmed that if people's needs changed staffing levels would be adjusted to meet those needs.

Our observations confirmed that there was sufficient staff available to meet people's needs. Staff responded in a timely manner to people's needs, requests for assistance and reassured people who became anxious or upset due to their health conditions. We noted that though there was not a member of staff in each of the lounges and other communal areas of the home all the time, staff did respond to people's needs in a timely fashion.

Staff we spoke with told us there was enough staff on duty. One member of staff said, "There is enough time to undertake the nursing duties with the current occupancy. I trust the staff team so I can delegate any non - nursing duties to them." The staff on duty reflected the staff rota and the provider told us that he provided on-call support.

People's safety was supported by the provider's recruitment practices. Staff described the recruitment process and told us that relevant checks were carried out on their suitability to work with people. We looked at staff recruitment records which included the nurses and found relevant pre-employment checks had been carried out before staff worked unsupervised. A further check was undertaken on an annual basis to ascertain if the nurses were registered with the appropriate professional body.

People told us that they received their medicines when they should. However, one person told us that the application of their pain relieving gel was sporadic. They told us "Sometimes they put it on sometimes they don't." We viewed the medication administration records also known as [MAR] charts. We looked at a number of the records from the previous month's administration. This was because the day we visited was the first day of the new administration period. We did not see any missed signatures, which might indicate the medication had not been applied. However we did note that the pain relieving gel had not been transferred onto the MAR chart of the new administration period.

We observed that the nurse administer medicines, though completed the medicines records at the end of the process. This meant that there was a risk that an accurate record of medicines administered would not be kept. We asked the provider to send us their policy and procedure for medicine administration, but he did not do so. That meant we could not ascertain if this was an accepted practice in the home, and had been adequately risk assessed. The training records confirmed that nurses were trained in medicines management and their competency had been assessed. However it was not clear whether the poor practice we observed had been identified during competency checks.

The nurse told us that it had taken longer than usual to undertake the medication round on the day of our inspection because it was the first day of the administration 'month' and so took longer. We noted there were no protocols for medicines administered 'as and when required', otherwise known as 'PRN' medicines. This meant that there were no instructions for staff to follow about what individual circumstances 'as required' medicines were to be given.

We noted that, for one person a 'homely remedy' [general stock held at by the home] for pain relief was written onto the person's MAR chart. The reasons for the administration had not been explained on the back of the MAR chart. The nurse on duty explained they had requested an individual prescription for the person for the medicine to be commenced on a 'PRN' basis. We saw the fax request for this and it was dated on the day of our visit. During our inspection a PRN protocol was written about this for the person.

Medicines were stored safely and at the correct temperatures so that they remained effective. We saw there was a record of storage temperatures maintained on a daily basis. Staff were aware of what to do if the storage temperatures were not within those set by good practise. All medicines were administered by the nurses.

Good

Is the service effective?

Our findings

People told us that they found that staff were skilled and experienced in meeting their needs. Staff had received induction training and additional training for their job role. Staff involved in the delivery of care and treatment received practical training in the safe use of equipment and their competency had been assessed by a person appropriate to do so. One of the nurses told us they had applied for a phlebotomy course. They told us, "We have requested that I undertake the course so that I can take blood off people who live here as they know me and I know the best times of the day to do this." We noted the person was on a waiting list awaiting the training provider to give them a start date. The nurse also explained the provider was good on sourcing training. We observed two staff used a hoist to transfer a person safely. We noted the staff checked that the individual was comfortable throughout this manoeuvre and took care to maintain their dignity. That meant that staff had put their training into practice correctly.

One of the care staff said, "We have refresher training on a regular basis, which keeps you up to date with changes." A registered mental health nurse told us that they worked well with the clinical lead who was a registered general nurse. They told us that they had different clinical lead responsibilities. They went on to say, "The clinical lead and I work well together and shared [our] knowledge" and added, "we are a good mix together, a good knowledge mix."

The nurse went on to explain, "We [nurses] assess each other's medication competencies." She said that this was useful and she had learnt by doing this. The nurse also said she had a good knowledge of dementia and that she had recently undertaken updated training about dementia and person centred care.

We spoke with staff who were knowledgeable about people's needs and how people liked to be supported. We saw that where any changes to people's care and support needs were identified, these were communicated between the staff team at the 'handover meetings' and with other staff involved in the service received such as the cook.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager and staff had a good understanding of MCA and DoLS and their role to protect the rights of people using the service. Staff knew the procedure to follow where they suspected a person's liberty could be deprived. Staff told us that people had various levels of capacity and understanding, which varied throughout the day. We saw how staff supported people to make decisions about their daily life, and examples of these were in the care plans we looked at. We noted that one of the nurses had recently completed an MCA course.

We saw where a person had an 'advance decision' in place. That is where a person had made a decision about their care with regards to emergency treatment and resuscitation. We spoke with staff who were aware of how to protect people's decisions so that they could be assured that staff would act in accordance with their wishes.

People told us that they were given choices about the care they received. We saw that staff sought people's consent before assisting them with care, this was done with a conversation before the task began. We saw from people's care plans where mental capacity assessments had been undertaken. That was because staff used their knowledge and training to ensure people had the capacity to consent. The assessment we saw was detailed enough to confirm the person had varying capacity. That meant the person was able to make an informed choice of their meals, but was unable to undertake their own personal care.

People told us they had sufficient amounts to eat and drink. One person told us, "We have two brilliant cooks." Another person told us, "For breakfast I have had beans on toast and I have eaten it all up. The food here is brilliant." There was a choice of meals on most days of the week, although alternatives were always available and refreshments and snacks were offered between meals. One person said, "At dinner we usually have two choices except for Sunday when we have a Sunday roast." "Yesterday I had chicken, if I didn't like the option they would get me something else". "Another person said, "The food is good actually, is well prepared and it's fresh." Throughout the inspection we saw people were offered and supported with their drinks. We observed one person at breakfast, they were served their meal at a pace appropriate to them. The person chose porridge followed by toast, and was also offered their nutritional supplement as prescribed. We spoke to a number of relatives on the day and one stated, "She [the people's relative] likes the food."

Good

Is the service effective?

We saw where one person had been referred to the speech and language therapist (SALT) as the staff had identified they had swallowing difficulties. Following the review the person was on a 'fork mash diet'. That meant the staff had to ensure the food was broken down to a manageable size, and so make the meal safer for the person to eat. This instruction was added to the person's care plan following an assessment by a speech and language worker and we saw that the person received this type of diet.

The cook had information about people's dietary needs, food tolerance and preferences. The menu showed that a variety of meals were offered, which provided people with a choice of nutritionally balanced meals. The cook also prepared 'soft' and 'pureed' meals for people that had a SALT assessment. For example people that had difficulty with swallowing. The cook also prepared meals suitable for people with a health condition such as diabetes. The cook told us that food was fortified with rich ingredients such as full fat milk and double cream so that people did not lose weight. The cook told us there were plentiful food stocks and that food products were stored at the correct temperatures to keep them fresh.

We saw from people's care records that an assessment of their nutritional needs and plan of care was completed which took account of their dietary needs. People's weight was measured in accordance with their assessed need and staff knew how to help those who needed extra support. For example, we saw where one person was referred to the dietician and their plan of care included the recommendations made by the dietician. That showed that staff had followed the dietician's instructions and included the directions to improve the person's health and wellbeing.

People told us they had access to health care support as and when required. One person said, "I see the optician at the hospital." People's care records also confirmed that they received health care support from a range of health care professionals, which included doctors, specialist nurses, and specialist appointments at the hospital. Prior to our inspection visit we contacted a range of social and health care professionals and they told us that they had no concerns about the care provided.

Good

Is the service caring?

Our findings

People were complimentary about the staff's attitude and kindness. One person said, "Very kind staff, they can't do enough for you" and another said, "The carers have a good approach to the residents."

Relatives we spoke with were complimentary about the staff. They told us they were involved in their relative's care and were able to assist with some personal care tasks, which gave them a sense of inclusion. One relative said, "The staff are caring", and added "The nurses are friendly and deal with things." Another relative said "When I leave I don't feel worried about my relative."

We made a number of observations throughout the time of visit. We saw that positive relationships had developed between people that used the service and the staff team. Staff spoke with people in a friendly and respectful manner and we saw many conversations between staff and people throughout the day. We saw that a person became increasingly agitated as the day went on, due to their condition. We saw a member of staff intervene and speak with them in a quiet way to attempt to calm them down. That approach worked at first, but as time went on the person became more agitated. We observed staff members adapted the approach they used in order to communicate with and reduce the anxiety this person was experiencing. We observed one staff member gently waking a person by stroking their hand in order to offer them a drink.

People were involved in making decisions about their care. People told us that they were aware of their plans of care and that staff involved them in discussions about their care and support arrangements. One person who spoke with us told us that they had been involved in writing their care plans and risk assessments so that they would receive care and support in the way they preferred. People's care records confirmed that they or their family member had been involved in decisions made about their care and support. The care plans we looked at took account of how people wished to be supported. Records showed that these were reviewed regularly and updated when changes were identified. Staff spoken with had a good understanding of people's preferences and told us that they had read people's care records which contained information about what was important to them.

People told us that staff respected their privacy and dignity. One person said, "I do feel that they [the staff] respect my privacy and dignity. They always knock before they come into my room." Another person added, "The staff are caring, I get on well with them. They respect my privacy, they always knock the [bedroom] door. A relative told us "We think [named person] privacy and dignity is respected – we're not allowed in her room if she's being dress or washed."

Staff understood the importance of respecting and promoting people's privacy and took care when they supported people. Staff gave examples of how they maintained people's privacy and dignity when providing care and support. One staff member said, "When we hoist a lady we make sure she has a blanket over her legs." Our observations also confirmed this to be the case. We observed staff were polite, and there was a genuine warmth when staff and people communicated.

We also saw staff speaking discreetly with people about personal care issues, and saw them use a blanket to cover people when being hoisted to promote dignity. We also saw where two care workers were transferring a person from their wheelchair into a more comfortable chair in the lounge. We heard the care staff explain clearly in a sensitive manner what they were doing and why. We heard the nurse explain she was calling the doctor out to look at a health problem the person was experiencing and the person was reassured after this.

Requires improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed that met their individual needs and preferences. They told us that they could make choices about their daily lives and that staff respected their decisions. One person said, "I have choice. They [the staff] come and ask me if I'm OK. I don't want help and so they let me do things for myself. Another person said, "I chose to be in this room [the quiet lounge]. I like to sit in this room because it doesn't have a TV, it's quiet and I like to talk to my friends in here, when I'm not asleep."

Another person described how they were supported to go out of the home to continue to visit a community group they were a member off. They were originally accompanied by a member of staff, however the arrangement was not working well. The person made the provider aware of this and the situation was resolved. That meant the provider and staff team had worked to resolve the issue so that the person could continue to pursue their interest.

We looked at people's care records and found that people's needs were assessed prior to them moving into the service. This was to ensure that their needs could be met there. The assessment process also sought the views of people's relatives or their representatives. The plans of care were personalised and took account of how people liked to be supported, preferences, their likes and dislikes. It included the person's life history, hobbies, interests and what was important to them. We spoke to one person who confirmed they were involved in the care plan review process. They said, "The staff know me well, sometimes the staff talk with me about my care."

We saw that care plans for people's health conditions included guidance for staff about the care to be delivered and most of these had been amended should people's care and support needs change. For example, a care plan for the management of a pressure sore included detail of the specialist equipment needed for this person's care and how often care was to be provided. Associated care records identified that care was provided at the required times, in order to meet the person's needs. We saw a number of similar health care plans that were also well detailed, amended and updated. That meant people could be confident that staff were provided with information and were knowledgeable about people's needs.

However, the information recorded in some care plans did not reflect the care the person required. For example in one person's care plan it stated the person required support every hour to reduce the risk of sore skin. However, the staff we spoke with stated that was not required or part of the person's current care. The care plan also stated staff should document the person's food intake. Though when we spoke with staff they said this was not needed and that they just needed to keep an eye on what the person ate. That meant some of the records were contradictory to the staff team's understanding of care required and care delivered, which may not provide a consistency of care.

A number of people had visitors during our inspection and we saw that they were welcomed into the service. We saw a number of people took part in a floor game with staff and people told us that they had enjoyed this. We saw that staff supported and encouraged people to participate in the game and this was played at the individual's pace and ability. That meant that everyone who wanted to could join in.

Staff told us there was an activities plan in place, but it was not strictly adhered to because people were encouraged to suggest what activity they would prefer to undertake on a daily basis. We were not clear that activities were aimed at people's likes. When we spoke with people we were not sure their choices had been reflected in the activities on offer. We spoke with the deputy manager who confirmed she and a member of care staff were due to have activities training, in order to ensure that activities provided met people's individual needs and interests. We spoke with provider who acknowledged that activities needed to be improved and confirmed the planned training.

People told us that they would talk to the staff or the provider if they had any concerns. One person said, "I know the manager [Provider]. He does a good job." Another said, "I am able to speak to the staff and make suggestions." Relatives told us they knew how to raise concerns and were aware there was a copy of the provider's complaints procedure in the foyer of the service. People we spoke with told us that they found the provider and staff were approachable and that they acted on any issues they raised.

The provider had systems in place to record complaints. Records showed the service had not received any written complaints in the last 12 months. However, we spoke with one person who told us that they had spoken with the

Requires improvement

Is the service responsive?

provider about an issue but nothing had been recorded. We discussed this with the provider who told us that this issue had not been assessed as a formal complaint, however he was developing a system to record all issues people raised. This would ensure people's views were recorded so that actions could be taken if required.

Good

Is the service well-led?

Our findings

People who used the service and their visiting relatives spoke positively about the open culture and communication at the service. They told us that actions were taken in response to suggestions they put forward. One person using the service told us, "I can speak to the manager [Provider]. I told him that I wanted a chair and he got me this one [patting the arm of her chair]." Another person told us, "I am able to speak to the staff and make suggestions." Another person said that all the people using the service had been bought an Easter egg for the recent holiday celebration and that this had made them feel valued.

We also spoke with a number of relatives one of whom told us, "Two things needed to be done when Mum first came [into the home], they were done within 36 hours". Another relative said "We see the manager a couple of times a week. His wife comes every day."

A registered manager was in post and this was also the provider of the service. The provider was supported by two nurses, with clinical lead responsibilities. The provider understood their responsibilities and displayed commitment to providing quality care. They told us that although they were not a registered nurse, they could oversee what was necessary, and the nurses oversaw each other's nursing practice. The nurse on duty on the day of the inspection told us that this arrangement worked well. The nurses kept their knowledge about health and social care up to date and knew how to access support from external health and social care professionals and organisations.

Staff had high praise for the provider. One person said, "The owners are very fair. They will bend over backwards to put things right."

We observed staff worked well together in a calm and organised way. Staff communicated well with people using the service, spoke clearly and gave specific information about the care being offered. This demonstrated a person centred approach to care.

Staff demonstrated a good understanding of their roles and responsibilities and knew how to access support. Staff had access to people's plans of care and received updates about people's care needs at the daily 'staff handover meetings'. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and to make suggestions as to how the service could be improved. Staff told us that their knowledge, skills and practice was kept up to date.

There were systems in place for the maintenance of the building and equipment. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and maintained on a regular basis. Staff were aware of the reporting procedure for faults and repairs. The registered manager had access to external contractors for maintenance and to manage any emergency repairs. The provider has introduced a closed circuit television cameras [CCTV] system into the public areas of the home. The provider explained that this did not invade people's privacy, but increased security for those living in the home.

The CCTV cameras are used to monitor staff interactions with people in the home. The provider or a representative used this to monitor the home out of hours. The provider negotiated the introduction of the cameras with the people that lived in the home and the local authority. That was to ensure people's privacy was maintained.

The provider visited the service regularly and provided people with an opportunity to put forward comments or raise concerns through regular communication. One person told us, "[Provider's name and his wife] are very approachable; I can tell them if I or my friends have any problems." We asked people and their relatives whether they had opportunities to join in with group meetings with other people who used the service. A person told us "There are no meetings. They don't ask me anything." Another person and a relative could not recall being invited to a group meeting. We spoke to the provider about the frequency of group meetings between staff people living in the home. We saw minutes of these meeting, some of which were run by the nurses in the home. The meetings take place periodically and we saw what people had discussed and that they had added items to the agenda to be discussed.

People and their relatives were also provided with an opportunity to express their views through service satisfaction questionnaires. These covered areas such as respect and choice, the environment, food and menu planning, and the time taken by staff to respond to call

Good

Is the service well-led?

bells. We saw that actions had been taken in response to people's feedback. For example, a new television had been purchased in one of the lounges and plans were in place for new garden furniture.

We saw where staff operated a quality control and quality assurance system through a number of areas in the home.

The nursing staff checked the medication system on a weekly basis, to ensure all medicines have been administered appropriately. We then saw where the provider undertook his own review which was to confirm that the reviews were valid, and follow up any issues of poor practice.