Optivo

Elm Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 5 and 6 September 2018. The visit on 5 September was unannounced and we arranged with the registered manager to return on 6 September to finish the inspection. This was the first inspection of the service after the provider changed in October 2017.

Elm Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service was purpose-built and accommodates up to 75 people across five separate units, each of which has separate adapted facilities. One of the units specialises in providing care to people with nursing care needs who are living with dementia. Three units provide support for people who require residential care and one of these units is for people who are also living with the experience of dementia. The fifth unit provides care for people with general nursing care needs.

The service has a registered manager. 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.

There were systems in place to protect people from abuse and staff had completed training in safeguarding people.

The provider assessed risks to people using the service and staff and acted to mitigate any risks they identified.

The provider completed checks on staff before they started work in the service to make sure they were suitable to work with people using the service.

People received the medicines they needed safely and as prescribed. People had access to the healthcare services they needed. People's care plans included information about their nutritional needs and staff kept records to show that people had enough to eat and drink.

Care and housekeeping staff kept the building clean to help control the risk of infection.

Nurses and care staff delivered people's care, treatment and support in line with current standards and guidance.

Staff had completed training the provider considered mandatory and additional training to meet the care needs of people using the service.

Staff sought consent from people they cared for in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff in the service treated people with kindness, respect and compassion.

The provider involved people using the service and their families in reviewing the care and support people received.

All staff working in the service respected people's privacy and dignity and encouraged people to remain as independent as possible.

People had an individual plan that detailed their care needs and preferences for the staff who cared for and supported them.

The provider had a policy and procedures for responding to any complaints they received.

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.

There were systems in place to protect people from abuse and staff had completed training in safeguarding people.

The provider assessed risks to people using the service and staff and acted to mitigate any risks they identified.

The provider completed checks on staff before they started work in the service to make sure they were suitable to work with people using the service.

People received the medicines they needed safely and as prescribed.

Care and housekeeping staff kept the building clean to help control the risk of infection.

Is the service effective?

Good

The service was effective.

Staff delivered people's care, treatment and support in line with current standards and guidance.

Staff had completed training the provider considered mandatory and additional training to meet the care needs of people using the service.

People's care plans included information about their nutritional needs and staff kept records to show that people had enough to eat and drink.

People had access to the healthcare services they needed.

Staff sought consent from people they cared for in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff in the service treated people with kindness, respect and compassion.

The provider involved people using the service and their families in reviewing the care and support people received.

All staff working in the service respected people's privacy and dignity and encouraged people to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

People had an individual plan that detailed their care needs and preferences for the staff who cared for and supported them.

The provider had a policy and procedures for responding to any complaints they received.

Is the service well-led?

Good

The service was well led.

The provider had systems to monitor quality in the service. Where they identified issues, they put action plans in place to address these.

The service conducted satisfaction surveys for people using the service and visitors. These provided information about the quality of the service provided.

Staff told us managers in the service and the provider's representatives were approachable and supportive.

The provider encouraged good communication with staff and people who used the service, which promoted a culture of openness and trust within the service.

Elm Lodge

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 comprehensive inspection took place on 5 and 6 September 2018. The visit on 5 September was unannounced and we arranged with the registered manager to return on 6 September to finish the inspection.

One inspector, an assistant inspector and an expert by experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the provider and the service. This included information the provider gave us when they registered the service and statutory notifications they sent us. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted eight health and social care professionals who worked with people using the service. We received comments from two people.

We also used information the provider sent us in the Provider Information Return on 9 July 2018. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection site visits we spoke with 18 people using the service, seven visitors, the registered manager, head of nursing and head of care, nursing, care, catering and domestic staff.

We reviewed the care records for eight people using the service, staff recruitment, supervision and training records for six members of staff, medicines management records for 14 people and other records related to the running of the service. These included complaints, accidents and incidents affecting people using the service, maintenance and equipment service records, audits and checks the provider carried out to monitor

quality in the service and make improvements. We also carried out a Short Observational Framework for Inspection (SOFI) observation exercise during lunch on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People using the service and their relatives told us people were cared for safely. Their comments included, "Yes' it's very safe, we are looked after 24 hours a day," "Very safe, no worries at all" and "They [the care staff] are very good. They keep everyone safe." A relative told us, "[Family member] wasn't safe at home. It's much better here, we don't have to worry about them." A second relative said, "They always tell us if anything happens. We are confident our [family member] is safe."

The provider had systems in place to protect people from abuse. They had a policy and procedures they reviewed regularly and staff completed training in safeguarding adults as part of the provider's mandatory training. Nurses and care staff we spoke with understood the provider's procedures for keeping people safe from abuse and they were able to tell us what they would do if they had concerns. Their comments included, "It's about protection for ourselves and for residents. If anything goes wrong with us or with residents it goes via the safeguarding team. The manager reports to safeguarding any meetings and outcomes. If the thing is serious then I go to line manager and raise it," "We listen to the resident, we write it down and then we report it to the nurse or senior on duty and we update them as well. If the nurse is not here then we tell the head. We explain to the person as well that we sorted this out and it will not happen again or let them know that we will sort it out as soon as possible" and "We all do safeguarding training. Everyone knows we must report any concerns straight away. We have a duty to keep people safe."

The provider assessed possible risks to people using the service and acted to mitigate any risks they identified. People's care records included risk assessments for falls, skin care, manual handling and nutrition. Where the assessment identified a risk, staff agreed a risk management plan to help keep the person safe. For example, where care staff supported one person to shower the risk assessment reminded them to make sure the bathroom floor was dry and the person's walking frame was in a good condition before assisting them. The nutrition risk assessment for a second person showed they were at risk of weight loss and needed a fortified diet. The risk management plan included guidance for care staff supporting the person with their meals and daily care notes and the monthly weight record showed their weight had stabilised. Staff reviewed people's risk assessments monthly or more frequently if needed. When they identified a change in the level of risk to the person, staff updated their care plan and risk assessment to make sure all staff had up to date information about the person's care needs.

The provider carried out checks on new nurse and care staff before they started to work with people using the service. The recruitment records we checked included an application form, interview record, references from previous employers, proof of the person's identity and right to work in the UK and a Disclosure and Barring Service (DBS) check. Where the member of staff was registered with a professional body such as the Nursing and Midwifery Council (NMC), the provider kept a record of their registration to make sure it was up to date. Care staff told us the provider had carried out these checks before they started work. One member of staff told us, "I had a DBS check, interview, and they followed up my references." A second member of staff said, "I had to prove I was registered with the NMC before I started work. They carried out other checks as well."

We saw there were enough nurses and care staff to meet people's care and support needs and people using the service and their relatives confirmed this. People's comments included, "I think there are enough staff, yes. You don't usually have to wait long if you need someone," "There are enough staff and they are very good" and "Sometimes at night you wait a bit longer if they are helping someone else but it's not too bad." People's relatives told us, "The staff are very good, they do their best but there are times when they are very busy and people have to wait" and "Overall, I think there are enough staff. When people are on breaks you have to wait sometimes but everybody understands. If it is really urgent, help is there."

When we asked nurses and care staff if there were enough staff on duty, most said there were. They said, "Yes, I think there are enough staff," and "Yes, the day shift I know, but I don't know about the night, the night staff don't complain so I think it is fine." However, not all the staff we spoke with agreed. One person said they preferred not to answer the question and another commented, "I feel that the needs of the residents in terms of care need to be revisited."

Following the inspection, we asked the registered manager about this and they told us, "The staffing level is based on residents' dependency levels which I do on a regular basis based on level of residents needs i.e. behavioural issues, feeding, regular observations / monitoring, high dependency needs and number of residents feeding at lunch times. The minimum staff for a group of 15 residents on a general nursing unit for example will be one registered nurse and three care workers with the activities coordinator assistant supporting during meal times, however If the need of residents changes, the arrangement will change. These arrangements do not include residents' escorts to the hospitals or outings.

People received the medicines they needed safely and as prescribed. Nurses had completed the Medicines Administration Record (MAR) charts we checked accurately and we found no errors or omissions. The provider stored medicines securely in a lockable room on each unit and nurses recorded the temperature of the rooms and fridges used for medicines storage daily. MAR sheets included a photograph of the person and some records included agreements that staff could administer some medicines covertly, with the agreement of people's relatives, their GP and pharmacist. Where people were prescribed medicines 'as required' (PRN), staff had clear guidance about the frequency and dosage they could administer.

Staff responsible for administering people's medicines told us they had completed training and had passed a competency assessment and the records we saw confirmed this. Staff told us, "Yes, I administer medication and I have had training. I don't leave medication with residents and I make sure they swallow with water. If they refuse, I'll try 3 times, I'll dispose of the medication and mark down that they refused. According to the MAR chart and the doses" and "Yes, you must really prompt some people and make sure that they take it, make sure they swallow it and drink the water after. Then you must wait a few minutes with some to make sure they take it."

The provider had a policy and procedures for the prevention and control of infection. One person using the service told us, "The daily cleaning and the cleanliness of the place is impressive. The cleaner comes in daily, look at my perfectly cleaned floor." A relative also said, "The place is spotless, the cleaners are excellent, they just get on with it."

All parts of the home were clean with no malodour and housekeeping staff had a clear system in place to ensure the home was kept clean and tidy. Records showed staff had completed training in infection control and handling chemicals used for cleaning. We saw all cleaning products in the kitchen areas were stored in locked cupboards when not in use and housekeeping staff always had sight of their cleaning equipment when they cleaned bedrooms, bathrooms and communal areas. This meant the risk of people using the service inappropriately accessing these chemicals had been reduced. Housekeeping staff told us they had

access to the cleaning materials and equipment they needed.

The provider, registered manager and staff carried out health and safety checks to make sure the service was safe. The provider had completed a fire safety risk assessment in March 2018 and we saw there was a Personal Emergency Evacuation Plan (PEEP) in place for each person using the service. This gave staff from the service and the emergency services information about the support each person needed in the event of an emergency that required them to evacuate the premises. There was a general risk assessment for the premises dated May 2018 and we saw that safety checks and service records for fire alarms and fire-fighting equipment were up to date. Gas and electrical safety certificates were up to date and the service's maintenance staff checked window opening restrictors weekly.

The provider recorded accidents and incidents that affected people using the service and acted to mitigate the risks and prevent recurrence. For example, following an error with one person's medicines the registered manager changed the service's procedures to make sure two nurses checked the monthly medicines delivery. They also arranged additional training for staff who were involved in the incident.

Nurses and care staff told us they felt supported to report any concerns or mistakes. They told us, "Everybody makes mistakes and we must admit it and make sure things are changed so it doesn't happen again in the future" and "Staff learn fast. We don't like negativity! We like the team bonding approach, family approach, when one person's sad it affects the rest of the team. I like to go home on a positive note, we do the best for our residents. If somethings gone wrong today it's not going to be repeated tomorrow, we'll try a different approach."

Good

Is the service effective?

Our findings

The registered manager and senior staff assessed people's care and support needs in line with current legislation and evidence based guidance. The provider's policies and procedures included references to guidance from health and social care organisations, including the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE).

Nurses and care staff working in the service had appropriate skills and experience. Staff told us they had received an induction when they started work in the service and records confirmed this. They told us the induction included training and working alongside other staff members. They also told us they could access the training they needed to care for and support people using the service and this included online and classroom based training.
The provider's training matrix showed all staff had completed training the provider considered mandatory. This included fire safety, patient handling, health and safety, food safety, infection control and safeguarding adults. In addition, the provider arranged training that was specific to the needs of people using the service, for example, dementia awareness and working in a person-centred way. The provider confirmed they had introduced the Care Certificate for staff who were new to working in social care services. This is an identified set of 15 standards which health and social care staff should adhere to in their daily working life.

Nurses and care staff told us they found the training helpful. Their comments included, "The training is specific to the role I'm doing. It's a good refresher because sometimes you keep doing things as routine. Until you ask yourself why am I doing this? It's quite specific to what I'm doing. Learning every home works slightly differently helps me to be more effective around this role,"
"The training is quite handy and useful, it gives me knowledge, like the manual handling training because we're getting new hoists. I did a dementia course, safeguarding and pressure sores," "I enjoy my training, it's an eye opener to bring more knowledge into the workplace" and "Yes, the training's amazing. I'm getting more experience. Sometimes you might forget and then you get a flashback. I have had face to face training. We have a board of training available and dates that we check. If our training is due then we go to that training."

Nurses and care staff supported people to make sure they had enough to eat and drink. Care plans included information about people's nutritional needs and how care staff would meet these in the service. The plans included nutritional risk assessments that identified when people might be at risk of not eating or drinking enough. When the assessment identified a possible risk, staff acted to refer them to a dietician or speech and language therapist for specialist advice. They kept records of the amounts people ate and drank and we saw these were well maintained. They also recorded people's weight regularly.

People and their relatives told us people enjoyed the food provided in the service. Their comments included, "I would say the food is generally pretty good, you don't hear many complaints," "It's very nice and the food isn't bad. My [family member] brings in some treats and they go in the fridge" and "I've had meals here with my [family member] and the food is good. There's a choice and the staff will always make something else if people don't like what's on the menu."

During lunchtime we carried out a Short Observational Framework for Inspection (SOFI) observation exercise on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We saw care staff offered people choices of food and drinks and gave them the time they needed to decide what they wanted to eat and drink. Dining tables were laid with cloths, place mats, serviettes, salt and pepper. Care staff were attentive and encouraged people to eat and drink. They asked each person if they wanted second helping. The atmosphere in the dining room was relaxed, care staff encouraged conversation and we saw each person had a positive experience while eating their meal.

People had access to the healthcare services they needed. Their care plans included information about their physical and mental health care needs and how nurses and care staff should meet these in the service. Care records showed people saw their GP when they needed to and care staff supported them to healthcare appointments. One person told us, "If I'm not feeling 100% I ask them to arrange an appointment with the doctor and I see (the GP) when they visit." A relative commented, "The local doctors' practice is superb and we are very happy with that, there's continuity of doctors." A healthcare professional confirmed that staff referred people appropriately and followed any advice or treatment plans they provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found the registered manager fully understood their responsibilities under the Act. When we asked nurses and care staff what they could tell us about the MCA they said, "I've had MCA training. People who cannot make the decision for themselves, it's for them" and "If they have the capacity we will try to support them by telling them what we have come to do and I encourage the carer to do that as well. If they haven't got capacity we do it in their best interest. If there is anything we can involve the family with to help us to make them understand."

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When necessary, the registered manager applied to the local authority for authorisation to ensure people's safety. For example, people using the service could not go out safely without support. On occasion, a person might have to wait until enough care workers were available before they could go out. Also, the provider locked some doors in the service to keep people safe. We saw that the registered manager had consulted local authorities responsible for people's placements in the service about these restrictions and they had been approved. The registered manager was aware of their responsibility to notify the Care Quality Commission of the outcome of any application to deprive a person of their liberty and they did this.

Good

Is the service caring?

Our findings

People using the service and their relatives told us staff were kind and caring. Their comments included, "I like everything – especially the food and the care – the care is perfect. I enjoy everything – it's a good place," "The carers are all nice and the residents are all friendly," "The care is fine. The staff look after the residents well," "I love it here. It's like a family house," "It's brilliant, the staff are nice. They treat my [family member] right. I have no complaints about the place, I have my dinner here sometimes. It's the best place in the world. The staff are nice, they're brilliant," "My [family member] is treated with extreme respect and consideration. My wife and I are contacted at times when we need to be and we're grateful for that – it's superb" and "I like the home and I'm very happy. There are decent people here, the food is good and the staff are pretty good."

During the inspection we saw that staff offered people choices about some aspects of their daily lives. They asked people what they wanted to eat and drink, where they wanted to spend their time and if they wanted to join in with group activities. When people made a choice, we saw that the staff respected this. When we asked nurses and care staff how they promoted choices for people using the service, they told us, "We give people choices; for meal time, for tea time and for bed time. We encourage people to do whatever they can for themselves and observe that they are safe when they are moving around," "We treat people with respect, ask them what their choices are, give them choices, and listen to them, get to know them, it's important to get to know them well" and "Ensure people know they have the right to choose, we have resident meetings every month where they can express issues and concerns. They can talk to us anytime throughout the day, it can be anyone. Residents are very aware that they have the right to speak up."

Staff in the service respected people's privacy and dignity. We saw they knocked on bedroom doors and waited for a response before entering and supported people with their personal care needs in their rooms or the communal bathrooms and toilets. When we asked nurses and care staff how they respected people's privacy, they told us, "Make sure we provide the maximum privacy and dignity when we go in their room; we knock and we wait until they answer if we can go in. If we are giving people personal care we ask them first, we always ask permission before we go ahead," "We do have people living with dementia who go back to their mother tongue, they speak English all their lives but with dementia they forgot everything. We must encourage them to speak English. If someone has had a stroke, maybe they can write what they want. Facial expressions help also, they can nod their head, if they want to go to the toilet they can nod their head yes," "It's really important not to assume that people can't do anything for themselves, they need to keep their independence. Helping them make tea, allowing them to choose their own foods, what they want to wear, not just assuming what they want and make sure they chose what they want" and "On the dementia unit we have some residents who cannot speak for themselves. You have to understand their expressions to know what they mean. We have people who have hearing problems and they have hearing aids. One person doesn't speak a lot but she understands what I'm saying. She will hold my hand and smile, that tells me she understands what I'm saying."

Good

Is the service responsive?

Our findings

People using the service and their relatives told us people received the care and support they needed. Their comments included, "We are looked after 24 hours a day. The home is well run, the care is adequate and the food is very good," "They look after me very well, I only have to ask if I need anything," "They have got to know my [family member] very well. They treat them like one of their own family" and "The place is not bad, but of course, there are ups and downs. I like the food. I like the tv and radio and enjoy going in to the garden."

People's care records included an assessment of their health and social care needs and nurses and care staff told us they used the assessment and risk assessments to develop a care plan for each person. The care plans we saw clearly identified the person's wishes as to how they wanted their care provided. The included information about people's likes and dislikes, preferences and routines. Nurses and care staff had reviewed each area of the plan monthly and had updated it where they had identified a change in care or support needs. The staff completed a record of the care and support they provided for each person during their shift and we saw these showed people were receiving care in line with their plan and their preferences. Where a person or their relatives had identified their wishes in relation to end of life care, these were recorded in the care plan. Where a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decision was agreed and authorised by the person's GP this was located at the front of the persons care plan folder.

When we asked nurses and care staff how they made sure people received care and support that was responsive to their needs, their comments included, "Get to know the person first, you have to observe their ways and learn how they are trying to tell you what it is they need. If they can't do it verbally, we have picture books and some residents will also write it down" and "When people are admitted their family complete the 'this is me' form. It includes everything about the resident; their food preferences, cultural needs, and religion. In some end of life care wishes they ask for a reverend towards the end of their life so we make sure that is done. Some like to go to church. The reverend used to come here some Sundays and take residents. For the cultural aspect of it, they cook meals according to cultural needs like for Caribbean and Indian residents"

The provider employed activity coordinators who worked with individuals and groups of people daily. People's care records included information about the activities they enjoyed and hobbies and interests they had before they moved in to the service. There was a weekly programme of activities and we saw, while care staff and the activity coordinators encouraged people to participate, they respected people's decisions if they chose not to take part. When we asked people about the activities provided, they commented, "There have been some day outings on offer – to Littlehampton and Ruislip Lido yesterday. I went to Littlehampton and the sea air was lovely. It would be good if we could use the garden more as it promotes conversation and general interest. I watch a little TV and listen to the radio," "There are outings on offer and they're very good" and "There are things going on but they are not all for me. There's always someone to chat with and I do enjoy the quizzes." We also saw that a relative had written to the registered manager to say, "I would like to thank your activities team for having arranged a series of events that have given a lot of pleasure to my [family member] recently."

The provider had a policy and procedures for responding to complaints they received. Records showed they investigated complaints in line with their procedures and acted to make sure people were satisfied with the outcome. For example, they replaced items that had gone missing and gave people a written apology. The registered manager had also reminded staff to make sure people's clothes were named and personal items were included in their room inventory.

People using the service and their relatives told us they knew how to make a complaint, if necessary. They commented, "I know how to make a complaint and would do that if necessary – but the need has not arisen," "I've never made a complaint, we're looked after very well," "I know there is a procedure but we've found you can speak to any of the staff and things get sorted" and "We were told about the complaints procedure when [family member] moved in but we have never needed to use it. I'm sure [the registered manager] would deal with anything we were concerned about."

Good

Is the service well-led?

Our findings

People using the service and their relatives told us they knew who the registered manager was and said they felt the service was well-managed. They told us, "[Registered manager's name] is the manager, she's very good," "[The registered manager] is good, very approachable and a good listener" and "I think it's well-led, they seem to be on top of things." A social care professional also told us, "Elm Lodge is effectively meeting all the 5 quality criteria (Safe, Effective, Caring, Responsive and Well Led) in providing care services to customers."

The provider had appointed a manager who originally registered with the Care Quality Commission (CQC) in 2011 and was reregistered in October 2017 when the provider changed. They told us they were a qualified nurse and had worked in hospitals and community services before becoming a deputy manager and manager in care homes for older people. They told us they kept up to date with developments in nursing and social care by completing training, attending provider meetings organised by the local authority and the local Skills For Care network and reading journals and websites. They also told us they were completing a Masters in Dementia Care.

The registered manager was supported by a Head of Nursing and a Head of Care. Nurses and care staff told us the management team was approachable and supportive. Their comments included, "We have the best manager in the world," "The home is well managed, if you need to know something you just ask," "The managers are good, they listen and ask for our opinions,"
"[The registered manager] is a good leader, very supportive. Whenever you ask for something or you have a problem she is very supportive to the staff," "I'm very happy. I have worked at 2 other places and this is the best. It's a good environment, friendly staff, management is so good. A lot of other things," "Yes, I feel supported. If I had issues or concerns I will go and speak to the manager and those issues are normally resolved, so I know I am supported," "Yes, I really enjoy my job, I enjoy working with the residents, I enjoy that smile and giving them something to look forward to," "I feel supported by my manager. If you have a problem go to her and she will support you with that. She did my induction very well. I love working with her, she follows policy and procedure" and "I feel supported because what I've noticed with my manager is that she is very confidential, if there's a problem she knows how to go about it. She's not one sided, she doesn't just take what I say, she likes to prove things. She deals with things in a professional manner."

Nurses and care staff we spoke with described the provider as a good employer and commented positively on the training and support they received. They told us, "Yes, I have regular supervision every 3 months, I'm due to have one this month. I also have an annual appraisal. The supervision sessions and appraisals are very helpful," "I have supervision every month and an annual appraisal. They help me with my work," "I started recently and have had supervision two times. It's really helpful" and "Supervision is a time when I feel anything that I've not been able to achieve or something that I wanted to discuss I can, as that is the right forum for it. We communicate. if it's something pertaining to me then I can bring it up. When I had my appraisal, I said I wanted to become more proficient in wound care, in other care homes I received a lot of patients with wound care / tissue viability and I wanted to learn how to manage them. The manager is aware that that is where I want my future training."

Staff also said they had regular meetings to discuss the service with managers and records confirmed this. They told us, "Staff meetings are constant where things need to be updated and information needs to be passed on, its frequent" and "Yes, we have staff meetings every month, the dates are set out but sometimes it changes based on what is happening. There is a yearly calendar for staff meetings. Yes, I feel I am listened to."

The provider involved people in planning and reviewing the care and support they received in the service. We saw managers, nurses and care staff involved people and their families in care plan reviews and the provider carried out annual satisfaction surveys to obtain people's view. The registered manager told us the provider had sent questionnaires to people in June 2018 and the results would be collated to develop an action plan to address issues people raised. We saw the last action plan from November 2017 and this showed the provider acted when people highlighted issues. For example, some people and their relatives had raised issues about laundry and cleaning in the service. The registered manager had acted to address these and told us there had been no complaints about these areas for six months.

The provider had systems in place to monitor quality in the service and make improvements. Together with staff in the service the provider carried out audits and acted to address areas where they identified the need for improvement. For example, monthly medicines audits by the heads of care and nursing identified areas for improvement and we saw the registered manager had circulated an action plan to all staff to improve the management of people's medicines. The registered manager told us that, because of the audit and action plan, the number of errors and omissions had been reduced.

The provider's care Training and Quality Assurance Officer told us the provider had reviewed the way they monitored quality in services and a senior manager now carried out a quality monitoring visit every four to six months. They reviewed the service against the characteristics for good and outstanding services and produced an action plan for the registered manager. We saw the provider's action plan review for July 2018 and this showed there had been progress in ensuring all staff completed training the provider considered mandatory and received regular supervision.