London Borough of Haringey

Osborne Grove Nursing Home

Inspection report

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Date of inspection visit: 4 & 25 November 2015
Date of publication: 04/01/2016

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

Overall summary

This inspection took place on 4 and 25 November 2015 and was unannounced which meant that nobody at the home knew about the visit in advance.

Osborne Grove Nursing Home is registered to provide accommodation and nursing care for up to 32 older people. The home had a registered manager in place however they were on extended leave. 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. An interim manager starting in August 2015 was in place at the home to cover the registered manager position.

The future of the home was uncertain during the first day of our inspection, as a decision was awaited about whether the provider would continue to run the service, and whether it might take on a more rehabilitative role. It

Summary of findings

was therefore a difficult time for people living at the home, their relatives and staff. Despite this we found a pleasant and relaxed atmosphere in the home, with staff providing a high standard of care.

We found that there were some shortfalls in how up to date people's care plans were and the recording of care provided to them. There was also room for improvement in the activities provided to people and encouragement for people to get out of bed during the day.

Staff were available to meet people's health and care needs. People spoke highly of the care and treatment that they or their relatives received, and we observed that people's privacy and dignity was protected effectively. Their consent was sought before care or treatment was provided, and they were consulted about the way the service was run. Where people were unable to go out without supervision and could not consent to this, appropriate legal procedures were followed. We observed patient and caring interactions from staff working with people during our visit.

People were satisfied with the food provided at the home and the support they received in this area. Medicines were stored and administered safely by trained staff. Risks to people were assessed, with plans in place to keep them safe from identified risks including the risk of abuse. The home was kept clean and tidy with infection control procedures followed.

Staff understood people's likes and dislikes regarding their care and treatment. People using the service, relatives and staff said the interim manager was approachable and supportive. Systems were in place to monitor the quality of the service .People and their relatives felt confident to express any concerns, so these could be addressed. There were areas requiring refurbishment in the home including some bathrooms and kitchenettes.

Staff said that they received good support from the home's management, and they had regular supervision and appraisal sessions and attended regular team meetings. They spoke highly of the training provided by the provider organisation. Safe recruitment systems were in place to ensure that fit and proper staff were employed within the home.

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?

Good

The service was safe. People's medicines were managed safely and the home was kept clean and hygienic.

People had individual risk assessments to identify risks and manage them. Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred.

Recruitment procedures were in place to determine the fitness of staff to work in the home, and there were sufficient staff on duty to meet people's needs.

Is the service effective?

Good

The service was effective. Staff received supervision and appraisal to support them in their role, and training to provide them with the skills and knowledge to care for people effectively.

People received effective support to meet their health care and nutritional needs. People were referred to the GP and other health care professionals as required.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported, and protected people's privacy and dignity. People's communication needs and equality and diversity needs were met.

People and their representatives were supported to make informed decisions about their care and support.

Is the service responsive?

Requires improvement

The service was not always responsive. Care plans were in place outlining people's care and treatment needs, however these were not always entirely current, and there were some gaps in assessment and monitoring records of people's needs.

People could take part in organised activities within the home, but many people remained in their bedrooms throughout the day.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People using the service and their relatives were encouraged to give feedback on the service and there was a complaints system in place.

Summary of findings

Is the service well-led?

The service was well-led. There were systems in place to monitor the quality of the service people received.

The management promoted an open culture in which people were encouraged to provide feedback.

Good 

Osborne Grove 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 last inspection of the home took place in April 2013 and the home was found to be compliant with the regulations inspected.

This inspection took place on 4 and 25 November 2015 and was unannounced. The inspection was carried out by two inspectors, a specialist professional advisor who was a nurse with knowledge of older people's needs, 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.

Prior to the inspection we reviewed the information we had about the service including notifications of significant incidents affecting people using the service.

There were 30 people living at the home at the time of our inspection. During the visit, we spoke with twelve people who lived at the home and eight relatives visiting the home and we met with two health and social care professionals visiting the service. We also spoke with three nurses, nine care staff, the activities coordinator, a chef, the interim manager and the interim adult provider manager.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being. We observed breakfast and lunch being served at the home.

We also looked at a sample of eleven care records of people who lived at the home, nine staff records, twelve people's medicines records, and other records related to the management of the service.

Good

Is the service safe?

Our findings

People told us that they felt the home was a safe place in which to live, they told us " `This is a good place – you do have peace of mind." No concerns were raised about the safety of the service. One relative of a person living at the home said that they had had concerns about the care provided in their own home, "but the ones here [staff] seem fine."

There was some anxiety amongst people living at the home,their relatives and the staff team about what the future held for the service. At the time of our first visit to the home a decision was due imminently as to whether the local authority would continue to operate the home. People had been told that they could remain in the home, but they did not feel secure without knowing who would be operating it. However their concerns had been allayed by the time of the second visit.

Relatives and health professionals did not have any concerns about the safety of people living at the home. During our visit we observed that when people exhibited behaviour that challenged the service, staff members addressing this calmly and pleasantly, and without confrontation. People and their relatives told us that they could talk to staff or the management if they were worried about anything.

We spoke with staff about their understanding of safeguarding people. Each member of staff was able to describe the various types of abuse that people living in the home might be vulnerable to. Staff mentioned the risk of neglect, bullying, abuse from other people living in the home, the risk of financial abuse and physical and sexual abuse. Staff were able to describe what they would do if they were concerned and the reporting procedures in place in the home. The staff we spoke with all said that they would report matters to external agencies should they consider the provider was not responding adequately to any concerns they raised. Records of safeguarding incidents indicated that these had been reported and addressed promptly, with learning resulting from each case taken forward to reduce the risk of reoccurrence. We looked at records of two people's personal monies kept for safekeeping in the home, and found that these were recorded appropriately to protect people from financial abuse in line with the home's policy.

Risk assessments in people's care records enabled risks to be managed effectively, and these were reviewed at least monthly. For example there were risk assessments in place for managing and preventing pressure sores, falls, and poor nutrition with care plans in place to reduce the risks. First aid kits were available in the home and staff were able to describe how they would manage particular emergencies in the home.

There were two care staff on each of the four units and a nurse on each floor. The last month's rota indicated that this was the minimum staffing for the home during the day. At night there was one nurse and four care staff covering the home. Many people required lifting and handling techniques, some with full body hoists and some with turntables for standing transfers. There were also several ceiling-fixed hoist rails leading from bed areas to toilets. Staff reported that there was always adequate equipment for lifting and handling, and all staff received moving and handling training on a regular basis.

Staff reported that they could be very busy at work they were a good team who supported each other. We onserved staff to be attentive and efficient, indicating that they knew people well, and supported them in a friendly manner. The team were observed to have good working relationships and communicated well. All conversations witnessed were about the work and the people living at the home.

People living at the home, their relatives and staff members told us that there were enough staff available to ensure people were well cared for although some staff noted that their workloads often meant that they were unable to get involved in activities with people in the home. Staff said that sickness and absences were usually covered effectively, with agency staff used if needed. The interim manager advised that the home was fully staffed but they were in the process of recruiting to some posts at the home including the front desk reception position.

Safe recruitment procedures were in place to ensure that staff were suitable to work with people. We looked at staff files of newly recruited staff members and more long term staff members. We saw evidence of people being checked for fitness to work including disclosure and barring checks which showed that staff did not have a criminal record, written references, identity checks, copies of employment histories and qualifications, application forms and interview notes maintained in the files.

Good

Is the service safe?

People told us that medicines were given on time and those who required pain relief said that this was provided without delay. We found that medicines were stored securely in a dedicated clinical room with the storage temperature recorded daily to ensure that it remained within the required range. However staff advised that they could not fit all the new medicines within the clinical room when they were delivered prior to the previous month's medicines being completed, and therefore had to store these in another lockable facility. We brought this to the attention of the interim manager who undertook to ensure that they were stored securely and at an appropriate temperature prior to their transfer to the clinical room.

Medicines were administered by nursing staff, who had undertaken the appropriate training and assessment. We observed medicines being administered appropriately during our visit, although we noticed that some people had their morning medicines in the late morning, due to their preference for getting up late. Medicine administration records were completed without any gaps, however the actual time that medicines were administered was not recorded for people who preferred to get up later. We brought this issue to the attention of the interim manager who said that this would be implemented to ensure that people were not given their next doses too close together. Discussion with the nurses indicated that they were aware of the need to ensure a suitable gap between doses of medicines for people who had their morning dose late. Liquid medicines in use were dated when opened in line with safe practice. Controlled drugs were also stored and administered appropriately. A recent pharmacist audit of medicines at the home had led to some recommendations which were being implemented by staff including avoiding overstocking on certain medicines.

The home was clean, tidy and odour free, with domestic and maintenance staff available. We observed care staff cleaning spillages where necessary rather than waiting for cleaning staff to arrive. However some areas of the home were in need of refurbishment including some bathrooms and the kitchenettes on each unit. The interim manager was aware of these issues and advised that they would be part of the refurbishment plan for the service once the future of the home was clarified.

Staff were observed to use personal protective equipment (gloves and aprons) when carrying out personal care tasks. People's personal equipment such as wheelchairs were clean and fit for purpose. Staff were trained in fire safety, and the interim manager had reviewed safety procedures at the home and ordered two new evacuation chairs. Fire safety records were up to date, including weekly testing of call points (observed during our visit) and servicing of all equipment.

Good

Is the service effective?

Our findings

People spoke positively about the support provided by staff, the food provided and health care support available. Comments included, "'I am okay here. Staff are fine," "The food is very good," and "I find the food more than okay."

People were supported by staff who had the necessary training to meet their needs. Staff were well informed and spoke knowledgeably about their role. They told us that there was good training at the home with regular refresher courses on key areas such as fire safety, moving and handling and safeguarding. One staff member told us they been encouraged to do a National Vocational Qualification certificate in care at levels two and three, and were going to be completing the Care Certificate shortly. All staff told us that they felt supported and received supervision in their work with people, which they found helpful. One member of staff said, "The standard of care here are much better than other homes I have worked in. Staff care about the people here and work as a team."

Staff who had recently started to work at the home had completed induction training. Training records showed that staff were supported to complete all areas of mandatory training in line with the provider's policy, and those who had not had been identified and were due to complete this training. Staff also had specific training on areas relevant to their role such as dementia, and end of life care. Care staff had the opportunity to attain a qualification in care. A training matrix chart was used to identify when staff needed training updated. Updates were due for staff in food safety, and first aid, and in managing challenging behaviour and report writing. The interim manager advised that he was awaiting a date for the next set of training to be held in these areas. There was a refresher training session in end of life care on the afternoon of the first day of our visit and several staff attended.

Staff expressed satisfaction that they were well supported in their roles. They felt equipped to deal with the daily routine and enjoyed working with the client group. Some had been employed for the seven years since the home was opened. It was evident that there had been some gaps in supervision sessions provided to people, so that this was not at the frequency stipulated by the provider organisation of every two months. However staff were receiving sessions at least quarterly and annual appraisals. The interim manager had started to address this issue, with new areas of responsibility assigned to the nursing team including providing supervision sessions to care staff.

Monthly staff meetings were being held for day staff, night staff and the nursing team. Minutes of these meetings indicated that they covered topics including staff allocations, areas of responsibility, training, medicines, nutrition, maintenance and infection control.

People said they were able to make choices about their care. We observed staff seeking consent before providing care to people. There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Care records included assessments as to whether people had capacity to make these decisions.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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 are called the Deprivation of Liberty Safeguards (DoLS).

Staff had received training on the MCA and DoLS. Staff were able to demonstrate how they insured people consented to their care describing the non-verbal signals and facial expressions people used and how choice could be offered but presenting options about clothing for example. They could explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. We observed that appropriate people were involved in making best interests decisions on people's behalf when needed for example in deciding whether bed rails should be used, or whether they preferred to have their door left open or closed. However in two of the files we looked at the evidence presented and the conclusions of MCA assessments were contradictory. Both these people were said to have capacity and to have understood information given to them, but the conclusions

Good

Is the service effective?

of the assessments were that a best interest decision should be made (which would only apply if they did not have capacity). It appeared that the questions within the assessment template had been misunderstood by staff filling them in and we brought this to the attention of the interim manager who undertook to address this issue.

DoLS applications had been made for people who were unable to go out of the home unsupervised, and expressed a wish to do so. Staff understood that further applications were needed for all people who were unable to consent to staying at the home, and one nurse had been assigned the task of overseeing these applications. Forms were completed in some people's files regarding their wishes regarding resuscitation, however as these were not on the forms required by emergency health care staff, there was a risk that might not be observed.

We carried out observations during breakfast and lunchtime to see the support people received with their meals. Drinks and snacks were served throughout the day and people were supported or prompted with food or drink as needed. Staff were attentive to people's needs and sat at an appropriate height to support people, and did so in an unhurried manner. Specialist adapted cutlery and crockery was available for people who needed this to promote their independence. Where people were on a soft diet, different items of food were pureed separately, giving them more choice about how they ate their meal. Some people who had difficulty swallowing also had a thickener added to drinks and these were recorded in food and fluid charts.

Breakfast for at least half of the people living at the home was served until quite late in the morning, according to their preference. This included a choice of cereals, porridge and toast, and staff told us that people could request a cooked breakfast at weekends. We observed one care worker requested to go out and purchase a baguette for one person living at the home, which they did in accordance with their wishes.

Few people had breakfast in the dining areas, and only about half of the people living in the home had lunch in the dining areas on each unit. Others had their meals in their bedrooms. People were offered a choice of meals one day before, however where they wanted an alternative on the day, this was provided. The menus included two choices for every meal, and some cultural options reflecting people's backgrounds. People enjoyed their meals, and were positive about the food served. Their nutritional needs were assessed and when they had particular needs or preferences regarding their diet these were recorded in their care plan. Their weight was being recorded in their care plans at least monthly and more often if there were concerns. Some people had a PEG (whereby they were fed directly by tube into their stomach). We observed nurses providing them with the prescribed nutrition. They were clear about the mechanisms and calculations for the continuous electric pumps.

People were supported to access the health care they needed. They told us that they were able to see their GP when they wanted. Medical care was provided from a number of local GP surgeries. Other visiting professionals included physiotherapy, podiatry, dentistry and oncology/ palliative care nurses. These professionals recorded clear information in people's care records in a designated section. We saw that people were referred to other health care professionals as required. For example people had been referred to a speech and language therapist for assessment of swallowing capacity and feeding requirements.

We spoke with two health and social care professionals who visited the home regularly and confirmed that staff and management responded to their suggestions and worked well with them. They noted that having several GPs was not ideal for ensuring efficient communication with staff at the home. The interim manager advised that the situation would be reviewed.

Good

Is the service caring?

Our findings

People told us that they were treated with kindness and respect and staff listened to their views about how they wished their needs to be met. One person said, "It's a very nice place. The girls are so lovely and kind. I have a named staff `minder' which is nice." Another person told us, "If you have to be in a home, this is the place to be." Relatives told us, "There's a good atmosphere. The staff really care about people," and "Care is absolutely fantastic."

Staff appeared to know people well, chatted with them and met their personal care needs discreetly and pleasantly. People told us that they felt secure enough to be able to speak up about anything they wanted. Staff knocked on people's doors and waited for a response before entering, mindful of people's privacy. They told us they had enough time to talk to people and recognise their needs. They demonstrated that they respected people's dignity and promoted their independence. We heard staff asking people about their care before doing anything. For example we observed one member of staff telling one person that dinner was available and that they intended to support them to eat.

People in the communal areas were appropriately dressed. Staff demonstrated a good knowledge of people and their likes and dislikes. We saw staff communicating with people effectively and used different ways of enhancing that communication by touch, ensuring they were at eye level with those residents who were seated, and altering the tone of their voice appropriately.

We observed staff showing an understanding of people's needs with regards to their disabilities, race, and gender. Care records showed that staff supported people to practice their religion, and have services within the home. We saw that one person whose main language was Greek. Key keywords were translated on a poster in his room to assist staff in speaking with him. They also treated people's relatives with respect and kindness. One person told us, "They gave me an 80th birthday party with all my family invited." There were no restrictions on visiting times.

Staff told us that if used, agency staff were usually regulars and knew the people living at the home well. There was a caring attitude displayed by permanent staff displaying enthusiasm and interest in the work. They told us, "I like it here or I would not have stayed this long," "I like the client group" and "There is good team work here."

There was an impression of each person being treated as a unique individual. Interactions witnessed were warm and friendly and communication was precise and clearly directed. People were addressed by their preferred names. One person being assisted with lunch required careful and patient attention and this was given throughout the meal and afterwards in the form of a routine mouth hygiene check.

Throughout the day most people's rooms had their doors open. We asked the nurses on duty about this and were told that the purpose was to avoid disturbing people during observations. However they said that if people expressed a preference their doors could be closed. We spoke with one person living at the home who confirmed that he preferred his door closed at night and that staff respected this. We saw that call bells were accessible to each person in their bedrooms.

Some rooms had been personalised, and the interim manager advised that it was one of his priorities to ensure that the remaining rooms were personalised, including some displays for people's ceilings if they spent significant time periods in bed. Communal areas of the home were decorated with art work undertaken by people living at the home including decorative mandalas, and photographs of people engaging in activities and events held in the home.

There were whiteboards in the communal areas of each unit including the date, month, season and weather to assist people with memory difficulties. However there were few other special measures in place to assist people who may be confused or suffer from dementia. People had the opportunity to feedback about their experience of care in the home at residents/relatives meetings.

Requires improvement

Is the service responsive?

Our findings

People were positive about the way staff responded to their changing needs but indicated that there were areas for improvement including provision of activities. One person told us that they were "very bored," sometimes, and another said, "I prefer to spend all my time in my room. There is nothing for me downstairs and no one I can talk to." Another person told us "It's okay for me," and a relative said, "It's good here. My [relatives] like it. The carers are very supportive but they need to have more activities for people."

At the time of the inspection the activities co-ordinator for the home was covering reception and administrative duties whilst there was a vacancy in this area. We observed records of group activities that had been arranged in recent months. These included live music performances, birthday celebrations, arts and crafts sessions, a raffle, reminiscence, hand massage and manicure sessions, singing, games and gentle exercise. There were photographs of people engaging in some of these activities and art work completed by people living at the home posted in communal areas within the home.

There were timetables for a morning and afternoon activity to be held on each unit each day, however records indicated that these were often not occurring. During our inspection there was music and televisions playing in several areas of the home but no other form of recreational activity observed. Some people told us about their personal pastimes such as reading, and collecting stamps. However we did not see records to evidence that people who stayed in their rooms were offered regular stimulation or individual activities. Discussion with staff and observation of staff duties within the home indicated that they often did not have time to engage in activities with people.

Two relatives told us that they thought their relative needed more encouragement to get out of bed, even for a short time each day. Only about half of the people living at the home had their lunch in the dining areas, with most people remaining in bed for most of the morning and a significant number of the others remaining in bed throughout the day of our inspection. Some of these people were unable to get out of bed for health reasons, but others were not encouraged to get out of bed unless they specifically asked to. The interim manager was aware of these issues and was looking at ways of adjusting staff working patterns to enable them to encourage more people to get up during the day, and offer more stimulation for people in the home.

Care plans provided good information about people's needs enabling staff to care for them effectively. They were reviewed monthly or more often when required, with details about changes recorded. There was detailed information about people's needs in respect of support for their health and personal care, and what staff should monitor to ensure their care was safe and effective. People's preferences were recorded such as the gender of care staff supporting them or if they wished to be left with a radio or television on particular channels. A section designated 'This is Me' included important personal information about people with input from the person who knew them best. There were good records of bruising or any other changes to skin integrity, including photographs when relevant and body charts completed. There were also behavioural monitoring records for people who had behaviour that challenged the service.

However it was not always possible to establish through case tracking whether care was being delivered in line with people's care plans and whether correct procedures as specified were carried out. For example care plans for people with a PEG site (for feeding directly into their stomach) required the tube to be rotated weekly and regular flushes of water every day. However there were gaps of two or three weeks in the records for turning the site, and few records of water flushes being undertaken in the last two months. Risk assessments for one person at risk of pressure ulcers identified actions for staff including the use of turning charts. We were unable to locate turning charts for this person and staff informed us that there was no longer a need for this as this person was now able to move around in bed. Monthly Waterlow assessments (to assess people's risk of developing pressure ulcers) were recorded, however we did find some gaps in these records for three people.

One person's care plan indicated that they preferred to have a shower, but daily notes indicated that they were given a daily bed bath instead. Another person had signed an opt out for hourly night observations, however these were still being recorded for them. Fluid charts were not always totalled on a daily basis to ensure that people were

Requires improvement

Is the service responsive?

not at risk of dehydration. We discussed these issues with the interim manager, who was aware of the need to update each person's care plan, and we saw that this was included as a priority in the current improvement plan for the home.

Clear records were maintained of all incidents and accidents occurring at the home, however these did not always describe preventative action to reduce the risk of a reoccurrence. We found good evidence of relevant health care professionals being involved in people's care in response to fluctuations in physical care and recent diagnostic tests. Health care professionals provided positive feedback about the attitudes and responsiveness of staff towards their input.

People living in the home and their relatives had some awareness of how to make a complaint and all but one found the management responsive to their concerns. One relative told us that they visited every day and felt able to express any concerns with the management. They had done so in the past and said that the response had been immediate. Staff felt they could raise concerns and make suggestions about the workplace conditions. They could do this directly with managers or at scheduled staff meetings.

Copies of the complaints procedure were available in the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the registered manager so the situation could be addressed promptly. Records showed that when issues had been raised these had been investigated and feedback was given to the people concerned. Complaints were used as part of on-going learning by the service so that improvements could be made to the care people received.

We recommend that care plans, activities and stimulation for people living at the home be reviewed to ensure that their needs are met proactively and responsively.

Good

Is the service well-led?

Our findings

People spoke positively about the management of the home, although it was an uncertain time for all concerned whilst the future of the home was being decided with a possible move towards more short term rehabilitative care. One relative felt that the home would benefit from a more open culture particularly with regard to addressing complaints.

An interim manager was covering the home while the registered manager remained on long term sick leave. We observed that he spent time speaking to staff and people living at the home during the inspection. Staff reported that whilst this uncertain period was causing them some concern about their future employment, management support had been good, and the current manager was a "good listener," supportive and helpful.

Staff told us that the interim manager and deputy manager were approachable and accessible and provided the support they needed. They told us that work was shared fairly, and there was a good atmosphere, and effective teamwork, with nurses helping out if care staff were particularly busy.

The deputy manager was seen contributing to team work on busy occasions in the day. Staff confirmed they had regular supervision and could request extra supervision if they felt the need, for example during or after end of life care episodes.

The interim manager had identified staff members to take a lead role in particular areas including medicines, care planning, activities, nutrition, health and safety, and training. One nurse acted as coordinator for staff training and kept the records up to date. She herself was embarking on a management course and felt her aspirations and potential promotion possibilities were being addressed by the organisation.

The service's charter of rights was displayed in reception. We found that people and their relatives were consulted about the care provided in the home at a meeting in September 2015, and another meeting was planned. Issues discussed included activities provision, staffing, menus and the future of the home. A compliments file was available in the home's reception indicating a high level of satisfaction with care provided to particular individuals. No recent survey of people's views had been conducted for the home whilst the future of the service remained uncertain, however the interim manager advised that this was due.

Approximately quarterly staff meetings had been held for day and night staff, with separate meetings held for nursing staff. At recent meetings issues discussed included medicines, infection control, GP contacts, and learning from incidents. The interim manager had arranged for these to be held monthly in future.

We asked the manager how they reviewed the quality of the service. A dignity audit carried out in early 2015 had indicated a large number of areas for improvement including staffing levels, cleanliness, food provision and support, poor continence care, and training gaps. It was evident from our inspection that significant changes had been made since this audit, bringing about improvements for the service.

A detailed quality assurance assessment had been conducted in January 2015, with a resulting improvement plan which was reviewed regularly. We met with the interim provider manager for the service who met with the interim manager at least monthly to review progress with the plan.

The most recent update of the plan from October 2015 indicated that internal reviews were being scheduled on a six weekly basis for people living at the home, the efficiency of the staff rota was under review, care plans were to be updated, a residents forum was being piloted, low profile beds were being ordered, and personalisation of rooms was a priority.

The interim manager attended regular provider manager meetings, and meetings with the local clinical commissioning group. An external audit was being undertaken of the home's rotas, and staff annual leave and sickness in the home. The home received a five star (the highest) rating at the most recent food hygiene inspection, and had up to date safety certificates for gas, water, and electrical installations and portable appliance testing. A weekly health and safety checklist was in place, with prompt action taken to address issues of concern.

People living in the home, relatives and staff confirmed that repairs and maintenance to the home environment were undertaken quickly once reported. There was a shortage of storage space in the home resulting in some bedrooms being rather cluttered with boxes, and bathrooms being

Good

Is the service well-led?

used to store hoists. The home was showing signs in places of the need for some upgrading of décor and the building infrastructure including bathrooms and kitchenettes on each unit. The interim manager advised that all bedrooms had recently been painted, and other areas of the home were due to be redecorated next.