HC-One Oval Limited

Market Lavington Care Home

Inspection report

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Market Lavington
Devizes
Wiltshire
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23 March 2018
26 March 2018

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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

Market Lavington Care Home 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.

Market Lavington accommodates up to 87 people across two separate buildings, each of which have separate adapted facilities. The residential building is known as Vicarage Gardens and was named by the people who live there. At the time of our inspection 67 people were living in Market Lavington Care Home.

The inspection took place on 22, 23 and 26 March 2018 and was unannounced on the first day.

At the last inspection there was a breach of the legal requirements in the area of risk. During this inspection we found that improvements had been made.

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 manager has worked at the home for many years and was present on day two of the inspection. The deputy manager and the unit manager were available on days one, two and three.

The ordering storage and disposal of medicines was managed safely. We observed the lunchtime medicines round and saw that medicines were given in a safe and caring way. Medicine administration records (MARs) were completed correctly. There were appropriate systems and records in place for ordering and disposing of medicines. However, we found some out of date medicines and missing protocols for 'as required' medicines from the records. We have made a recommendation about the management of some medicines.

Staff sought people's consent before carrying out any support and they had knowledge of the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS). However there were many locked doors in the residential part of the home which restricted access to some areas. We have made a recommendation about best practice for people living with dementia.

People told us they felt safe. Staff knew and understood their responsibilities for safeguarding people against potential risk or harm, and were able to tell us how and when they would report any concerns. Staffing levels were appropriate to meet people's needs and staff recruitment practices were conducted correctly.

People were supported by staff who had access to training to equip them with the skills and knowledge they needed. Staff benefited from regular one to one supervision sessions to discuss their needs and development.

People and their relatives told us the staff were caring. We observed and heard many kind and compassionate interactions between staff and the people they were supporting. However, some interactions and information lacked dignity. We have made a recommendation about the practise of person centred care methods.

Care and support plans were individualised and contained information on people's likes, dislikes and preferred routines. People were supported to have maximum choice and control of their lives and staff supported people to make decisions.

There were systems in place to monitor and improve the quality and safety of the service provided. People, their relatives and staff were encouraged to share their views on the quality of the service people received. Where actions to improve had been identified these had been acted upon.

The home had a new provider and the registered manager was effectively supporting people, their relatives and the whole staff team with the changes.

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 personal safety had been assessed and plans were in place to minimise risks.

Staff were knowledgeable in recognising signs of potential abuse and what to do if they had any concerns.

Medicines were managed safely.

There were sufficient numbers of staff to support people's care needs and safe recruitment processes were in place.

Is the service effective?

Good

The service was effective.

Staff received the necessary training and had the skills to meet people's needs.

Staff benefited from induction and one to one supervision with their line manager.

People were being supported in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People's rooms were individualised and contained their personal belongings.

Staff were caring and compassionate in their approach and had a good understanding of people's needs.

Is the service responsive?

Good

The service was responsive.

Care and support plans were personalised and reviewed regularly, there was evidence of people and their relatives being involved in their care planning.

People were supported to follow their interests and there were groups and activities available as well as one to one time.

People and their relatives said they were able to raise any concerns and felt confident these would be acted upon.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

Staff said they felt able to approach any member of the management team for support and guidance.

Staff enjoyed working at the home and felt supported through the current change of provider.

Market Lavington Care 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 home has recently changed providers to HC-One (Oval); we inspected this service due to this change in registration.

This inspection took place on 22 and 23 and 26 March 2018 and was unannounced on the first day. The inspection team consisted of one inspector, one medicines inspector and one 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 areas of expertise for this expert by experience was in caring for older people and for people with a physical or learning disability.

Before the inspection, the provider completed 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. We looked at information held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required, by law, to tell us about.

We spoke with 10 people, five relatives, eight members of care staff, the administrator, the deputy manager, unit manager and registered manager. We spoke with three healthcare professionals who visit the service. During the inspection we looked at six care and support plans, four staff files, medicines records and other records relating to the management of the service. We also carried out observations, including a short observational framework inspection (SOFI).

Good

Is the service safe?

Our findings

People were protected from the risks of harm. A range of individual risk assessments and action plans were in place. For example, in one person's care and support plan we observed various risk assessments for moving and handling including a specific assessment for a 'rise and recline chair', 'falls', 'bed rails and bumpers.' Action plans included guidance for staff on how to manage the risks, for example, to safely use the rise and recline chair, staff were to help the person with positioning. For the use of bed rails and bumpers, the person was to be checked overnight every two hours to maintain their comfort and safety. We saw that risk assessments had been reviewed monthly for changes. Other care plans we observed had similar risk assessments in place, for example 'the risk of falls' and the monthly reviews had recorded, 'no falls identified this month.'

People told us they felt safe living at Market Lavington Care Home, one person told us, "I feel very safe here", another said, "If I want or need anything I only have to ask and they'll get it for me, the staff here are ever so good, yes, I feel very safe."

People were protected from the risks of potential abuse or harm. The home has a safeguarding policy and procedure in place and the Local Authority contact details and flowchart were on display in office areas. The staff we spoke with knew and understood how to identify abuse and how and when to report it. They had received the previous provider's mandatory training in safeguarding and records showed when this had been completed. Further training from the new provider was planned. Comments from members of staff included, "I would report anything that wasn't right, and I'm quite happy to go to the home manager and I would contact Wiltshire Council", another told us, "I have had safeguarding training and I would report any concerns to the GP and their family" and "It's about protecting vulnerable adults and I would go straight to [the registered manager] and [the deputy manager]."

The staff we spoke with were also aware of how to and when to whistle-blow, "I've never had to whistle-blow but if I had to I would have no concerns." Whistleblowing procedures ensure staff's (whistleblower) protection from reprisals when they raise concerns of misconduct witnessed by other staff towards people. At the time of our inspection, the service had reported incidents of safeguarding concerns appropriately.

Staffing levels meant that people received care and treatment in a timely manner. We observed that people cared for in bed had access to their call bells and were answered promptly when used. Sufficient numbers of nursing and caring staff were on duty rotas showed there was very little use of agency care staff. A staff member told us, "there is enough staff, I never feel like we need more, we balance the work between us all and if there is anyone off sick we use our own staff first, it's quite rare that we use agency."

Safe recruitment processes were in place. We looked at five staff files and all of the required safety checks were in place which included DBS, appropriate references and identity checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people. New staff were subject to an induction period and were shadowed until their competency was demonstrated.

During our inspection we looked at the systems in place to manage medicines. Medicines were stored securely and access was restricted to authorised staff. Temperatures were being recorded daily to ensure medicines were kept at appropriate temperatures and were within the recommended range. There were suitable arrangements for storing and recording medicines that required extra security. Opening dates were being recorded on liquid medicines. However, we did find one bottle of eardrops which had this recorded but had not been disposed of within the 28 days required. We also found one out of date medicine and one expired pack of blood glucose test strips. These had not been used since going out of date and were removed from the stock on the day. There were appropriate systems and records in place for ordering and disposing of medicines.

Staff administering medicines had been appropriately trained and annual competency assessments were completed. All medicines were administered by the staff and to ensure it was safe for people that wanted to self administer their medicines, risk assessments for this were to be completed.

We observed the lunchtime medicines round and saw that medicines were given in a safe and caring way. Nurses and senior staff used medicines administration records (MAR) charts to record when medicines had been administered. There were no gaps in the 12 MAR charts we reviewed and records showed that people were given their medicines in the way prescribed for them. Handwritten additions had been dated, signed and double-checked to confirm their accuracy. Medicines that were prescribed to be given as a variable dose such as 'one or two tablets' were recorded to show the actual quantity administered. Non-medicated creams and other external preparations were applied by staff and were recorded on a separate administration chart. There were some gaps in these administration records so it was not clear if the cream had been applied. This had also been identified in a recent internal audit.

Staff had additional guidance (protocols) for medicines prescribed to be taken 'when required' and they explained when medicines could be given. However, we saw a number of protocols missing from records on the day of inspection. This meant staff did not have access to additional information to enable them to give medicines as intended by the prescriber.

We recommend that the home consider current guidance on 'when required' medicines protocols , the safe disposal of medicines and the recording of the application of creams.

We observed that infection control practices were in place. The buildings were clean and tidy, with no odours. Bathrooms and communal areas had supplies of sanitising gel and were well stocked with toilet rolls and paper towels. The staff we spoke with knowledgeable about infection control processes including the safe use and storage of cleaning materials and the safe disposal of waste. They had been trained in infection control practices and told us the methods used, for example using different cloths and mops and always using PPE (personal protective equipment). There were fire exit signs visible, and fire doors were closed. Window restrictors were fitted on the upstairs communal dining area windows. Personal Emergency Evacuation Plans (PEEPs) on how staff were to support people in the safe evacuation of the property were in place.

We also observed thermometers in bathrooms to check water temperatures and radiators were covered. Maintenance checks were carried out and showed that water temperatures from the hot water supply were safe and completed weekly. There was also guidance for staff in bathrooms around 'safe bath and showering' and 'precautions to follow to reduce the risk of scalding.' In the kitchen areas there were maintenance checks on the hot water supply, and general kitchen safety guides.

The home had systems in place to monitor incidents, identify themes and take appropriate actions.

Some people required close monitoring of their weight and skin integrity. For example, one person had a plan of care of how to minimise risks. A detailed care and treatment plan was in place which included repositioning charts and body maps used to highlight the area of concern and to track healing and changes. These were appropriately dated.

Weight monitoring charts and a malnutrition universal screening tool (MUST) were used to assess the potential risks of malnutrition for another person. Documents completed by staff showed that this person was currently 'well-nourished and hydrated.'

A nurse told us fluid and food intake charts were only used when there was a need for them otherwise "they lose their value." They said that during the first week of a new admission, people were on these charts for staff to gain some 'baseline' information such as the person's appetite and weight.

Good

Is the service effective?

Our findings

People had been involved in their assessment and care plan development. Care records contained detailed information about their health and social care needs. We observed people had their life history recorded, detailing their preferred name, previous occupation, favourite memories and things which were important to them. Daily care logs showed where interaction using these details had been positive and the person was able to respond "we've had a good life." People were supported to make choices and enabled to make decisions. We saw DNAR orders (do not attempt resuscitation) and TEPs (treatment and escalation plans) which had been devised in conjunction with the GP, the person and their family.

The home has 'resident of the day', which means the person has extra special attention, such as their favourite meal or a special trip. Their care and support plan was reviewed with them and their relative and updated where necessary. Their room was deep cleaned and their family were invited in to share in special activities. One person's daily care stated, '[relative] contacted as [person] was resident of the day, no concerns raised and [they] are very happy with the care [person] receives.'

People were supported by staff who had access to training to equip them with the skills and knowledge they needed. Staff had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (MCA/DoLS); behaviour that challenges; the care of a person with dementia; pressure area care and safeguarding. Staff told us, "we go through workbooks and have face to face training" and "there is plenty of training, I've recently had good dementia training."

Staff had access to an on line training consultancy programme and all staff had training based on the Care Certificate (a set of standards that health and social care workers adhere to in their daily working life). This training covered areas such as, person centred care, dignity, equality and diversity, communication, health and safety, and infection control.

All new staff were subject to an induction period where training, observation and assessment in competency were undertaken. Staff were able to shadow more experienced staff and learn 'hands on'. Staff told us and records confirmed, they received support through regular one to one supervision. The meetings were used to discuss staff progress and identify any learning needs.

We observed the lunch time meal service. The atmosphere was pleasant and calm and the background music was appropriate to people's ages and a few people sang along together to the songs. The dining rooms had menus. Staff interacted with people when serving the meal and drinks. When people were eating, the staff were asking what they would like and if everything was OK with their meal. Staff stated to one person they were encouraging to eat, "It's not a big meal today [name of person], I should eat it. It's chicken, you like chicken." Another person was encouraged to drink plenty of fluids by being served the drink they preferred, "I love this juice" and staff responded with, "I know it's your favourite." We observed other staff members taking trays to people who ate in their rooms.

Later in the afternoon, a staff member came into the lounge area and sat with each person and spoke with

them about the menu choices for the next day's meal. People were offered alternatives if they didn't fancy the option. A care and support plan we looked at stated '[the person] likes to choose [their] meals from the menu daily.' The kitchen staff were informed when people required specific diets.

The service worked closely with other professionals to ensure that people were supported to maintain good health. During an observed handover we saw staff contact other health professionals where appropriate and involve the multi-disciplinary team in people's care.
The care and support plan for one person gave information and guidance on specific illnesses to help the staff understand certain behaviours. For another person their care and support plans showed involvement of the domiciliary dentist. A nurse told us, "we have really good relationships with the GP's and if we were concerned, they would come." The staff work closely with the continence and community nursing services.

The residential and dementia care section of the home had memory boxes outside of the rooms so people could easily recognise their own rooms. People were encouraged to bring personal items as they had photos, pictures, ornaments and furnishings that personalised the room and to make it more familiar. We observed one person had a delivery of their own chairs from home which they were very happy with and staff commented, "Oh, they look lovely in your room." However, we observed many keypads, locked doors and 'staff only' notices which did not make it feel homely and placed restrictions on where people had access.

We recommend that the home considers guidance on least restrictive practices, based on current best practice in relation to the specialist needs of people living with dementia.

The home sought people's consent and signed forms were in the care and support plans we observed. The home had carried out the necessary processes to ensure that the rights of people who lacked capacity were protected.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

We saw that one person who was not able to make the decision independently, to live in the home, was supported by an 'independent mental capacity advocate' (IMCA) who had been appointed to ensure that the person's best interests were fully considered. A DoLS application had been made for this person to the 'supervisory body' (the local authority) in accordance with the legal process.

Staff had completed MCA training, they demonstrated an understanding of the principles and were able to apply this to their work. One staff member told us, "Mental Capacity means to always assume the person has capacity unless you have reason to doubt it, we would do a best interest and it's in the care plan" another said "It's about the ability to make day to day decisions, and I would support them to do that as much as they can." A nurse told us, "there is a lot of consideration around capacity and if the person can make a decision."

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring. Comments included, "the staff are very kind here" and "I get three meals a day, I'm well cared for and I feel safe." A relative told us, "the staff are really caring, they know my [relative] very well." One of the many thank you cards and letters we saw said, "thank you for all the care you have given me I will miss the laughs we had."

The staff we spoke with were able to explain how they would care for a person in a dignified way, "It's about being respectful, so making sure doors and curtains are closed and I would get consent." We observed that consent was gained before support being provided, knocking on doors and staff asking permission to assist. A member of staff told us that, "If the person said no initially, then I would say OK and give them time and go back and ask again."

We observed one staff member not talking very much to the person they were assisting to eat at lunchtime. This member of staff responded to another person saying, "I'm feeding someone at the moment." Another staff member did not respond when one person spoke to them as they were filling up their glass. We felt these responses were not dignified.

The small kitchen dining areas had wipe boards with people's room numbers and their specific likes and dislikes. For example, 'room 28 likes hot food to be served HOT likes carrots or red cabbage.' It would be more dignified not to have people's information for others to read.

We recommend that the service seek advice and guidance from a reputable source about the practise of person centred care methods.

We heard a staff member talking very kindly and gently to a person who was upset with another person. They sat closely to the person, held their hand and comforted them. Another staff member was observed chatting to a person and asking if she "fancied having a walk outside" to see the daffodils. The staff member encouraged the person to button up their coat and put on their hat, enabling them to do these tasks for themselves. They held hands, had kind words, chit chat and laughter. A visiting professional commented, "the staff are always nice, very attentive, they explained to [the person] why they were here, took them to see their room and didn't rush them or anything."

Staff had received guidance on how to offer emotional support to people. For example, a person's spouse had recently died and the care plan detailed the person's preference to talk about their grief. One member of the activities team said that they were organising their time better so that they could spend more time with people in their rooms, just holding hands or doing a jigsaw, chatting to people and finding out about them. The registered manager told us that the ethos of the new provider was all about kindness and care being equitable, regardless of a person's situation, "everyone should have care."

The staff we spoke with talked affectionately about the people they provided care for and enjoyed being able to offer them time as well as provide care. One staff member said "I love seeing [the people] and love

coming to work" another said "I love it, it's a lovely home to work in." Daily care logs evidenced that staff interacted in an emotional way as well as providing physical support. For example, '[person] is having a good day today, cheerful and enjoyed a chat' , '[person] and I enjoyed a chat and shared a smile or two' and '[person] really enjoying sitting in [their] room looking out into the garden watching the birds; [they] said now that Spring is here [the person] is looking forward to going into the garden more.' One member of staff had painted a picture for a person, who said, "A member of staff done that for me, she knows I used to paint a bit and she only just took it up, so I said to her paint a beautiful sunset, I would love a beautiful sunset, and that's what she done for me, and framed it as well and put it up for me."

People were involved in the care they received. We observed one person looking through their drawer for a clean nightie. The staff member was helping and explained that their nightie had gone to be washed in the laundry and it would be back later. The person said "Oh I like that one" and the staff member said, "Yes I know that one's your favourite isn't it, but it had to be washed so it'll be back by tomorrow, choose one of your others for tonight." The person got two out and asked the staff member to hold them up so she could choose, "Would you like me to put this one under your pillow ready for tonight?" the person said "Oh yes please dear, thank you." We saw that care plans were reviewed with the person and their relatives being involved in the process,'[person] continues to be supported by staff so she can be involved in her care and make daily choices and decisions.'

Comments from people's relatives were positive, one relative said, "My mother is very happy here and all her needs are met and we couldn't be happier" and another said, "We think she is happier here than the home she used to live in, we are glad we got a place for her here." However, one relative we spoke with wanted to be kept more informed with regards to the provider changing and another would like to know more about planned activities to help communication with her relative. This was agreed by the unit manager at the time of the inspection.

People's dignity and privacy were respected. Care plans were written using respectful language and to protect people's dignity, photographs of wounds were placed into an envelope inside the care record folder. People's care and support records were stored securely to ensure privacy.
We observed dignified interaction, for example a staff member discreetly asking a person to go with them so that they could assist them. The staff member offered the person choices of where they wanted to go to be assisted and the person chose the bathroom.

Good

Is the service responsive?

Our findings

People's care and support plans were personalised and reviewed regularly. They included details of the support people required and what they were able to do independently. For example in one person's care and support plan it stated that the person could communicate their needs effectively but was not always realistic about their ability with standing. This person's care and support plan was reviewed and updated and a new plan of care for assisting with transfers included, 'all transfers are with full maxi move hoist and green edge sling.' The care and support plan evidenced that when the person was correctly positioned in their chair they were more independent. Staff had documented 'as long as [person] is in a well-supported position, [person] can drink from a glass to take their medication.' Another person's care and support plan stated, '[person] likes his bedroom door to be kept open, [person] enjoys a full cooked breakfast, a mug of coffee with two sugars.' A recent update showed that this person was now receiving a soft diet due to a decline in their health.However, "[person] continues to eat well with assistance and is able to inform staff if he is hungry, [person] has gained weight over one month."

One person's care and support plan contained a Pool Activity Level profile (PAL) as recommended by The National Institute for Clinical Excellence Clinical Guidelines for Dementia (NICE 2006). PAL has been widely used as the framework for providing activity based care for people with cognitive impairments, including dementia. This gave specific direction on how staff were to interact and respond to the person's challenging behaviours. For example, 'respond calmly to repetition as if it is the first time you are responding', 'use body language and facial expression to assist with communication.'

We observed one person who was experiencing pain and shouted out for assistance. A staff member responded quickly and was heard to say they would check the person's medicine and asked if there was anything else they could do for the person. The nurse on duty also responded promptly and gently explained to the person why she was not able to administer further medication. The nurse tried a different method of pain relief and made a hot water bottle with a cover and used this to try to give the person some comfort.

People were encouraged and supported to maintain an interest in social activities. There were 'well being' programmes available on notice boards and in the main corridors, with pictures to identify the activity throughout the day. Care and support plans detailed the types of previous pass times people were interested in and if they had any impairment which could affect their communication and how this could be addressed, for example sight or hearing loss.

Activities included painting, quizzes and Zoolab. In the summer months there were more outdoor activities such as planting up pots for the garden and trips out to the bluebell woods or the garden centre. The home had an open door visiting policy and relatives and friends were able to come and go as they pleased. There were two full time activities coordinators for the whole home.

The activities coordinator was flexible and reactive to people's requirements and changed the programme accordingly. One staff member said, "It is very much about the moment here, as we may plan a quiz but then

the few people that [attend] may not want a quiz or be capable of the quiz so I have to adjust what I'm doing for the needs of the people who [attend]." They have frequent visits to the local café, pub and shopping trips using the bus for people using wheelchairs.

People and their relatives were able to raise a concern or a complaint and were confident it would be acted upon. One person said, "I've never had to make a complaint because there's never been anything to complain about." Another person said, If I'm not happy about anything I will just tell a member of staff, they're all pretty good and they all listen, you pretty much talk to any of them." The registered manager confirmed that [they] would respond immediately face to face, in writing or an email. They said, "If things are dealt with at the time then it doesn't escalate." The home has a complaints policy and procedure in place. Staff were also able to confirm how to make a complaint if they felt the need to do so.

People's care and support plans contained 'future decision care plans' which detailed people's preferences for end of life care. One person's care detailed that their preference and decision was to remain at the home. The staff had recorded, '[person] says he would like a peaceful, natural death.' The home had close links with the local hospice, who advised on end of life care planning.

Good

Is the service well-led?

Our findings

Market Lavington Care Home was going through a challenging transition period to a new provider. A clear vision, ethos and strategy was being fed down from the new provider to the whole staff group through the management team. The registered manager told us that she did not want to bombard and overload staff and was filtering the changes down as they were coming in. The new provider had spoken with staff about their ideas. One idea was that they want to make the home more 'homely' and less clinical. One staff member said, "the emphasis is on kindness, and I think it's going to be brilliant." A nurse told us, "[the new provider] is making good changes and have been helpful and positive." The registered manager had recently attended the new provider's 'welcome conference' and said "I felt immediately comfortable, every person I have spoken with so far has a background in care. There is lots of support from other homes and managers." The home has a daily morning 'flash meeting' to communicate important information for staff.

There was a registered manager in post. The staff we spoke with were very complimentary of the support they received from the management team. Comments included, "brilliant, great communication", "I can go to them with anything", "really open and supportive." The registered manager told us that they liked to help people develop and this is something which will be encouraged from the new provider, she told us, "The new provider is very receptive to suggestions on what is good and new ideas from staff, they will listen and it makes you feel that you have a voice" and "I'm pretty optimistic." A staff member told us that, "career development is fabulous, I have progressed with the registered manager, I transfer my skills and am looking now at [the new provider]."

The home has residents and relatives meetings where they can discuss what was working or not working. Some comments from relatives included needing to be kept up to date with the current changes. During the inspection, the management team said they were looking at ways to improve how they communicated with relatives and to 'keep them in the loop' more. For example the home has a new newsletter for people, their relatives and visitors to inform them of current 'home' news such as activities and trips to look forward to and special events. Current ratings were displayed in the main reception area of the home and are on the homes website.

The registered manager had effective processes and systems in place to monitor the quality of the services being delivered. The data was sent via the provider's intranet to be reviewed by their quality team and trends and patterns could be observed for each person. Care quality checks included medicines, infection control and accidents and incidents. We also observed that
regular maintenance checks of the building and supporting services such as gas, electricity, water and fire alarm checks are carried out monthly. Where issues had been identified actions had been put in place to address them.

The home has close links with the multi-disciplinary team. They have GP surgery link nurses who visit regularly, tissue viability nurses and the local hospice team. The registered manager regularly attends Wiltshire Care Partnership meetings for networking, learning and development.

There were regular staff meetings to keep up to date, to share good practice and identify areas to improve, which were documented and actions taken where appropriate. The home has close links with the local community. They have frequent visits to the pub and café, invite the toddler group in for singing nursery rhymes and join the village school and church for Remembrance Sunday, Christmas and other church services.