Pine View Care Homes Ltd

Royal Manor Nursing Home

Inspection report

346 Uttoxeter New Road
Derby
Derbyshire
DE22 3HS

Tel: 01332340100

Date of inspection visit:
12 December 2017

Date of publication:
19 February 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 inspection visit took place on 12 December 2017. At the last inspection in October 2016 the service was rated as Requires Improvement. At this inspection, we found the provider had made some improvements to the service and others were planned or in progress.

Royal Manor Nursing Home is a care home which provides residential and nursing care to older people including people recovering from physical and mental health issues and some who are living with dementia. 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. Royal Manor Nursing Home is registered to provide care for up to 31 people. At the time of our inspection there were 24 people using the service.

The service had 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.

Potential risks people were exposed to had been identified and assessed. Risk assessments provided information and guidance to support staff to carry out their role. However, information in some records was contradictory and could be confusing for staff. Staff were knowledgeable about the needs of people whose behaviours could challenge. Records required further development to ensure staff were provided with clear guidance on interventions and responses to keep people safe.

Staff were able to describe the signs and symptoms of abuse and felt confident to report them. The provider's safeguarding policy required reviewing to provide people and staff with contact details for external agencies to support them to raise concerns outside of the service.

Effective recruitment processes were followed and there were enough staff to meet people's needs. People received their medicines safely and as prescribed.

Systems were in place to ensure the premises were kept clean and hygienic so that people were protected by the prevention and control of infection. We found two items of furniture that presented a risk to the control of infection.

There were arrangements in place for staff to monitor and take action when people experienced accidents or incidents. Further work was required to collect this information and use it to identify trends and patterns in accidents and incidents within the service to improve safety.

People's needs and choices were assessed and their provided in line with their wishes, preference and desired outcomes. People were supported to be involved and make decisions and choices about their care.

We made a recommendation about care plans.

Staff were provided with regular opportunities to keep their knowledge and skills up to date. This included essential training and on-going development training. This supported staff to provide effective care based on current best practice.

People were supported to have sufficient to eat and drink in line with their dietary needs. People were supported by staff to use and access a wide variety of other services and health care professionals to maintain their health and well-being. Staff supported people to access health appointments when required to make sure they received continuing healthcare to meet their needs.

Staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA). They gained people's consent before providing care and respected people's right to decline their care.

The provider was in the process of upgrading the décor of the premises to support people using the service.

People had developed positive relationships with staff, who were kind and caring and treated people with respect. Staff understood people's individual needs and preferred means of communicating and this support people to receive and share information about their care. Care was provided in a way that supported people to maintain their independence whilst respecting their right to privacy and dignity.

Care plans provided staff with detailed information and guidance about people's likes, dislikes, preferences and guidance from any professionals involved in their care. People and their relatives were involved in planning all aspects of their care and support, including reviews of their care to ensure their needs were being met. Records were regularly reviewed to ensure care met people's current needs. This helped to enable staff to provide personalised care.

People were supported to pursue hobbies and interests and could choose from a wide range of activities, including group and one-to-one sessions. This helped to reduce the risk of people feeling socially isolated.

People, relatives and staff knew how to raise concerns and make a complaint if they needed to. Complaints had been investigated and action taken to resolve people's concerns. The registered manager used complaints to bring about improvements within the service.

The management and leadership within the service had a clear structure and managers demonstrated they were knowledgeable about people's needs, the key issues and challenges within the service. Staff felt supported and able to share their views with managers and the provider. Staff were positive about the improvements made since our last inspection which had resulted in more effective communication and improvements in the care provided.

The provider had systems in place to monitor the quality of the service. These included audits of key aspects of the service. People and those important to them were supported to share their views about the quality of care they received. These were used to drive improvements and develop the service to ensure people received good care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were systems in place to protect people from the risk of abuse and staff were aware of their responsibilities. Risks were assessed, records required further detail to provide the information all staff needed to keep people safe from harm or injury. People were supported to take their medicines safely.

The provider analysed and reviewed each accident and incident. Systems required further development to ensure processes were effective in identifying trends and patterns to reduce the risk of accidents/incident or near misses re-occurring.

Is the service effective?

Good

The service was effective.

People's needs were assessed and met by staff who had completed the training they needed to provide effective care. Staff received supervision to support their professional development. People were supported to maintain their health and well-being.

Staff understood the principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline their care.

Is the service caring?

Good

The service was caring.

People and their relatives felt staff were kind and caring. People were involved in developing their care plans and provided with support to make choices and decisions about their care.

Staff treated people with respect and could explain how they protected people's right to privacy and dignity. We saw all but one staff member applied this in practice.

Is the service responsive?

Good

The service was responsive.

People and those important to them were involved in the development and review of their care. Care plans and assessments were personalised to meet individual needs, wishes and preference.

People were supported to pursue hobbies and interests of their choice. A complaints policy was in place and people knew how to complain if they needed to.

Is the service well-led?

Good

The service was well-led.

The management and leadership of the service were supportive of people's needs and provided staff with the guidance and support they needed to provide good care.

People and staff were supported to share their views about the service. Audits and checks were used to drive improvements and develop the service.

Royal Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 December 2017 and was unannounced.

The inspection team consisted of one adult social care inspector, a Specialist Advisor whose area of specialism was Mental Health and Dementia 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. Our Expert-by-Experience had experience in supporting people living with dementia.

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 also reviewed notifications we had received from the service. Providers are required to notify us about specific events and incidents that occur in the service. We contacted commissioners, responsible for funding some of the people using the service, to gain their views on the care provided. They told us the provider needed to make further improvements to meet their quality standards. Our review of this information enabled us to ensure that we were aware of, and could address any potential areas of concern.

During this inspection, we spoke with four people who used the service, four relatives, the registered manager who was also the registered provider and six members of staff, including the compliance manager who was responsible for the quality of care in the service. We sampled six people's care plans and records to see if people were receiving the care they needed. We sampled four staff files including the recruitment process. We looked at some of the provider's quality assurance and audit records to see how they monitored the quality of the service and other records relating to the day-to-day running of the service. We observed care provided in communal areas. This helped us to evaluate the quality of interactions that took place between people and the staff who supported them.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person told us, "I feel safe here, rather than on my own. They [staff] position my equipment so I can get to it easily and safely." Relatives spoke positively about the care and support their family members' received and told us they felt the service was safe. One relative told us, "[Name of family member] is safe here. I visit her most days and I've no cause for concern. They [staff] rang me once because she had a bruise and they didn't know how she got it. I've no concerns." Another relative told us their family member had not been using the service for long but they were safe in the service because they had not had any falls, which had been a concern prior to using the service.

Staff were able to tell us about the signs and types of abuse. Most staff were confident about how they would report any allegations or actual abuse. One staff member told us, "I feel people are safe because they are observed and supported. I am aware of the [providers'] safeguarding policy and procedures. I feel confident to report concerns to the nurse or the owner and am aware of the need to maintain confidentiality." The staff member was able to identify external agencies they could go to if they needed to escalate their concerns. Another staff member was able to describe how they monitored people for changes in behaviours or moods, which could be indicators of abuse. They told us, "People are safe because there is enough staff and we don't cut corners. I would report any concerns to the nurses. I know I can contact the local authority safeguarding or CQC with concerns."

We reviewed the provider's safeguarding policy. This included information about types of abuse, responsibilities of agencies, whistleblowing and case studies to support staff to understand possible indicators of abuse and how to support people who were at risk of or experienced actual abuse. One staff member was not fully aware of external agencies they could go to raise concerns about safeguarding (protecting people from abuse). They told us they would have to look this information up on-line. We noted the policy did not include contact details of external agencies to support staff to make referrals outside of the service. The compliance manager told us they would review the policy to ensure these details were included.

Staff told us they had completed training in protecting people from abuse and this was confirmed in records we saw. Staff were supported to keep their knowledge and skills up to date through distance learning training which included best practice in protecting people from the risk of abuse.

Risk assessments were in place and were included in people's care plans. For instance, where one person was at risk due to their mobility needs, their risk assessment detailed the equipment staff needed to use to reduce the risk. A second person was identified as being at risk of falling in a particular area of the service. Staff had responded by moving the person to a ground floor room and increasing supervision during key times which had reduced the falls for the person. Staff demonstrated they understood how to keep people safe. One staff member told us, "Where people may be at risk, we are aware of this and observe and supervise. We have observation charts in place so we can identify if the needs of the person have changed." Another staff member told us, "We follow risk assessments. For example, if a person needs hoisting, we always use two staff to support them and use the right equipment. We don't take any short cuts."

Information in some risk assessments that we sampled was contradictory. For example, a person had been assessed as being at high risk of falls and required supervision when they walked around the service. We reviewed other records in their care plan which identified they were at medium risk of falls and did not require supervision. This information may be confusing for staff who were new to supporting the person. We raised this with the compliance manager who told us they would review records to ensure they were accurate and reflected people's current needs.

We looked at how the risks associated with behaviour that challenges us were managed. We found people's care plans did not always provide clear guidance for staff to respond and manage challenging situations. For example, records identified people may demonstrate behaviours that may challenge due to their health needs. However, guidance for staff on how to intervene and respond to these situations lacked detail. For instance, one person was identified as becoming agitated if they felt confronted by staff. Records instructed staff to 'Diffuse, use a low tone,' and leave to calm for 30 minutes. There was no reference as to how staff should diffuse the behaviour to reduce the person's agitation. When we spoke with staff, they were able to describe, in detail, possible triggers and distraction techniques. This meant that although existing staff were familiar with the person's needs, records would not support staff who were new to the person to understand how they should respond in the event the person became agitated. The compliance manager told us they would review records to ensure they included the information staff needed.

The provider had fire policies and procedures in place to ensure regular safety checks were carried out. We saw people had an emergency evacuation plan (PEEP) in place, which contained information about the support people needed to safely evacuate the premises. The provider used a colour coding system of red, amber or green to indicate the level of risk and support each person required in the event they needed to evacuate the building and symbols were placed above people's bedroom doors as a quick reference for staff. Staff had completed training in fire awareness and health and safety which helped to provide them with information regarding their role and responsibilities in keeping people safe.

At our last inspection we asked the provider to make improvements to ensure staff were deployed in sufficient numbers to ensure people were cared for safely. Staff told us they felt there enough staff around and they did not feel rushed which enabled them to provide safe care. A relative told us, "There is enough staff and a good mix of skills and knowledge." We saw staff were busy but had time to spend talking with people and were meeting their needs. We reviewed staff rotas, which showed staffing levels were consistent with what our observations at the time of the inspection.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures. Staff files included evidence of employment history, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out criminal record and barring checks on individuals who intend to work with people who use care and support services and helps employers to make safer recruitment decisions.

People received the support they needed to take their medicines safely. One person told us, "Yes, they handle the medication okay." A relative told us their family member could decline to take their medicines and when they did, staff always let them know.

We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately. This included the management of controlled drugs. Protocols were in place for medicines prescribed as and when required [PRN}. Where medicine was administered covertly [administered in food or drink], this was supported by protocols. Records showed people's rights had been considered and best interest procedures had been

followed.

We observed staff followed infection control procedures. We saw staff wore clean gloves and aprons when supporting people with their personal care and when preparing meals. Gloves were available in communal areas and hand sanitizer units were available throughout the service for people, staff and visitors. Staff told us they had completed training in infection control and standards were monitored by the compliance manager, and this was confirmed in records we saw.

People's rooms and communal areas were clean, although some furniture required replacement. We found two armchairs in a communal area where seats were ripped, exposing the inner stuffing. These were potential risks in managing infection control. The compliance manager told us the provider would remove the chairs immediately following our visit.

The provider understood their responsibilities to review concerns in relation to health and safety and near misses. Staff recorded all accidents and incidents and these were analysed and reviewed on an individual basis. For example, one person had experienced an increase in falls. Records showed action had been taken in response to each fall, which included increased observations. An analysis of the falls identified that these happened in a particular area of the service and as such the provider had taken action to reduce the risk of further falls. Systems were not in place to closely analyse accidents and incidents to look for any trends. This is important to enable the provider to identify any trends or patterns that may affect more than one person. The compliance manager told us they would implement a system to address these concerns.

Good

Is the service effective?

Our findings

Staff told us they had the required skills and knowledge to support people using the service. One staff member said, "I have completed a lot of training, all the essential training and some development. [Name of provider] has his own training packs. At the moment I am undertaking additional development training. They [provider] encourage you to develop through training." Another staff member told us, "I have just completed training in Dementia and Dysphasia [swallowing difficulties]. I feel confident I have completed enough training to meet people's current needs."

One relative told us, "I think the staff have the right mix of knowledge and skills to care for [name of family member]. They seem to know what they are doing. They communicate with me; they'll give me a ring and tell me what's going on. They keep me informed."

The compliance manager told us all staff were required to undertake induction training into the role of the care worker. This included the completion of a work booklet which enabled the staff member to reflect on their working practices with their line manager. Staff were also expected to complete the Care Certificate. This is a set of nationally recognised standards which support staff working in care and support to develop the skills, knowledge and behaviours needed in their role. Training was provided through a combination of distance learning and face-to-face, which was evaluated through staff supervision. Records showed staff had undertaken a range of training and were provided with opportunities to update their knowledge and skills to support best practice.

People's needs were assessed during an initial assessment prior to them using the service. The assessment covered people's physical and emotional needs, their wishes and preferences which enabled staff to meet diverse needs. Each person was supported to identify an outcome of their care, and this ranged from support to manage health conditions to daily living skills. Assessments and care plans were shared with other health and social care professionals who were involved in the person's care, which helped to ensure the care provided met people's assessed needs.

Staff told us they felt supported in their roles. One staff member told us, "I do have supervisions. They [managers] feedback on where I need to improve. They [managers] give you a pat on the back to acknowledge good work." Another staff member told us, "I do have supervisions but they are infrequent. I have really good support from the team and feel I can approach [name of provider] if I want to get something off my chest or make suggestions. They do support us informally." Nurses told us they completed peer supervisions between them but this was not documented.

People and relatives spoke positively about the meals provided. One person told us, "The food is wonderful! We have two very good cooks. Today I thoroughly enjoyed my lunch." A relative told us, "The menu is on the wall every day. People have a choice of food and snacks and staff monitor [name of family member] food." Another relative told us their family member needed encouragement and support to eat. They told us staff provided this support and monitored their family member's weight. During the lunchtime meal, we saw staff provided the person with appropriate support as the relative described.

We observed the lunchtime meal to understand people's mealtime experience. People were offered a choice of two cooked meals, followed by a dessert, The food was nutritious and well presented and people were consulted about portion sizes and condiments to accompany their meal. A choice of drinks was offered. Tables were set with tablecloths and flowers. The provider had recently re-arranged the layout of the dining room following recommendations by an external agency. They told us they were consulting with people and staff as to which arrangement they felt worked best. Some people told us they did not like the arrangement as they did not want to face people whilst they were eating. We saw people were able to choose where they wanted to sit, with some people preferring to sit at smaller, side tables.

People were supported to maintain a healthy, balanced diet. Where people were at risk of poor nutrition, we saw staff responded to this. For example, one person had not eaten very much of their meal. Staff liaised with the cook to inform them of this and advised us they would try with an alternative choice a short time later. Where people required staff support to eat their meals, this was provided in a sensitive way and at the person's preferred pace. People were supported to take their time to eat their meal which added to a positive meal-time experience.

One person was supported to eat their meal in the lounge in line with their assessed needs. We saw staff consulted with the person and advised them what they had on their plate and checked if they were happy with their meal. The person required staff prompts to ensure they did not eat their meal too quickly, putting them at risk of choking. We saw this support was not provided consistently. For example, the person ate their main meal very quickly, causing them to cough. However, they received staff prompts to drink and eat their dessert and as a result they consumed these at a much slower pace. We raised these concerns with the registered manager who told us they would ensure staff supported the person consistently.

People were supported to maintain their health and well-being. People's care plans included guidance about their health needs. For example, where one person had previously had a pressure sore, their care plan included a 'wound file' which detailed risks, prevention and treatment. A body map had been completed to guide staff on areas most at risk. Records showed external health professionals had been involved and advice provided on care and treatment had been included in the person's care records.

Staff maintained regular interactions with health professionals to address concerns and records kept were detailed. People were supported to access routine health appointments in addition to specific healthcare to support them to manage their health conditions. People were monitored when concerns were identified and handover documents were in place for staff to communicate any concerns or changes in between shifts. This helped to ensure effective communication between staff and health professionals when people's needs changed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their bests 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).

People were supported to make choices and decisions about their care. People's care plans included mental capacity assessments which detailed decisions people were able to make, what support they

needed and the best time of day and environment for people to make choices and decisions. Where people had DoLS authorisations in place, for example choice of care home or because they required constant supervision, these were kept under review and new applications made in a timely manner and any conditions complied with.

Staff demonstrated an understanding of the guidelines within the MCA. Staff told us they had completed training in mental capacity and this was confirmed in records we saw. We saw staff sought consent from people before providing care and support. Where people declined their care, we saw staff respected their decision and tried different approaches to gain people's consent. Staff told us sometimes the approaches worked but other times people continued to decline care. At these times, staff respected the person's choices, recorded the outcome and informed senior staff. Where people lacked mental capacity to decline care and treatment in their best interests, for example medicines, protocols were in place which were supported by decision specific mental capacity assessments and best interest decisions. Records showed these were regularly reviewed.

The provider was in the process of upgrading the premises to support people using the service. Work already completed at the time of our inspection included different coloured doors to bedrooms to enable people to recognise their room, safety gates to stairways, tactile wall art and décor and an activities room which included provided a bar as well as a private area for relatives to meet with their family members. The compliance manager told us further work was planned which included memory boxes outside of bedrooms which they were in the process of developing with people and their families to support reminiscence, name plates for bedroom doors and dementia friendly signage to support people to move around the premises.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us staff were kind and caring. One person told us, "The staff treat me with dignity and respect. They are all kind." A relative told us, "The staff are kind and caring and they respect [name of family member] dignity. We are happy and glad we picked this home." Another relative told us, "The staff are kind. I haven't seen any behaviour that has caused me concern. No raised voices or anything like that."

Staff understood the best communication methods for people and were knowledgeable about the people they supported. This was evident during discussions where each member of staff demonstrated good knowledge about people's likes and dislikes, preferences and how to manage complex behaviours or medical problems. Staff used communication boards and books to support people with specific communication needs to express their views and make choices and decisions about their care.

Staff shared with us how much they enjoyed their work. Comments included, "It's the one-to-one moments that make the job. When you have a break through with someone who is living with dementia and they connect with you. The good days make the job worth it," and "I get satisfaction from helping someone. Making people more comfortable and supporting their dignity in what they may find embarrassing situations is rewarding." Staff told us they had time to care and we observed positive relationships between people and staff.

People were treated as individuals and supported to make decisions and choices about the way they wanted their care to be provided. Care plans reflected people's preferences and outcomes they wanted. For example, routines that were important to them and how they wished to be supported. For instance, for one person it was important that staff supported them to keep their bedroom clean and tidy. For another person, it was important that staff supported them to maintain their health and stay 'pain-free.' Records showed staff were aware of this and recorded support had been provided in line with people's wishes.

Information on advocacy services was available if people needed to use them. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

Most staff demonstrated they knew how to provide care in a dignified way. Staff were able to describe how they protected people's privacy and dignity when supporting them with personal care. For example, by closing doors and curtains, ensuring people remained covered and asking visitors to leave whilst people were receiving care. We observed staff addressed people by their preferred name and spoke with them with respect and compassion. Staff knocked on people's bedroom doors before entering, announced themselves and checked people were happy for them to be in the room. One member of staff did not fully observe a person's privacy and dignity in a communal area, where the person was sat with two visitors. The staff member approached the person and asked, in a loud voice if it was time for the person to go to the toilet. We raised this lack of awareness with the compliance manager who told us they would address this following our inspection.

Good

Is the service responsive?

Our findings

People and relatives felt staff were responsive to their individual needs. One person told us, "They [staff] know I enjoy a shower, it's important to me, and there is a fantastic shower room now. I can seriously say I enjoy the whole experience of having a shower. Staff can be humorous in encouraging you to be independent." A relative told us, "[Name of family member] likes to be independent and do things for herself. Staff know this is important to her and let her whilst checking on her." Another relative told us how their family member did not know what to do when they first started using the service. They told us staff were quick to identify this and gave them a little job which they did each day. Staff recognised that it was important for the person to feel involved and to be helpful.

Staff regularly spoke with people about how they would like to be supported and outcomes they wanted from the care provided. People and those close to them were supported to contribute to their care planning where they were able to do so. The assessment and care planning process considered people's values, beliefs, hobbies and interests alongside their goals for the future. Care plans included a summary of the person's life history, significant events and what and who was important to them. Guidance was provided regarding how people liked to be supported, preferred routines and what they liked around them. This information was used by staff to provide personalised care.

Care plans were held electronically and accessed by relevant staff only. We found care records were lengthy and it was not always easy to see at a glance what a person's needs and wishes were.

People and their relatives were involved in reviews of their care to ensure the care provided met their current needs. Reviews were undertaken regularly or in response to a change in a person's needs. For example, where one person had experienced falls, records showed their care plan had been reviewed and updated to reflect support around prevention of falls and intervention from staff.

The provider had explored ways in which technology could enhance people's lives. For example, staff were trying a new model of senor mat based on laser beams which could support people who were at risk of falls during the night. Staff were using an electronic system to record care records and staff told us this had had a positive impact on the way they worked as they were able to record 'in the moment' and information was stored in the same place. The provider told us they were able to log onto the system at any time and if they had any concerns regarding records, for example incomplete records, they could contact the service quickly and ask for a rationale.

People were supported to follow their interests and take part in social activities. The provider employed a member of staff who was responsible for activities within the service. They told us they provided a wide range of activities in response to people's interests and needs. Group activities, such as bingo, dominoes or arts and crafts were available. A visiting library provided books and magazines for people to browse through. Additional activities were provided on a one-to-one basis. For example, they told us one person liked the Queen so the activity co-ordinator brought in magazines with pictures of the monarch in them and helped the person make a scrap book which they looked through together. Another person experienced moments

of disorientation and looked for a bus to catch so the activity co-ordinator found bus timetables and spent time 'waiting' with the person. They told us this helped to reduce the person's anxiety.

We observed group games and an arts and crafts activity during our visit. We saw people enjoyed participating in the activities. Some people preferred to sit and watch rather than join in and this was encouraged by staff. One person sang Christmas carols to the group and other people clapped in appreciation. These planned and spontaneous activities helped to reduce the risk of people feeling isolated within the service.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it. For example, people were supported to communicate using individual communication boards and books. However, the compliance manager was unable to locate these resources during our inspection visit. Where people had specific communication needs, these were recorded in care plans. For example, one person required staff to speak clearly, in a loud voice, maintain eye contact and use a communication board. The provider did not have a policy outlining how they complied with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The compliance manager told us they would ensure the provider put this in place following our visit and that people's care plans clearly recorded any specific needs regarding accessing information.

A complaints policy was in place and information was accessible on noticeboards in communal areas for people, staff, visitors and relatives. The complaints policy required further review to include information about the Local Government Ombudsman. This is important to support people to escalate their complaint if they felt the service had not resolved their complaint. The compliance manager told us they would review and update the policy.

People and relatives told us they felt able to raise concerns and complaints if they needed to. The provider had received three complaints in the last twelve months. We saw the provider kept records of details of complaints and action taken to resolve the complaint. Records showed complainants had been happy with the action taken by the provider and felt their complaints had been resolved to their satisfaction. The provider used complaints to bring about improvements for people, either individually or for the service, for instance in staff working practices.

Good

Is the service well-led?

Our findings

People and relatives were generally positive about the management and leadership of the service. One person told us, "They do things the way I want them to. There is always a nurse in charge and that's good. Staff are very approachable." Relatives told us they felt able to visit when they wished and were always made to feel welcome by staff. One relative told us, "It's not regimented here, for example, people can have food when they want. The owners are very nice. They know all the residents by name and say hello to them when they come. The owners come every day." Another relative told us, "Staff keep me informed and tell me what's going on. I have informal talks with staff everyday. I know a lot of the staff by name. Rarely do I see a new face."

The service had a registered manager in post who was also the owner. They were supported by a compliance manager who managed the day-to-day running of the service. They worked closely with the nursing staff who were responsible for day-to-day care and support and providing daily supervision, monitoring and support of staff. This clear leadership structure supported effective communication and encouraged staff to be included in decision making and information sharing.

Staff told us the registered manager and senior staff had an open approach and were easy to talk to. Staff felt there had been improvements to the service since our last inspection and these were on-going. One staff member told us, "[Name of registered manager] spends time talking to the residents and staff. He does listen. For example, we asked him for some pressure mats and we got them straight away. The home has changed for the better since the last inspection. The compliance lead has been a great benefit. She has helped to increase our knowledge and is supportive to staff." Other comments from staff were, "There have been changes which are good, for example the activities are really good now. People are more stimulated." and "I think the service is well-led. [Name of registered manager] is approachable and gives us feedback informally on how we are doing. I can't pick any faults," and "Communication is a lot better now. The new IT system supports better information sharing. [Name of owners] are approachable. I can raise issues and make suggestions and these are listened to, and "I like all the improvements they [provider] is trying to make. It [the service] is still getting there but things are a lot better."

Staff were supported to share their views through staff meetings. We looked at records relating to meetings held in May and September 2017 and saw a range of issues were discussed. These included improving working practices, sharing information and discussing best practice. Where staff had made suggestions for improvements, these had been discussed and implemented where practicable.

Staff told us they received feedback about their work and performance but formal supervision was irregular. Staff told us they were clear in the areas where they were competent and received support in areas in which they needed to develop. The compliance manager told us more formal supervisions were planned for staff.

Managers and staff told us the staff team worked well together. The staff team was diverse and this was recognised and supported. For example, staff were aware and respectful of each other's cultures and provided cover so they could celebrate key festivals and events. The providers Equality policy described a

culture where people and staff were treated equally with zero tolerance of discrimination and this was confirmed by staff who we spoke with.

The quality of the care was regularly monitored. Audits were undertaken by the compliance manager and included care records, health and safety, complaints and medicines. These helped to highlight areas where the service was performing well and the areas which required development. Where standards fell short of expectations, these were investigated and actions taken to bring about improvement. For example, where care records had not been completed to required standard, this had been addressed with staff and examples provided of best practice. Monitoring charts to support people to maintain their health, such as weight, fluid and turning charts, were audited and records checked to ensure action had been taken if there had been changes in people's needs. Where there were concerns, for instance during the night, the compliance manager undertook unannounced spot checks to assure themselves that people were receiving good care. Actions plans were developed and shared with the registered manager who was responsible for signing these off to confirm improvements had been made. This demonstrated that the registered manager used quality assurance to drive improvements within the service.

Surveys were sent out to people and relatives to gain their views about the service. Comments shared during surveys sent out in June 2017 showed that people and their relatives were generally happy with their care.

The registered manager demonstrated they understood their responsibilities and what was expected of them regarding their legal obligation to notify us about certain events. Appropriate notifications had been made about significant events within the service. The registered manager was clear on the challenges of the service and where improvements were needed. It was clear that work was in progress to bring about improvements they had detailed within their Provider Information Return and these were on-going to ensure the continued development of the service.