Premium Healthcare Limited

Hythe Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection visit was carried out on 08 January 2015 and was unannounced. The previous inspection was carried out in July 2013, and there were no concerns.

Hythe Nursing Home provides accommodation and nursing care for up to 40 older people. The premises consist of an older detached house, with the addition of two newer built wings at either side. The home is situated in a residential area of Hythe, set back on a hill.

Accommodation is provided on two floors, with access to all areas via two passenger lifts. One of the communal rooms and access to the garden is on the lower ground floor.

The service is run by a registered manager, who was present on the day of the inspection visit. (A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). No applications had been made to the DoLS department for depriving people of their liberty for their own safety.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so.

The service had systems in place for on-going monitoring of the environment and facilities. This included maintenance checks, and health and safety checks. The premises were well-maintained, and had undergone a complete renovation during the past year. Risk assessments were implemented for each person living in the home, highlighting specific concerns which could affect their welfare and safety. This included the risk of falls, risks associated with using bed rails, and risks with the facilities and equipment within their own rooms. Some people had specialist pressure-relieving mattresses and cushions, and checks included ensuring there were no trailing wires which could lead to accidents. The registered manager monitored any accidents to assess the frequency and location of these. She identified if there were any patterns, and if there was action which could be taken to prevent future accidents.

People spoke highly of the staff, and said they felt safe and secure with them. People who were asked if they felt safe in the home all responded positively, with comments such as "Oh yes, it's all safe here". There were sufficient numbers of staff to meet people's needs, and to give them time, and not to rush them. This included nurses throughout the twenty-four hours. The service had robust recruitment procedures to ensure that staff were suitable for their different job roles. Records of on-going staff training, supervision and appraisals confirmed that staff were working to appropriate standards and were supported by their line managers. Staff were encouraged to attend meetings, and to take their part in the development of the service.

Nursing staff managed and administered medicines for people using safe practices. People received their medicines on time.

People and their relatives said that they were invited to discuss their care planning, and that staff provided good communication about any changes needed. Records confirmed that people were asked for their consent and agreement to different aspects of their care.

The food was well presented and people said that the food was good. It included sufficient choice to provide people with a varied and nutritious diet. The chefs were familiar with people's different dietary needs and their likes and dislikes; and spoke to people every day to obtain their feedback about the food.

Nursing staff carried out on-going checks for people's health needs, and contacted other health professionals for support and advice. Nurses held responsibility for different areas of health care, such as wound care, medicines and continence care. This enabled them to concentrate on specific aspects of the work and to inform other nurses of updates and changes in their given subjects. Other health professionals who came into the home included hospice nurses, who assessed people in regards to end of life care. They advised staff about keeping people comfortable and pain-free.

The staff treated people with respect, dignity and gentle affection, and people spoke positively about them with comments such as "They are all good to me, and very caring". Staff were well informed about people's previous lifestyles and the subjects that interested them. Two activities co-ordinators managed events and day to day activities. People were supported in carrying out their own interests, such as knitting, playing 'scrabble', and reading newspapers; and in taking part in group activities such as listening to a pianist, reminiscence and exercises. The activities co-ordinators spent time with people who were confined to their own rooms due to their frailty or their personal choice, so that they did not feel isolated.

People were confident that they could raise any concerns with the staff or registered manager, and that these

Summary of findings

would be properly dealt with. The registered manager had a visible presence in the home, and it was evident that people and their relatives knew her well. She told people at the time of admission that she had an open door policy, and encouraged people to voice any concerns or complaints so that they could be addressed. The complaints log demonstrated there were reliable processes to follow up complaints appropriately.

People and their relatives were asked to express their views every day about how they were feeling and how they felt their needs were being met by the home. There were processes in place to obtain people's views in writing, using in-house questionnaires, and encouraging people to voice their opinions to external websites such as NHS Choices. The provider had recently engaged an external company to carry out additional satisfaction surveys so that this would be clearly seen as an independent process, enabling people to fully express their views. People spoke highly of the home with comments such as, "At every visit I see how caring everyone is. Everyone is there to please. My relative is very happy and content." And, "Relaxed and caring professionalism. We could not have wished for a better place for our relative".

Records were neatly and accurately maintained, and were up to date and correctly signed and dated. There were systems in place for the on-going monitoring of the service through daily, weekly and monthly checks and audits. The manager and staff maintained a culture of continuous improvement, and in ensuring that 'people came first' in all aspects of the service.

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 said they felt safe in the home, and that staff looked after them well. They said that the nurse call alarm pendants helped them to feel secure, as they could always call for assistance.

Environmental checks and individual risk assessments were carried out. Staff recruitment procedures were carried out correctly and staffing levels were maintained to ensure people's needs were met.

Staff were trained in safeguarding and emergency procedures. Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff had suitable knowledge, training and skills to carry out their jobs effectively.

The registered manager and nurses understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

The service provided a variety of food and drinks to provide people with a nutritious diet. Staff were knowledgeable about people's health needs and ensured these were met.

Is the service caring?

Good

The service was caring. Staff protected people's dignity and privacy, and treated them with respect and kindness.

Staff communicated well with people and their relatives, giving them explanations and reassurance about their care and health needs.

People were encouraged to retain their independence as far as possible. Friends and family were able to visit at any time.

Is the service responsive?

Good

The service was responsive. People were involved in their care planning and the staff were committed to ensuring that people received person-centred care.

People were supported in carrying out their preferred lifestyles and in taking part in activities of their choice.

There were procedures in place to ensure that people's concerns or complaints were listened to, and were responded to appropriately. Learning from complaints was used to bring about on-going improvements to the service.

Is the service well-led?

Good

The service was well-led. The registered manager led the staff team in providing an ethos of continual development.

People's views were obtained and were used to bring about improvements to the service.

Summary of findings

There were reliable systems in place to monitor the service's progress and quality using audits and questionnaires. Records were kept up to date and were accurately maintained.

Hythe 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 checked whether the provider was 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 inspection took place on 08 January 2015 and was unannounced. It was carried out by one inspector, a specialist nurse advisor, and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service, and the expert was experienced in older people's care.

Before the inspection, we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) A notification is information about important events which the service is required to tell us about the law. We talked with the previous inspector to obtain information about the service before the inspection. We contacted three health and social care professionals for their views of the service.

We viewed all areas of the service, and talked with 17 people who were receiving care and treatment. Conversations mostly took place with individual people in their own rooms. We also had conversations with five relatives and visitors, and 11 members of staff as well as the manager and one of the Directors.

During the inspection visit, we reviewed a variety of documents. These included eight people's care plans. We viewed four staff recruitment files, staff induction and training records, staffing rotas for two weeks, medicine administration records, health and safety records, environmental risk assessments, activities records, quality assurance questionnaires and family surveys from 2014, minutes for staff meetings, audits, the service users' guide, and some of the home's policies and procedures.

Good

Is the service safe?

Our findings

People said that they felt safe in the home, and visitors said they were sure people were safe. One person said, "Very safe, oh yes!" Another person was quite amused and said "The question never occurred to me before!" Other comments included, "They are all good to me, and very caring"; and "I have never had anyone rude to me at all. I think it's wonderful here". Each person had a nurse call alarm 'pendant' that they could wear and carry with them. People told us that this was a comfort to them, as they knew that they could call for assistance from anywhere in the home or sitting out in the garden.

Staff training records showed that all of the staff had received training in safeguarding adults during 2014. Staff confirmed their understanding of the different types of abuse and what action to take if they suspected abuse might have taken place. They were also informed about the home's whistleblowing policy, whereby staff should be able to report concerns about other staff members in a way that did not cause them discrimination. One staff member said "I would not hesitate to speak to the manager if I saw something that I was worried about". The registered manager was familiar with the processes to follow if any abuse was suspected in the home; and how to contact the local authority safeguarding team. There was a copy of the local safeguarding protocols in the registered manager's office and in the nurses' office, so that it was easily accessible to staff.

The premises were well maintained, and a maintenance man carried out environmental checks for the home's safety. These included checks for fire alarm systems, fire doors and emergency lighting; hot and cold water temperatures; and 'PAT' testing for electrical items. Other checks were carried out by external agencies, such as legionella testing; checks for fire extinguishers; and servicing for hoists and passenger lifts. A record of fire drills showed that these were carried out every two to three months, and included the names of staff who attended. Monthly room assessments were completed for each bedroom. These included checks for all plumbing fixtures, light fittings, electrical sockets, radiator covers, doors and windows; and checks that grab rails were firmly secured. The maintenance man also checked that the nurse call system was functioning correctly in each room.

Each person had a 'Personal Emergency Evacuation Plan' (PEEP) to show their specific needs in the event of an emergency in the home. Individual emergency plans were colour coded in red, yellow or green to show the level of assistance each person would need with their mobility. These were contained in a 'Snatch' file near to the home's entrance, which also included the fire zones, a list of the staff currently on duty; and the action to take on hearing the fire alarm.

People's care plan files included risk assessments for their needs, such as bed rail assessments, and falls risk assessments. Risk assessments were highlighted if the person had a high risk of falls, and the assessment showed any action taken to reduce the risk. Some people had bed rails in use. These were an integral part of the specialist nursing beds, and the staff carried out checks to ensure they fitted the beds correctly and were in a good state of repair. Bed rail assessments included reviewing if they would reduce the person's independence, and if a person would be at greater risk to their safety with or without bed rails.

Accidents and incidents were recorded and followed up by the staff, and the reports were reviewed by the registered manager. This enabled her to identify if any patterns were occurring, and if action could be taken to prevent further accidents.

Staff recruitment procedures included required checks, such as checking the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. Nurses were required to show that their nursing 'PIN' number was up to date. A record was kept of the interview process.

People thought there were sufficient numbers of staff on duty, with comments such as "I think there's enough staff", although their general perception was that staff worked hard and were very busy. There were at least two nurses on duty every day, and often three, and one nurse at night. A relative commented, "We have no worries at all about the standards of nursing care, we know our mother is well cared for." There were a minimum of seven care staff on duty in the mornings, six in the afternoons and evenings, and three at night. Their shifts usually started at 8am, but this had recently been adjusted so that two care staff started their shift at 7am. This provided extra staff at a busy

Good

Is the service safe?

time of day when many people required personal care at the same time. Numbers of care staff had also been increased during the afternoons and evenings, in response to more people needing two staff to assist them with personal care. There were suitable numbers of ancillary staff in the home, including administrators with different responsibilities, catering and kitchen staff, laundry staff, domestic and maintenance staff. Numbers of domestic staff were increased on some days, to enable them to carry out extra tasks such as deep cleaning of rooms.

Medicines were stored in locked medicine trolleys, which were kept in a locked clinical room when they were not in use. There were clear processes in place for ordering medicines and for disposing of unused medicines in line with national guidance. The clinical rooms included a medicines fridge and a controlled drugs (CD) cupboard for correct storage of specific medicines. Room and fridge temperatures were recorded daily to ensure medicines were being stored at the required temperatures. CD records were clearly maintained. The CD cupboard was just large enough for the amount of CD medicines being stored. The registered manager told us that this had already been noted, and a larger CD cupboard was being ordered.

We observed that medicines administration followed safe practices. Nurses spent time with people to ensure they had taken their medicines correctly, and signed the medication administration record ('MAR' chart) immediately afterwards. MAR charts contained clear directions, and had been accurately completed, with no gaps in signatures. There were additional instructions in place for administering 'as necessary' (PRN) medicines, and for people with particular medical conditions. For example, there were charts in place for people who had diabetes, showing the action to take if the person's blood sugar was very low or very high. This provided consistency in the actions by nursing staff, and ensured they followed the GP's instructions.

Oxygen was stored in the clinical room, and one person was having oxygen administered in their bedroom. The bedroom door had a hazard warning notice on it to alert people to the additional fire hazard that this posed. The clinical room door did not have an oxygen hazard warning notice. The senior nurse printed out a warning sign immediately, and the registered manager said that formal hazard warning notices would be purchased.

Good

Is the service effective?

Our findings

People spoke very positively about the staff and how helpful they were. Comments included, "They are all good to me, and very caring", and, "All the staff are very helpful, they look after me well". Another said, "All the staff are very helpful. Some are newer and they say, am I doing this right? I like that!" People were confident that their health needs were managed well. Several said they had seen a doctor recently. One person said, "They get a doctor if I need one. I've seen him twice. And it is the same doctor." Another person said an optician's appointment had been made at their request; and a different person talked about the help they were given with taking some specific medicines.

People said that staff explained things to them, and gave them the support they needed. One person expressed how staff reassured her when she needed to be moved with the assistance of a hoist. All staff completed required training as part of their probationary period. This included training in moving and handling, infection control, health and safety and basic food hygiene. New staff carried out induction training, which included topics such as communication skills and 'role of the care worker'. The registered manager had recently updated the induction programme so that it was more practical for new staff. They had been asked to evaluate the training, and said they had found it "Very productive and thorough", and "Very good, it made me feel more comfortable in my role". All staff had received training in dementia care, as some older people demonstrated levels of confusion, even if there was no diagnosis of dementia. Staff said that the training had helped them to understand people better and how to empathise with them. One of the nurses was qualified as a moving and handling trainer. This enabled her to carry out practical training with staff in-house, and assess their competency.

Nursing staff had the opportunity to carry out training courses relevant to the nursing care required. For example, nurses were trained in wound care, catheterisation, venepuncture and PEG feeding. (A 'PEG' or Percutaneous endoscopic gastrostomy is a procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when their oral intake is not adequate). The nurses had different areas of responsibility so that they could concentrate on a specific aspect of nursing care, and pass on updates to the other nurses.

Nursing staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This enabled them to carry out mental capacity assessments to ensure that people could fully understand the relevant information when they needed to make decisions. People sometimes lacked full mental capacity to make complex decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people's independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. This included meetings with their next of kin, representative or advocate, and with health and social care professionals, to make decisions on their behalf and in their best interests. There was no-one in the service who was assessed as needing to be deprived of their liberty for their own safety, and therefore no applications had been made for DoLS authorisations.

Staff were supported through individual supervision sessions with their head of department, the manager, or nurses. This included practical supervision so that staff could be assessed for their understanding and competency with different tasks. For example, care staff received practical supervision with skills such as assisting people by using a hoist, supporting people with positional changes, and record-keeping for fluid balance charts. All staff had yearly appraisals, which gave them encouragement with the development of their skills, as well as identifying any training needs.

Staff were encouraged to study for formal qualifications, and most of the care staff had completed training in National Vocational Qualifications (NVQ) or diplomas, to levels 2 or 3 in health and social care. (NVQs are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability to carry out their job to the required standard).

People were encouraged to retain their independence and to carry out their preferred lifestyles. Staff obtained verbal consent from people before assisting the with personal care tasks. People were asked for written consent to show

that their care plans had been discussed with them, and to show they agreed with them. Written consent was also obtained for taking photographs (for example for identity purposes, or to demonstrate how wounds were healing).

People said that staff gave them clear information and discussed things with them. This included daily choices for food and drink. Most people were complimentary about the food, with comments such as "The food is good here. I've never gone hungry yet!", "The food is ok", and "It's good food, you can't grumble." A relative who visited frequently said the food was "Wonderful", and another person raised their thumb emphatically when asked about the food. Two people particularly liked the fresh fruit offered during mid-morning, which was displayed on individual plates with a choice of different fruits cut up and ready to eat.

People were able to eat in their own rooms or the dining room according to choice. At the time of the inspection, a number of people had recently suffered flu or chest infections and said they did not feel well enough to leave their rooms, and so there were less people than usual eating and socialising together. There was a variety of foods offered at breakfast times, and people could have a cooked breakfast if they wished. The cook said that "Many did." A main course and dessert was served at lunch times, with alternative choices for people if they wished; and a variety of dishes were offered at tea times, including a hot option. Snacks and hot or cold drinks were always available, and were frequently offered to people throughout the day.

Some people needed assistance with eating and drinking. Care staff helped them in a pleasant and calm manner. We noticed that a person who needed to stay in bed had had the bed raised to a suitable angle to aid them with eating and swallowing and their digestion. Care staff let people eat at their own pace, and talked with them about the food, and took time to assist them.

Nursing staff carried out nutritional assessments with people when they moved into the home, ensuring that their dietary needs were met, and that catering staff were informed about their food preferences and any allergies. People were usually weighed monthly, unless there were concerns about their weight when weekly weighing could be more appropriate. Weight records showed if there had been any significant weight gains or losses, and what action was taken in response to this. For example, people with low weights might be offered a fortified diet or supplementary drinks to help increase their calorie intake.

Nursing staff referred people to see their GP as needed, and referrals were made to other health professionals if a need was identified. For example, a person with a PEG feed had regular visits from a dietician to monitor their food and fluid intake. Other people had been visited by speech and language therapists to assess difficulty with speech or swallowing; physiotherapists for mobility; and occupational therapists for items of specialised equipment. Professional support was requested from a community tissue viability nurse for people with pressure ulcers of grade 3 and above. Most people who had pressure ulcers had been admitted with them. Nursing staff contacted hospice nurses for support and advice for people who were receiving end of life care, to ensure they were provided with suitable pain relief and could be kept as comfortable as possible. The nurses were trained in recognising people's deteriorating conditions, how to monitor vital signs, and how to administer oxygen as required.

The nursing staff discussed the different care they gave, and spoke knowledgeably about what to do in regards to people's different health care. For example, a person who had developed a urinary tract infection, had had this identified promptly through nurses sending a urine sample for assessment, and antibiotics had been prescribed. The fluid charts for this period demonstrated that the person had been encouraged to drink more to aid clearing the infection.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the staff, with comments such as “They are all good to me, and very caring”; and “They are charming, I love them all!” The service had two beds which were for intermediate care for people with short-term health needs. These were often for people who had been in hospital, but who were not ready to manage at home. One of these people said, “The staff help with anything I want, but I try to do things myself”, and the other said “They are very good here.” Other people said, “The carers try and look after all my flowers and plants for me” as an example of their caring attitudes, and ,“When the care staff have helped me, they stop at the door, as they leave the room, turn and make sure they’ve not forgotten anything”. A relative said that the staff “Bend over backwards to help my wife”; and another relative said, “I’m happy because my husband seems happy here. All the staff are very nice.”

Staff ensured people’s privacy and dignity was maintained, through listening to what they wanted, and carrying out personal care discreetly in their own rooms or bathrooms. They knocked on doors and waited for a response before going in, showing their respect for people’s private space. Staff talked with people and explained what was happening, even if they might not be able to understand fully, due to illness or impaired mental capacity.

Staff demonstrated a good relationship with people and their relatives. Relatives knew staff by their first names and the communication between them was cheerful. Family and friends were able to visit at any time, and said that the staff were welcoming and always offered them a drink. People’s relatives said that the staff were very good about communicating with them, informing them about any changes in their family member’s health care, or any concerns. Most people had full mental capacity, but some chose to include their relatives to act on their behalf, or to take part in discussing aspects of their care. The registered manager and nurses were informed about how to contact and involve advocacy services for anyone who needed someone to represent them.

People’s rooms were personalised according to their taste, and a record of their personal belongings was completed on admission. All of the bedrooms were for single use and most had en-suite toilet and/or shower facilities. The service provided each room with a television, although some people chose to bring in their own. People said they were happy with their rooms, and a response on a questionnaire stated, “I would recommend the home completely, and all the rooms are bright and cheerful”.

We saw that other responses on questionnaires from 2014 were very positive. One person had written, “On every visit I see how caring everyone is, everyone is there to please. My relative is happy and content.” Others said “We have found the staff to be very caring and helpful”; “The staff provide a warm and welcoming atmosphere”; “One staff member is particularly good at engaging with my mum”; and “The standard of care is second to none.”

The staff showed compassionate care towards people who were at the end of their lives, and the nursing staff requested support and advice from hospice nurses where this was indicated. During our inspection one person received the news of the death of a close relative. This was shared discreetly with staff, so that they did not go cheerfully into the room, but were aware of being gentle and understanding. The nurses said that the person wished to be left on their own at one point during the day, and ensured that catering and cleaning staff were also informed about not disturbing them. One of the nurses had spent time comforting the person, and asking if there was any help they could give, such as contacting other relatives or friends, so that the person felt supported.

Good

Is the service responsive?

Our findings

People's care plans included their personal histories, details of their previous lifestyles, and their likes and dislikes. This enabled staff to care for them in ways that were applicable for them. Some people preferred to stay in their own rooms, and liked to have their doors left open so that they did not feel isolated. A person who preferred to remain in their own room described how the activities organiser went to read the newspaper with her most days. They added, "I am still interested in people, so it's good". Another person said they had made friends in the home and said, "We play scrabble on Sunday afternoons and sew and knit together. There are things to do here, but I tend to stay in my room at the moment, because I have not been well". A different person said, "I love piano music, and they have two people who come in to play regularly. I go to the lounge then so I can listen."

Care plans contained details of people's health and care needs, with individualised plans for all aspects of care, such as personal hygiene care, nutrition, mobility, sleeping and social activities. These included details of people's preferences, and things they needed help with or could do independently. For example, one plan stated that the person preferred a shower to a bath, needed help with washing and dressing, but was able to eat and drink independently. People's mobility plans showed if they could walk with a Zimmer frame, if they could transfer from a wheelchair to an armchair with support from one care staff, or if they required assistance to move using a hoist. These specified the hoist to be used, the size of the sling, and documented that two care staff were needed for all transfers.

People said that staff usually responded to them quite quickly if they used their call bells. They had pendant alarms as well as call points in their rooms, so that they could always call for assistance. People said, "I ring the buzzer and I never have to wait long, not even at night. I feel quite pampered here!" and one person explained, "If they are busy, they say 'hang on, we'll be with you soon', and this works". Another person said "I press the buzzer and usually don't wait too long". Several people said they sometimes had to wait for a short while in the day time, but usually had their bells answered promptly at night.

Care plans identified if people had any allergies, their food likes and dislikes, details of their families, and if they could communicate clearly. Staff recognised that it was important to obtain as much information as possible from people's relatives if the person lacked verbal communication, so that they could familiarise themselves with the person's character and treat them appropriately. This included past history, such as war times, as well as their interests such as cooking, gardening and pets.

The service employed an activities co-ordinator who kept records of the individual time spent with people, and if they had taken part in group activities. A weekly activities plan was provided to each person, and included items such as crafts, word searches, exercises, reminiscence, quizzes, games, watching films, flower pressing, painting and cooking. Activities varied according to the people living in the home and their preferences at any one time. People who stayed in their rooms were given individual time, which might include reading to them, or just chatting with them. The service had events such as a Summer BBQ and a Christmas party. People were supported in going out of the home or out with relatives when they were able to do this.

People's spiritual needs and beliefs were taken into account, and arrangements were made for ministers or clergy to visit people if they wished. A lay preacher brought Holy Communion into the home for some people on a regular basis.

People were confident that they could raise any concerns with the staff or the registered manager, and said they would not hesitate to complain if they needed to. One said, "I would tell whoever was in charge that day", and another said, "I would probably talk to the manager." Some people used quality assurance surveys as a means of raising concerns, and we saw that these were appropriately addressed. For example, one person had wanted to discuss their food portion sizes with the chef, and the registered manager had ensured that this was carried out, to the person's satisfaction.

Any concerns or complaints were documented by the registered manager, and original letters or e-mails were retained on file. Concerns raised during the past year had been fully investigated by the registered manager, and followed up to ensure people were satisfied with the outcome. Staff dealt with day to day matters promptly, so that they did not escalate into complaints. The complaints procedure was included in information given to people at admission, and was displayed in the entrance hall. There had been no formal complaints during the previous year.

Good

Is the service well-led?

Our findings

People said that the registered manager was approachable and responded to their views and concerns. She had an open door policy and a visible presence in the home, which enabled people to feel confident that she would listen to their views and address any issues. Her open door policy was made clear to people at the time of admission, so that they knew from the start that they could talk with her at any time. The registered manager worked closely with senior nurses, and said that they had found it more effective to have a senior team of three nurses than one deputy manager. The senior nurses had different areas of responsibility, which spread the workload. One of the nurses was supernumerary on all of the early shifts from Monday to Fridays, to provide support and leadership and manage administrative duties. People said they could speak to the staff any time if they had any concerns. Staff in different job roles made themselves available to people; for example, the chefs went round and spoke to each person every afternoon after lunch so as to obtain feedback about if they had enjoyed their meals.

Staff were encouraged to share their views about the service and raise any ideas. New staff had been asked to evaluate the induction programme after it had been altered, to assess if it was more practical and helpful than it had been previously. Staff meetings were carried out on a regular basis, and included general meetings and meeting for different groups of staff. Minutes from a care staff meeting showed that staffing numbers at different times of day had been discussed with nurses and care staff, so that they could give first-hand knowledge of people's needs and how many staff were needed in different areas of the building. Staff had also discussed recent training, stating that dementia training had been helpful. A nurses' meeting had included discussions about correct completion of documentation, and ensuring some items of equipment were properly cleaned. The registered manager listened closely to staff views, and this was demonstrated in recent changes in the home. These included changing the dining room around to make it more accessible to people, and to provide an area with pleasant sea views. The registered manager and staff said that they "Always looked at different ways of doing things" as this was the ethos of the home for continual improvement.

The registered manager and one of the company's directors regularly discussed changes which would improve the service. Current work was being carried out to alter a vacant room which had a bath in the en-suite room. This was being altered to a wet shower facility, so that it would be more suitable for the person to use. There were plans to alter another room with a bath in the same way, in the near future. The director met with the registered manager each week to go over different aspects of the running of the home, and was frequently in the home so that he knew any problems that occurred.

Quality assurance processes were carried out with in-house surveys, and using an external company where people could post cards to them anonymously. This was a new venture to provide people with different ways of giving their feedback. People had started to use this method, and had so far made only positive comments about the home. It included questions such as how people rated the home in regards to people being consulted about their care, being treated with privacy and dignity and the standard of meals at the home. There was space for people to write freely about their experiences of the home. The registered manager said that in-house events such as a Summer BBQ were a good opportunity to chat with people's friends and relatives and obtain their feedback.

In-house satisfaction surveys had been given to people in the home and sent to family members during 2014. These had been sensitively produced in large print for people living in the home. The questions had included how people felt about their personal care and support, if they were able to get up and go to bed at their preferred times, and how they felt about the food, the premises, social activities and the management. Responses were very positive, and any negative comments had been followed up.

Auditing processes were carried out to monitor the quality of the service. The registered manager and senior nurses carried out auditing procedures; and a separate medicines audit was carried out annually by the dispensing pharmacy. Other audits included monthly care plan audits, and a review of accidents and incidents. The registered manager ensured that care plans were kept up to date; and identified if there was a pattern to any of the accidents and if action could be taken to avert future accidents.

The registered manager had systems in place which enabled her to locate records quickly. People's personal

Good

Is the service well-led?

records were kept in a locked area so as to retain their confidentiality. Records contained appropriate information, had been properly signed and dated where applicable, and were kept up to date.