Marshmead Limited

Turfcote Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on the 27, 28 February 2018 and 9 March 2018 and the first day was unannounced.

At our inspection on 27 June 2017 we found breaches of legal requirements. There were concerns about the unavailability of suitable activities for people in the home, records in care plans were incomplete with poor recording of support and care reviews and the service's checks and audits were not picking up on issues.

We asked the provider to make improvements in all of these areas and they kept CQC informed of the changes that had been made.

At this inspection we found that improvements had been made in all of these areas but that further steps were required in relation to the provision of activities for people.

We found that there were activities available for people and that the home had employed an activities coordinator. However, there were days when sufficient activities were not arranged and the activities coordinator required training. Records in care plans were complete and accurate and the service's auditing systems were highlighting issues of potential concern and checks were being made to ensure that the service operated effectively.

Turfcote Care Home with Nursing is a 'care home' in Rossendale in the county of Lancashire. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The home is registered to provide accommodation and support for up to 76 people and cares for people, including those living with dementia and general nursing and personal care. At the time of our inspection 46 people were using the service.

There was a registered manager in place who had been registered since 1 October 2010. 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.

People using the service said they felt safe and that staff treated them well. There were enough staff on duty and deployed throughout the home to meet people's care and support needs. Safeguarding adult's procedures were robust and staff understood how to safeguard people they supported. There was a whistle-blowing procedure available and staff said they would use it if they needed to. Appropriate recruitment checks took place before staff started work.

People were supported to maintain a balanced diet and had access to a range of healthcare professionals when required. People received appropriate end of life care and support.

We found that people and their relatives, where appropriate, had been involved in planning for their care needs. Care plans and risk assessments provided clear information and guidance for staff on how to support people using the service with their needs. People and their relatives knew about the home's complaint's procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

The registered manager and provider conducted regular checks to make sure people were receiving appropriate care and support. The registered manager took into account the views of people using the service, their relatives and staff through meetings and surveys. The results were analysed by the provider and action was taken to make improvements at the home. Staff said they enjoyed working at the home and received appropriate training and good support from the management team.

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.

Medicines were managed and stored safely and records showed that people were receiving their medicines as prescribed by health care professionals.

People told us they felt safe and well cared for.

There were enough staff deployed within the service and appropriate staff recruitment procedures were in place.

There were arrangements to deal with emergencies and staff were aware of signs of abuse and what action they should take.

There was a whistle-blowing procedure available and staff said they would use it if they needed to.

There were arrangements in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

Staff had completed an induction when they started work and received training relevant to the needs of people using the service.

The provider looked at ways to support people to eat and drink sufficient for their needs, and to protect against the risks of inadequate nutrition and dehydration.

Staff sought consent from people when offering them care and treatment. The registered manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People had access to a wide range of healthcare services to ensure their day to day health needs were met.

Is the service caring?

Good

The service was caring.

Staff spoke to people in a respectful and dignified manner.

Staff knew people well and were aware of their preferences and routines.

People and their relatives were involved in making decisions about their day to day care.

There were arrangements in place to meet people's end of life care needs.

Records including medicines records were held securely and confidentially.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care files included detailed information and guidance for staff about how their needs should be met.

People were provided with a range of activities but further improvements were required around this to ensure all people were regularly engaged.

People knew about the home's complaint's procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Good

The service was well-led.

There were appropriate arrangements in place for monitoring the quality and safety of the service that people received.

Staff said they enjoyed working at the home and received good support from the management team.

There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

The management team and provider carried out unannounced night time and weekend checks at the home to make sure people were safe and receiving appropriate care and support.

Turfcote Care Home with Nursing

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 was meeting 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 unannounced inspection was carried out on the 27, 28 February 2018 and 9 March 2018. The inspection team on the first day consisted of an adult social care inspector, a specialist advisor who was a senior nurse and an expert by experience. There was an inspector and an assistant inspector on the second day and one inspector on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 this information together with other information we held about the home including notifications they had sent us. A notification is information about important events that the service is required to send us by law. We also received feedback from health care professionals that we used to help inform our inspection planning.

We spent time observing the care and support being provided to people, spoke with nine people who used the service and five relatives. We also spoke with six members of staff, the provider, the registered manager and four health care professionals. We looked at eight people's care records and five staff recruitment files (who had been recruited since the inspection on 27 June 2017) and five staff training files. We also looked at records relating to the management of the service including audits, incident logs, staff rotas and minutes from meetings. In addition, we looked at all areas of the building including bedrooms, communal areas, the kitchen, the main office and outside grounds.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 27 June 2017 we established that health care records were incomplete and there was poor implementation of health care support, checks and reviews.

These issues amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in these areas. Where health care professionals had advised that people's health should be regularly monitored, records were completed by nursing staff and carers that supported that these checks were taking place. We noted that where staff had concerns about the records and the conditions of people, they were quick to call on the help of experts such as specialist nurses and doctors. A health care professional said, "Any checks and tests are always completed to my satisfaction and are never missed."

People's care files also included a wide range of risk assessments in areas including falls, moving and handling, medicines, weight loss, nutritional needs, continence care and skin integrity. People had individualised risk assessments on behaviours that may challenge and their medical conditions. This provided guidance to staff on how they should support people so that the risk to them could be minimised. For example, where people were assessed as being at risk of falling, there were plans in place to support them. We also saw records confirming staff had been monitoring their safety on a regular basis and the use of technical devices to aid early detection of risk.

People were also supported with eating and drinking and we saw that the service was monitoring people's weight regularly and where appropriate making referrals to health care professionals. We saw examples of how the MUST risk assessment tool was completed in order to identify people's risk of malnutrition. MUST is a Malnutrition Universal Screening Tool and is a five step screening tool used to identify adults who are malnourished or at risk of being undernourished. A health care professional said, "There has been an improvement at this home since the deputy manager returned. This is especially around clinical care."

People told us that they felt safe and were well treated. One person said, "I feel really safe here." A relative said, "The home is well run and I'm sure my relative is safe." A health care professional said, "I don't have concerns. Staff are good at recognising issues and call me in appropriately."

Throughout the three days of the inspection we saw that there were enough staff on duty to meet people's needs and observed good staff presence with trained nurses always on duty supported by care staff. During talks with the registered manager, the deputy and staff they demonstrated a clear understanding of the types of abuse that could occur in a home and the signs they would look for. They were also aware of the action to take if they thought someone was at risk of abuse including who they would report any safeguarding concerns to. Records confirmed that the registered and deputy manager and all staff had received training on safeguarding adults from abuse. A member of staff said, "I wouldn't hesitate in reporting any concerns and am sure that the manager would act appropriately."

Before the inspection we had received notifications of two incidents involving injuries. One of the incidents was being investigated by the local safeguarding team. We reviewed the records relating to these incidents and action taken by the registered manager and the provider. We found appropriate action had been taken and any lessons had been learnt.

The service continued to arrange a staff review three times a day that staff referred to as a 'safety huddle'. We observed one of these meetings and saw that staff were encouraged to raise concerns over people in their care and to discuss with nursing staff how people were responding to care, treatment and support. We saw that a nurse was concerned over one person's eating abilities and immediately after the meeting referred the person to a dietician. One member of staff said, "These meeting are crucial to my role and they allow me to speak with nurses to ensure that people are safe. They are a positive development."

Recruitment checks were carried out before staff started working at the home. We looked at the personnel files of five members of staff that worked at the home and who had been recruited since the last inspection on 27 June 2017. The files contained completed application forms that included reference to their previous health and social care experience, their qualifications and employment history. Each file included two references, health declarations, proof of identification and evidence that criminal record checks had been obtained for all staff.

There were systems in place to ensure that people consistently received their medicines as prescribed by health care professionals. Medicines were stored in two designated medicines rooms that could only be accessed by staff responsible for administering medicines. The medicine room's temperatures and medicines fridge temperatures were monitored and recorded and we noted that they fell within safe ranges. The medicines fridge was locked and sharps bins did not contain inappropriate items.

We observed medicines being administered to people on the first and second days of the inspection and saw that staff sought their permission before medicine was administered. People were gently encouraged to take their medicine. We checked the balances of medicines stored in the medicine room against people's Medicines Administration Records (MAR) and found these records were up to date and accurate. The MAR also included a photograph of the person, as well as details of their known allergies and details of staff members authorised to administer medicines. Staff were also specifically trained to administer medicines and we noted that their competency was regularly checked. This helped reduce the risks associated with medicines administration.

The MAR showed that people were receiving their medicines when they needed them and any reasons for not administering medicines was recorded. We saw up to date protocols were in place to advise staff when and under what circumstances people should receive any medicines that had been prescribed 'as required'. Staff told us what they would do when people required an 'as required' medicine. They also told us what they would do if a person missed their medicines and how they would report any safety incidents.

There were arrangements in place to deal with foreseeable emergencies. People had personal emergency evacuation plans (PEEPS) which highlighted the level of support they required to evacuate the building safely. Staff we spoke with knew what to do in the event of a fire. They told us there were regular fire drills so they were reminded about their roles in such an event. Records confirmed that staff received training on fire safety. We saw records confirming that the fire alarm was tested on a weekly basis, regular fire drills had been carried out and that evacuation drills occurred annually.

The provider was completing weekly checks on the safe operation of the home's fire doors and an independent review they had commissioned in July 2017 had not revealed any significant safety issues.

Records of accidents and incidents were maintained that contained information about each incident and any action that had been taken. For example a review of a person's risk assessment, or the making a GP referral. This helped reduce the risks of similar incidents occurring in future.

During this inspection we noted that the building, bedrooms, communal areas and the environment were clean and tidy. Personal protective equipment was available to staff at convenient locations situated around the home. We noted that records supported that risks of infections had been managed and regular infection control audits had been undertaken.

Records showed that the provider completed checks on equipment to ensure that they were safe and had been serviced. Environmental risk assessments and health and safety checks were also being completed. These included electrical installation, gas safety and legionella testing and water temperature monitoring.

Good

Is the service effective?

Our findings

One person using the service told us, "The staff know me very well and what my needs are." Another person said, "The staff are consistent with the care they give me." A relative said, "The staff know what they are doing here. There are some new staff and it's good to see that training is on-going."

Staff said they had completed an induction in line with the 'Care Certificate' when they started work and they were up to date with the provider's mandatory training. The Care Certificate is a nationally recognised qualification and aims to equip staff who are new to health and social care with the knowledge and skills that they need to provide safe, compassionate care. One member of staff told us they were shadowed by experienced staff as part of their induction before they were permitted to work alone.

We looked at staff training records that confirmed that staff had completed an induction when they started work. This included training the provider considered mandatory and training relevant to the needs of people using the service. Mandatory training included safeguarding adults, health and safety, moving and handling, infection control, first aid awareness and fire safety. One member of staff told us the registered manager and provider had supported them to access specialised training and had been flexible with their shifts. Another staff member told us they had been supported to gain additional training in pressure ulcer management.

Where nurses had recently been employed we saw the provider had obtained evidence of their previous training and experience. For example, one nurse had previously worked at a hospital and had training on catheterisation, dementia care, medicines and moving and handling. We saw this nurse had completed an induction and had been monitored by a senior nurse who was also the deputy manager.

Staff told us they received regular supervision, an annual appraisal of their work performance and said they were well supported by the registered and deputy managers. One member of staff said, "I get supervision every two months and had an annual appraisal last year. I like working at the home. I like the residents and the staff. There is good teamwork here, we all support each other." Records we saw confirmed that staff were receiving regular formal supervision and an annual appraisal of their work performance.

We noted that the provider had recently engaged in a programme with a local NHS trust to train suitable carers to become 'Nursing Associates'. Nursing Associates are regulated by the Nursing and Midwifery Counsel and support Registered Nurses to work in partnership delivering high quality care. Involvement in the programme supported that the provider was utilising the skills and knowledge of care staff and allowing staff to progress and achieve their potential.

We saw that people's healthcare and support needs were assessed before they moved into the home. These assessments covered areas including, moving and handling, mobility, nutrition, communication, sleeping, emotional and spiritual needs, activities, medicines, continence and end of life care. The deputy manager, who also acted as the home's clinical lead, told us that care plans were developed using the assessment information and kept under regular review. They contained information about people's medical and physical needs. For example, one person's care plan included information about a person's susceptibility to

falling from bed and how relatives had alerted staff about their view that the risk could be mitigated by moving the bed close to the floor and the placement of special padding on the floor at night. We noted that this precaution had been implemented by staff when the person started to live at the home.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager demonstrated a good understanding of the MCA and DoLS. They said that most people using the service had capacity to make some decisions about their own care and treatment. We saw that capacity assessments were completed for specific decisions and retained in people's care files. Where the manager had concerns regarding a person's ability to make specific decisions they had worked with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA.

We saw that since the last inspection on 27 June 2017, one application had been made to the local authority to deprive a person of their liberty. We considered the application and noted that it had been appropriately made with the correct amount of detail and information so that the authorising authority could make an informed decision. Where applications had been authorised, we saw that the appropriate documents were in place and kept under review and any conditions of authorisation were being followed by staff.

We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. A DNACPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. However the process for completion must be correct otherwise the form can be deemed invalid. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. These had been fully completed, involving people using the service, and their relatives, where appropriate, and signed by their GP.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements, food likes and dislikes, food allergies and their care and support needs. Care plans included information relating to people's dietary needs for staff to refer to. For example, one person's care plan stated, "Will need prompting to use specialist cutlery and assistance with meals." Nutrition and diet risk assessments were in place. We saw referrals had been made to the dietician and GP following weight loss. We found speech and language therapist's advice had been sought for people with swallowing difficulties. A health professional who supported people requiring enteral feeding said, "The staff make appropriate referrals to our team. Food and fluid charts are in place and people's weight is accurately monitored."

We observed how people were being supported and cared for at lunchtime. A daily menu was displayed on a notice board in the dining room in each unit for people to make their choices from. One person using the service told us, "The cook is great. They really try hard to make nice meals for us." Another person told us,

"The food is okay. We get lots to drink. You can ask for what you want to eat." Some people required support with eating and some ate independently. The atmosphere in the dining room was relaxed and not rushed and there were enough staff to assist people when required. Some people ate their meals in their rooms in accordance with their preferences. We saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day and these were available in the lounges on each unit.

We found there was clear and frequent communication between each unit and the kitchen regarding people's dietary preferences and requirements. We spoke with the chef. They showed us documents which alerted kitchen staff to people's dietary risks, personal preferences and cultural and medical needs. The chef said they accommodated people's personal preferences by offering range of choices each meal time. For example, they cooked separate meals if people requested one that was not on the day's menu. We also noted that the kitchen was clean and well-kept and had been awarded a five star hygiene rating from the local authority.

People were supported to maintain good health and had access to health care support. Where there were concerns people were referred to appropriate health professionals. An Advanced Nurse Practitioner told us they visited the home three times a week or when required to attend to people's needs. They told us the home was supporting people properly and meeting people's needs. They said that since the deputy manager had returned to work from extended leave, improvements had been noted. Staff followed peoples care plans and actively sought advice from health care professionals when they needed it.

Good

Is the service caring?

Our findings

People said that staff were caring. They also commented that the registered manager, deputy and provider knew them well. One person told us, "All the staff know my name and care about me." A relative said, "Nice place. I am happy that my relative is cared for." A health care professional told us, "Staff are very caring in their approach."

If people could not express their view the service ensured that the person's relative was involved. We noted that on the occasions when relatives or other supporters were unavailable, people had access to a professional representative who acted as an advocate. An advocate is a specially trained person who can help support people if they do not have capacity to make particular decisions.

All of the care files we looked at were respectfully written and included a section on personal histories. This recorded the person's hobbies and interests, details of significant events and favourite places, and the jobs they used to do. A member of the care staff said, "We all try to be cheerful and are actually interested in our residents."

When looking at the care plans we saw that where people had decided to make comment, end of life care plans and consent forms requiring the person's agreement regarding their care and treatment were in place.

During the inspection we noted that staff knew people well and understood their needs. We saw examples of good care and saw that people were treated with understanding, compassion and dignity. Staff actively listened to people and encouraged them to communicate their needs. For example, we observed a member of staff assisting a person to walk a short distance using a frame. The person had recently had an operation and the care and support was dignified and reassuring. We also saw staff responding to people's needs in a calm effective manner supporting them with everyday tasks and responding to requests for drinks and snacks.

Staff knocked on people's doors requesting permission to enter when they were present. One person said, "There is lots of respect here. No-one ever comes in without knocking." Where people needed support with personal care, staff ensured their privacy by drawing curtains and shutting doors. Staff told us they tried to maintain people's privacy, dignity and independence as much as possible by supporting them to manage as many aspects of their care that they could. They said that they explained what they were doing and sought permission to carry out personal care tasks. They told us they offered people choices, for example, with the clothes they wanted to wear or the food they wanted to eat. One member of staff said, "I treat people as I'd like to be treated and take my time with them."

People were provided with appropriate information about the home in the form of a service user guide. This guide ensured people were aware of the standard of care to expect, details of access to health care professionals, the service's complaint's procedure and information about the service and facilities provided at the home.

Staff said they made sure information about people was kept locked away so that confidentiality was maintained at all times. We saw that personal documentation including care plans were locked away in the main office and medicines records were locked away in the medicines' room. This meant that only authorised staff accessed people's records.

Good

Is the service responsive?

Our findings

At our inspection on 27 June 2017 we found that improvement were required in relation to the provision of activities for people to participate in at the home. There were no staff who were solely designated to provide activities and staff at the inspection commented that they didn't have time to regularly provide activities to people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we noted that the service had improved in this area. A designated member of staff had been appointed to an activities coordinator role and we observed people participating in activities around the home.

Although we saw that on the second day of the inspection, people were supported to engage in a range of activities, on the first day there was an absence of meaningful activities and this coincided with the co-ordinator having a day off. One relative and a member of staff said that it would help if the activities coordinator was employed full-time instead of the three days a week they currently worked. There was also a concern that the activities were not always suitable for people with limited mental capacity. The activities coordinator said that they were supported to provide activities on a part time basis and that their role was solely to arrange and conduct activities in the home. Records supported that they had not received any specific training for this role and the registered manager said, "We accept that the coordinator will require training and guidance so that they can develop to ensure every person in the home is provided for."

We recommend that the provider continue with improvements in this area and take steps to ensure that the activities coordinator receives training around the provision of activities for people at all levels of capability.

On the second day of the inspection we saw that young people from a local school were visiting the home. They were engaging with residents at the home playing games and chatting and we noted that everyone was enjoying the company and there was a light-heartedness to the event. A representative from the school said, "The home has supported us for many years. Our students look forward to the visits and the residents seem to benefit as well." This meant that the home was taking steps to avoid social isolation for its residents and fostered community relationships.

Care plans included information such as how people liked to be addressed, their likes and dislikes, details about their personal history, their hobbies, pastimes and interests and guidance to staff about how their care and support needs should be met. For example, one person's care plan advised staff to speak loudly and clearly to a person and ensure the person could see them because they had a hearing issue.

All of the care plans and risk assessments we looked at had been reviewed on a monthly basis, or more frequently if required, to ensure they were reflective or people's current needs. We also saw that daily notes were recorded of the care and support delivered to people.

Records showed that people and their relatives were also involved in an annual review of care planning. Views from people and relatives were recorded and confirmed their agreement to the care plan. A nurse member of staff showed us daily handover sheet used at the home. They said this ensured people received continuity of care. During the inspection we observed a handover meeting where the deputy manager and staff shared any immediate changes to people's needs and any development that had occurred over-night. Staff said that these meetings were useful and also used to make sure that staff were aware of any new admissions and their care needs.

The provider had an accessible information policy covering the requirements of the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. NHS and adult social care services are legally required to follow this standard.

In line with this standard, the provider had ensured that most policies relevant to people who used the service such as the complaints' policy, had been provided in accessible way. This was often through a person's relative. The provider said, "We produce our policies in different formats. Whatever the resident needs, we will arrange for a policy document to be provided."

The provider had a complaint's procedure in place that was included in the service user guide. It told people how to complain, who to contact and what would happen. The document did require some additional information so that people were aware of their rights to elevate complaints to a higher authority. The provider included this information in a new policy document that we saw on the last day of the inspection. People said they knew about the complaint's procedure and told us they would tell staff or management staff if they were not happy, or if they needed to make a complaint. The provider maintained a complaint's file that included a copy of the complaint's procedure and forms for recording and responding to complaints. The records showed that there had not been any complaints since the last inspection on 27 June 2017.

The service supported and encouraged the use of technology to assist and support people. During the inspection we saw the use of technological aids to assist staff to support people such as the use of motion sensors to assist in the prevention of falls. The service was also a user of a nationally recognised televisual communication system where nursing staff could link with other healthcare specialists to assist in the diagnosis and treatment of people. This system is recognised as helping to reduce admissions to hospitals and in the early treatment of health conditions.

Good

Is the service well-led?

Our findings

At our inspection on 27 June 2017 we found that the service was not completing audits that were picking up on the issues that were found during the inspection. Audits of care plans were not establishing that peoples' needs had changed and accordingly plans needed to be amended and observations such as temperature and weight were being missed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in this area. The registered and deputy manager and the provider had undertaken a range of audits in relation to areas of the service including care planning, health and safety, cleaning, fire checks and quality assurance records. We saw action had been taken in response to audit findings. For example, a check on a care file had revealed that there was equivocal information around someone's mental capacity. The deputy manager had used the occasion to completely review the person's capacity and remind staff of best practice.

A visiting health care professional said, "On my observation the home is well managed." Another said, "The home has made substantial improvements especially since the deputy manager has returned. They are concentrating on clinical issues with the manager managing the home. The balance seems to be right."

The provider had made unannounced checks during evening shifts and the provider and registered manager also made visits to the home at weekends and conducted checks of the home's cleanliness. Where issues had been identified, we noted that appropriate changes had been made. For example, a recent check had identified a defect with a fire door that was immediately corrected. Thereafter we noted that the provider had made daily checks on the problematic door and demonstrated at the inspection how the issue had been rectified. The registered manager had made a spot visit at a weekend lunch serving and observed staff not wearing their correct uniform. We noted that this had been immediately seen to and raised in the next full staff meeting where staff were reminded of the hygiene policy.

Staff told us they liked working at the home and praised the support they received from the registered manager and their deputy. We saw minutes from a staff meeting in January 2018 where a new member of staff said that they felt welcomed and praised the support received from management and staff. The minutes showed that staff were able to raise concerns over the condition of people and any suggestions to improve people's health. At the same meeting we noted that management used the session as an opportunity to remind staff of important policies such as the use of mobile phones and medications' error notifications to pharmacy and GP's.

There was an out of hours on call system in operation that ensured that management support and advice was always available to staff when they needed it. One staff member told us, "The two managers and nursing staff are very supportive. We can raise any sort of issue. Everything is open."

People told us that they attended formal resident meetings to discuss aspects of the service and how improvements could be made to the running of the home. We saw minutes from a meeting in January 2018 where residents commented about activities and suggestions for 'movie night' and arts and craft sessions. We noted that people commented about arrangements for the forthcoming Valentine's Day and actively participated in the arrangements. A person said, "We meet regularly and ask the manager about all sorts of stuff including meals and entertainment."

The provider took into account the views of people using the service and their relatives about the quality of care provided at the home through surveys. The registered manager said they used feedback from the surveys to make improvements at the home. A residents and relatives survey had been carried out in November 2017 and we noted that action had been taken in response to the feedback received. For example, changes had been made to the decoration in parts of the home and some items of furniture had been replaced. This meant that the service responded to people in order to provide support and care that was reflective of their wishes.

At the inspection we noted that the home had links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local commissioning group, local pharmacies, advanced nurse practitioners, specialist doctors and local GPs. The registered manager and provider had systems to ensure the home shared appropriate information and assessments with other agencies for the benefit of people who lived at the home.