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Blakesley House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 July 2018 and was unannounced. The service was last inspected on 28 July 2016 when we rated the service good overall and in all the five key questions. At the comprehensive inspection on 18 July 2018 we rated the service 'good' overall but we made a recommendation in relation to the environment.

Blakesley House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Blakesley House Nursing Home provides accommodation and nursing care for up to 22. At the time of our inspection there were 11 people living at the home.

The provider is registered as an Individual and as such is not required to have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider runs and manages the service.

Not all the environment was suitable for people living at the service, particularly those living with dementia. The garden was bare and uninviting, not easily accessible and people were unable to use it appropriately.

The service was clean and had systems to protect people by the prevention and control of infection, however, liquid soap and hand gel were not topped up in the staff toilet and entrance hall so these would be readily available when needed.

There were systems and processes in place to protect people from the risk of harm. There were enough staff on duty to meet people's needs.

Checks were carried out during the recruitment process to ensure only suitable staff were employed.

There were arrangements in place for the safe management of people's medicines and regular checks were undertaken.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were supported by staff who were suitably trained, supervised and appraised.

Staff were caring and treated people with dignity and respect. Care plans addressed each person's individual needs, including what was important to them, and how they wanted to be supported.

People were able to take part in a range of activities. They were cared for in a way that took account of their diversity, values and human rights.

People's end of life wishes were discussed and recorded.

People living at the home, their relatives and stakeholders told us that the manager and senior team were approachable and supportive. People and their relatives were supported to raise concerns and make suggestions about where improvements could be made.

The provider had effective systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed.

The manager kept themselves informed of developments within the social care sector and cascaded important information to the rest of the staff 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.

The provider had infection control procedures in place and the home was clean and odour free, however the liquid soap in the staff toilet and hand gel in the entrance hall had not been topped up.

Staff had received training in the administration of medicines and there were effective systems in place to ensure that medicines were managed safely.

There were enough staff on duty to keep people safe and meet their needs. Recruitment procedures were in place to ensure that only suitable staff were appointed to work with people who used the service.

There were appropriate procedures in place for the safeguarding of people who used the service and these were being followed.

The risks to people's safety were identified and managed appropriately. The provider had processes in place for the recording and investigation of incidents and accidents.

Is the service effective?

Requires Improvement

The service was not always effective.

The garden was neglected, not easily accessible and did not meet the needs of people using the service.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were cared for by staff who were suitably trained, supervised and appraised.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a friendly and caring way. Relatives and professionals felt that people using the service were well cared for.

Care plans contained people's personal history, likes and dislikes. People were supported by caring staff who respected their dignity, human rights and diverse needs.

Where people were able to make choices, they told us that staff respected these.

Is the service responsive?

Good

The service was responsive.

A range of activities were organised and external entertainers visited regularly. The manager had made some improvement in the provision of specific activities for people living with dementia.

Assessments were carried out before people were admitted to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

Is the service well-led?

Good

The service was well-led.

There were systems in place to assess and monitor the quality of the service.

There were regular meetings for staff and people who used the service which encouraged openness and the sharing of information.

People and their relatives were sent questionnaires to ask their views in relation to the quality of the care provided.

People, relatives and professionals we spoke with thought the home was well-led and that the staff and senior team were approachable and worked well as a team.

The staff told us they felt supported by the manager and there was good communication among the staff team.

Blakesley House 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 comprehensive inspection took place on 18 July 2018 and was unannounced. The inspection was carried out by one inspector, a nurse specialist advisor 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.

Before the inspection, we reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The registered manager had sent us a Provider Information Return (PIR) in July 2018. 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.

During our visit, we spent some time observing staff delivering care and support to people, to help us understand people's experiences of using the service. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We also looked at records, including care plans for seven people, four staff records and records relating to the management of the service. We spoke with four people who used the service, three relatives, five staff including the manager, the nurse in charge, the chef and two care staff. We also spoke with two healthcare professionals who were visiting at the time of our inspection.

Good

Is the service safe?

Our findings

All the people we spoke with indicated they felt safe in the home and trusted the staff who supported them. One person told us, "Yes, the staff are alright", "Yes, at the moment (I feel safe). I haven't seen anything wrong. Everyone seems happy", "I'm ok. If something happened, I wouldn't let them get away with it" and "Yes very much so (feel safe)."

People were protected from the risk of infection and staff used appropriate personal protective equipment, such as gloves and aprons. All areas of the home were odour-free, clean and tidy and free of any hazards and all cleaning products were safely locked away. However, we noticed that there was no soap in the staff toilet and the hand gel container in the entrance hall was empty throughout the day. We fed this back to the manager who told us they would ensure this was replaced immediately.

The provider had a health and safety policy in place, and staff told us they were aware of this. There were processes and checks in place to ensure a safe environment was provided to people, staff and visitors, which included gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers and moving and handling equipment such as hoists and wheelchairs. Environmental risk assessments were in place and included electrical appliances, lighting, smoke detectors, call bells, fire doors and window restrictors.

Where there were risks to people's safety and wellbeing, these had been assessed. Risk assessments and plans were available and included risk from falls, skin integrity, choking, malnutrition, mobility and moving and handling. Person-specific risk assessments and management plans were available and based on individual risks that had been identified. We saw detailed guidance was available for staff to follow on how to mitigate these risks. For example, a person using the service was being cared for in bed and staff had identified they were at risk of skin deterioration. We saw that appropriate pressure relieving equipment was in place and regularly checked and there was an up to date turning chart in place. A new orthopaedic chair had been supplied and staff told us they were awaiting training for its use. We saw that the plan was written in a person-specific manner and included recommendations for staff to follow. Records showed and a healthcare professional confirmed that nobody at the home had pressure sores. This indicated that the provider had put appropriate systems in place to minimise the risk of pressure ulcers to people who used the service.

People told us they received their medicines as prescribed. All the people who used the service needed support from staff to manage their medicines. We looked at all the medicines administration records (MAR) charts for all the people using the service and saw these were completed appropriately and there were no gaps in staff signatures.

There was a policy and procedures in place for the management of medicines and staff were aware of these. The senior staff undertook frequent medicines audits and these were thorough. Most medicines were

supplied in blister packs and we saw that medicines had been administered according to instructions recorded on these.

We checked random samples of boxed medicines to be given 'as required' (PRN). We saw that staff recorded the date of opening on each box which helped them to keep an accurate record of the medicines. Staff recorded appropriately when these had been given and kept a record of the amount left in the box. We noticed that the amount recorded corresponded to the amount left in the boxes. Staff undertook twice daily checks of medicines and signed for each check. In addition, the manager carried out monthly audits of medicines, including stock, recording, ordering, storage and staff training. This indicated that people received their medicines appropriately and as prescribed.

The medicines were kept in a small duty office. We saw that staff recorded the daily temperature of the drug trolley and the room. According to the records, the maximum temperature was 25 degrees. However, on the day of our inspection, the temperature reached 28 degrees. We discussed this with the nurse in charge who told us they had turned off the fan temporarily because we were in the room and the noise of the fan meant they found it difficult to hear our questions. We discussed this with the manager who told us they would speak with all staff and ensure the fan was kept on at all times. We also recommended that the manager consulted the pharmacist for advice.

The provider had systems in place to protect people from the risk of abuse. People confirmed they would know who to contact if they had any concerns. One relative told us, "I have never seen any marks on [Family member] and when you ask him, he would say" and another said, "I'm very familiar with these environments and I have not seen anything negative. The staff are good." Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. The service had a safeguarding policy and procedures in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the care staff and people using the service as required, and involving healthcare professionals as needed.

Incidents and accidents were recorded and analysed by the manager to identify any issues or trends. We saw evidence that incidents and accidents were responded to appropriately. For example, where a person had a fall, they had been checked by the GP and measures were in place to reduce the risk of reoccurrence. Lessons were learned when things went wrong. The manager told us they ensured that they communicated well with staff and put measures in place to prevent incidents from happening again. They said, "It is our responsibility to do everything in our power to prevent elderly and vulnerable residents from injury. Risk assessment is always done after a fall. The GP will be notified of every fall because his input on prevention of fall is very important."

The provider had taken steps to protect people in the event of a fire, and we saw that there was an up to date risk assessment in place. There were regular fire drills and weekly fire alarm tests, and staff were aware of the fire procedure. One staff member told us, "My colleagues would check where the fire is coming from. I would also check using the panel then call 999. We would evacuate those who could walk first then those who are bed bound. We have sheets to assist this." People's records contained individual fire risk assessments and personal emergency evacuation plans (PEEPS). These included a summary of people's impairments and abilities, and the appropriate action to be taken in the event of fire.

People told us they were happy with the staffing levels, and we saw that there were enough staff on duty on the day of our inspection. One person stated, "That's not a problem. When I need something, they come to

me." A relative agreed and said, "I would say there probably is [enough staff]." There were suitable arrangements in place to cover in the event of staff sickness. We viewed the staff rota for four weeks and saw that all shifts were covered appropriately.

Recruitment practices ensured staff employed were suitable to support people. Checks were carried out before staff started working for the service. These included checks to ensure staff had the relevant previous experience and qualifications, obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a Disclosure and Barring Service record check was completed.

Requires Improvement

Is the service effective?

Our findings

People did not always benefit from an environment that was designed to meet their needs. We saw that the garden was not well maintained or easily accessible for people to enjoy. It was bare, lacked colour and looked uninviting, and there were dead plants and weeds. There was an abandoned shopping trolley on the side of the garden and another one and an old armchair behind the shed. There was no garden furniture, and no flowers or plants. The Social Care Institute for Excellence (SCIE) states that 'As well as giving exposure to natural light (which provides vitamin D, so important to good health), a garden or outdoor space provides a place for familiar activities such as digging or cutting grass or hanging out the washing, and a place for exercise. A garden also offers a unique opportunity to provide a feast for the senses. Fragrant and vibrantly coloured plants and shrubs can provide excellent sensory stimulation." We did not witness anybody enjoying the garden on the day of our visit.

Some bedrooms were bare and did not display personal items, although others were personalised and reflected people's choices and interests. The manager told us that some people had not been here very long. They added that they would liaise with people and relatives to make their bedrooms more homely and personalised. Communal areas displayed art work that people had created, although these were in a side corridor and were not immediately obvious. A staff member told us, "I did say we should display these in the lounge so people could see them and be proud."

We recommend that the provider seek relevant guidance to improve the premises including the garden to benefit people who use the service, in particular those living with the experience of dementia.

There were two sensory tubes in the lounge which the manager said that "Some people loved". Bathrooms and toilets were accessible and there was a lift available to assist people who could not use the stairs.

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care and support. Their comments included, "We talk", "Everything is ok. If I don't want something, I just tell them" and "I've never had to interfere. They ask if we are happy."

Assessments included background information which helped staff understand each person and their individual needs. Relatives thought that the staff team provided a service that met people's individual needs. One relative stated, "[Family member] has only been here a few months, but so far, so good" and another said, "I am happy, yes. [Family member] is tidy and well kempt. He gets along well with the carers. He is always clean and well looked after." A healthcare professional told us, "I have nothing negative. Staff work hard" and another stated that people were "well looked after."

People were supported by staff who had appropriate skills and experience. We viewed the training matrix which showed the training that staff had undertaken and which training they were due to refresh. Subjects included safeguarding, health and safety, medicines administration, food hygiene, moving and handling and infection control. There were also courses specific to the needs of the people who used the service such

as dementia awareness, skin tear management and duty of care. In addition, there were in-house courses which staff were encouraged to attend, for example, hydration and nutrition, looking after your back and bathing and grooming a person confined to bed. We saw that all training was up to date, and staff confirmed that they undertook yearly refreshers. This meant that staff employed by the service had the skills and knowledge to deliver the care to the expected standard.

Most of the staff working at the service had been there for a long time and most had achieved recognised qualifications in Health and Social Care. The provider had implemented the Care Certificate for new staff. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

During the inspection we spoke with members of staff and looked at four staff files to assess how they were supported within their roles. One staff member told us, "I have many colleagues with years of experience who help and advise me." Staff told us and we saw evidence that they were receiving regular formal supervision from the manager. This provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. In addition, the provider carried out "at a glance" supervision. This consisted of observations of staff carrying out tasks such as supervision of junior staff, leading handover meetings and medicines rounds. Staff also received a yearly appraisal. This provided an opportunity for staff and their manager to reflect on their performance and to identify any training needs or career aspirations.

The 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).

All people using the service had an initial mental capacity assessment carried out. The manager told us that all the people living at the service lacked capacity and they had made DoLS applications to the local authority but a backlog meant that authorisations had not yet been granted and existing ones were due to be renewed. The manager showed us evidence of frequent correspondence with the local authority's DoLS team.

Staff told us that they encouraged people to be as independent as they could be. People confirmed that staff gave them the chance to make daily choices. One person told us, "Yes, I do things for myself" and another said, "Yes, they ask our opinion and let us try out things for ourselves." Staff had training in the MCA, and showed a good understanding of its principles. We saw evidence in the care records we checked that people were consulted and consent was obtained. Where people were to, they had signed the records themselves indicating their consent to the care being provided. Consent to take and display photographs was obtained, and we saw evidence of this in all the care files we looked at.

Some people were using bedrails. Care records showed that there were appropriate assessments in place, and included the reasons for the use of bedrails, considered alternatives, discussion with the person or their representative or a best interests discussion.

The staff recognised the importance of food, nutrition and a healthy diet for people's wellbeing and as an important aspect of their daily life. People told us they enjoyed the food they ate and were given choice.

Their comments included, "It's alright. It's edible" and "It's very good. It's home from home, just like my mother made. If you say you don't like something, they won't do it again." Relatives agreed and said, "[Family member] is fussy, and [they] are certainly eating", "The odd meal I have seen, [Family member] has been fine with" and "[Family member] is having Asian food which is what [they] wanted. So, I think [they] do enjoy it." We saw that menus were displayed and reflected what was served on the day. People were given choice at the point of serving. The food was hot and looked appetising. Staff supported people who required assistance with their meals.

People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plan. Nutritional care plans contained guidelines for staff to ensure they understood and met people's individual needs. For example, "Keep [person] upright during meals" for a person who was at risk of choking. We saw that for this person, a nutritional needs assessment was in place, following advice from the Speech and Language Therapist (SALT). Recommendations included a pureed diet and the use of thickener for liquids. We saw that staff followed the recommended guidelines during our inspection.

Staff displayed a good knowledge of people's nutritional needs and preferences. Menus were created according to people's likes and dislikes. People who wished for different food were catered for. This helped ensure people's preferences were met. People's diverse and cultural dietary needs were being met. For example, we saw that a person using the service required a vegetarian diet and meals specific to their culture and were served this. The chef told us, "[Person] is vegetarian and only likes food from [their] country. So I cook what [they] like every day." We saw the person eating their meal happily and with enthusiasm. All food was correctly stored and fridge temperatures checked every day.

People received the support they needed to stay healthy. Records showed that people's health needs were monitored and any concerns were recorded and followed up. There was evidence that people were referred to the relevant healthcare professionals when needed to ensure they received appropriate treatment. The GP conducted weekly visits to the home and took part in people's reviews. They were visiting people on the day of our inspection and told us that they had "No concern" and people were "well looked after."

Good

Is the service caring?

Our findings

People and relatives told us, and we saw that people were treated with kindness, compassion and dignity. One person told us the best thing about the service was, "Feeling happy and relaxed. If you want something, they'll do it and if it's not the best option, they'll explain that. They want to make us happy and comfortable." A relative echoed this and said, "There are two staff who treat [family member] very well. From what I have seen, they are kind." A healthcare professional confirmed this and said, "People are always happy and positive. The girls are lovely. [Staff member] is lovely and caring. Always checking. You can see [they] have that gift. A caring nature."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. It was clear from all the staff we spoke with that respect, dignity and personal choice were values they all shared and which they were proud of. One staff member told us, "I know all the residents like my own family. Their preferences, their moods, likes and dislikes."

We saw a range of thank you cards and letters from friends and relatives. Some comments we saw included, "May I thank you and your dedicated staff for looking after my [family member]", "As well as providing all his basic needs, we felt that you cared for [family member] as an individual" and "Although bedridden, [family member] has never had any bedsores and was always clean, well-groomed and content."

Staff displayed a gentle and patient approach throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. They were attentive to people's needs throughout the day and responded promptly and discreetly.

Care plans contained guidelines for staff about how to support people and respect their dignity. For example, "[Person's] personal space will be respected at all times" and "[Person] will be asked her preferences and this will be respected."

Staff demonstrated a good level of engagement with people. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day. There was a calm and unrushed atmosphere.

Each person who used the service had a communication care plan. This included the person's communication needs and how staff could meet these. Some staff were multi-lingual and we saw that they were able to communicate with a person for whom English was not their first language. For example, the person had asked in their language to go for a nap after lunch and this was respected.

People were consulted about how they wanted their care and support to be given and what they wanted to do. The manager held regular meetings for people. We viewed a range of the minutes of these meetings and saw they included what people wished to discuss and actions to be taken. For example, what kind of food

they wanted and suggestions for any activities.

The service had also signed up to be "Dignity Champions". A dignity champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. Each person living at the service had a 'dignity in care' profile. This included advice to staff about how to provide person-centred care and meet the needs of people. Instructions included, "Show proper respect for [person's] belongings", "Ensure you knock before you enter the room" and "This is [person's] room and although you have a job to do, you are still a guest." There was a range of 'Dignity' posters displayed around the home to inform staff and visitors about treating people with respect.

People's religious and cultural needs were respected, and care plans included details of this. One person told us, "There is always a priest coming and going, and they would take me to mass if I wanted."

Good

Is the service responsive?

Our findings

At our last inspection on 28 July 2016, we recommended that the provider seeks relevant guidance to improve the provision of activities for people living with the experience of dementia. At this inspection, we saw that some improvements had been made.

On the day of our inspection, a massage therapist was visiting and we saw that a person was enjoying this service. They told us, "This is wonderful." Staff told us they encouraged and supported people to undertake activities of interest to them. People's opinion about the activities provided varied. One person told us, "I thinks lots of things go on and they ask me if I want to get involved, but I don't go often" and another said, "There are no activities. If you want something to do, go out. Sometimes people come to play music." There were activity assessments in place and a record of activities undertaken by each person. These detailed the type of activities each person liked and the support required for them to undertake these. For example, one person who particularly enjoyed a type of music was listening to this when we visited.

Regular activities were undertaken and included chair exercises, in-house entertainment, drama therapist, shopping and art therapy. There was a list of events arranged for 2018. These included Easter egg hunt, barbecue, shoe sale and bonfire night. There was a large activity board in the lounge detailing all the activities for the week. We saw that on the day of our inspection, chair exercises were planned for the morning and the hairdresser for the afternoon. However, none of these took place. We discussed this with the manager who told us the hairdresser came every two weeks and other activities were taking place the week they did not come. They also explained that the morning had been particularly busy and this meant they had not been able to do the chair exercises. However, they pointed out that the volunteers had undertaken various activities with people throughout the morning. We witnessed the volunteers spending time with various people individually, reading, colouring and having chats. We saw photographs of celebrations such as a person's 100th birthday.

The care plans were standardised but comprehensive and contained detailed information of the needs of each person and how to meet these. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences in a range of areas such as personal care, eating and drinking and medicines. Each care plan had a 'personal profile'. This included the person's background, personality, likes and dislikes, preferred activities, interests and hobbies, religious and cultural preferences and medical history. We saw in the records we viewed these had been signed by people or their representatives. Staff told us they had access to care plans and knew how to meet people's needs. Daily records were written by staff at the end of each shift. We saw that these were written in a person-centred manner, using appropriate language, and included a summary of the person's day, such as any appointments, concerns and social interactions.

The service had a complaints procedure in place and this was available to people who used the service. There had been no complaints received in the last year. People told us they knew who to complain to if they had a concern and felt confident about raising any issues. One person told us, "I've never wanted to (make a complaint) but if I did, I would speak to a member of staff then ask to speak with someone senior and discuss it with them" and another said, "I can't make a complaint about things I haven't seen happen. If I

don't like something, I tell them." A relative added that they had "no complaints."

People were supported to make their own decisions about how they wanted to be supported at the end of their lives. People had been involved in devising advanced care plans. These were documents which took into consideration how people wanted their care to be provided at the end of their life. These took account of their culture and religion and included how they wanted their funerals to be conducted. For example, one person who used the service wished for a cremation in line with their religious beliefs and another wished to have the last rites from a catholic priest. These decisions were regularly reviewed, and people had signed to indicate they agreed with what had been recorded. There was a memorial book to help remember people who had lived in the home, which contained photographs of people who had died and thank you cards and letters from relatives.

The home was accredited to the Gold Standard Framework (GSF) since 2013. They were reassessed in August 2016 to ensure they were still meeting the standards necessary to maintain their accreditation and had been successful. GSF is an approach to planning and preparing for end of life care.

Good

Is the service well-led?

Our findings

The provider had been the registered person and owner of the service since 1991 and of a smaller home nearby since 1984. They were supported by a deputy manager who provided management cover at the weekends, an administrator, and a team of qualified nurses and care staff.

The manager carried out regular audits. It was clear from the evidence gathered during our inspection that the audits were thorough and identified issues. Audits included accidents and incidents, medicines, staff training and supervision. The manager also undertook specific observations of tasks carried out by staff, such as observation of a nurse leading a handover meeting, writing a care plan and supervising a junior member of staff. Any observations or concerns were recorded and followed up at the next supervision. For example, one record had identified that records were not written legibly. The manager also ensured that senior staff's medicines competencies were checked regularly.

People were complimentary about the registered manager and the senior team and told us they thought the service was well run. Their comments included, "I find them all very nice", "You hardly see them, they only come to say hello" and "She's a nice lady. I've met her a couple of times." Relatives agreed and said, "[Manager] seems to be ok" and "She is nice. I mainly interact with the carers and nurses because they spend the most time with [Family member]." Staff told us they felt supported by the manager and enjoyed working for the service.

Staff informed us they had regular meetings and records confirmed this. The items discussed included people's care needs, health and safety, safeguarding, inspections and upcoming events. Outcomes of complaints, incidents and accidents were also discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. There were daily handover meetings. These helped ensure that staff coming on duty were informed of any concerns about people's health and wellbeing and could follow up on anything outstanding such as taking a person to an appointment. These meetings contributed to good communication among the staff team.

People, their representatives and staff were encouraged to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether people's needs were being met. It also included questions about the quality of the food, the environment and their social needs. We saw that the results showed an overall satisfaction with the quality of the service. The results were collated and an action plan put in place if someone had highlighted a concern.

The manager had completed a programme of redecoration and maintenance of the home. This included the replacement of the call bell system, cleaning and changing curtains, painting the exterior of the building, changing damaged flooring and purchasing new armchairs. Where daily maintenance checks identified defects, action was taken without delay. For example, on the day of our inspection, a fault meant that the fire alarm was activated and could not be stopped. We saw that all checks were done promptly and the electrician was called to repair the fault.

The manager attended regular meetings organised by the local authority and kept abreast of developments within the social care sector by attending provider forums and conferences. They told us they found these helpful and informative, and provided them with the opportunity to liaise with other managers and share information. Relevant information was cascaded among the staff team during staff meetings so that staff could improve their practice and feel valued.