PK Healthcare Limited

Roxton 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

Summary of findings

Overall summary

This unannounced inspection took place on 17 February 2017 with a return announced visit on the 20 February. At the last inspection, the service was rated with an overall good although their recreational activities and encouraging peoples' interests and hobbies required some improvement. At this inspection we found there had been an improvement.

Roxton Nursing Home is a residential care and nursing home providing accommodation for up to 45 people with a range of care and support needs including people living with dementia. At the time of our visit 42 people were living at the home. There are three floors to the home with the first and second floors accommodating people with more complex needs, some of whom are cared for in bed.

There was a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection improvement was required for some people because they did not have sufficient group or individual social activity to prevent them from being isolated. Although there had been an overall improvement, there remained a mixture of opinions and views from people and relatives around the quality of the activities and interests being offered. We found the provider had employed permanent staff to develop activities, hobbies and interests with people. External agencies visited the home twice a week to develop exercises and musical interests and volunteers from the local community were regular visitors and spent time talking with and reading to people.

People and relatives told us they felt the home was a safe environment for people to live in. Staff spoken with could identify the different types of abuse and explained how they would report abuse. People were protected from the risk of harm and abuse because staff knew what to do and were effectively supported by the provider's policies and processes. Risks to people were being monitored and staff identified risks to people and explained how those risks should be managed. Staff had a good understanding of the risks and the action that was required. The care plans and risk assessments were reviewed and updated regularly.

We saw all staff were busy but were available to provide support to people when needed. This included support for people to eat, drink and move around the home safely. Requests for assistance from people were responded to promptly. The provider's recruitment processes ensured suitable staff were safely recruited.

People received appropriate support to take their prescribed medicines and records were kept of the medicine administered to people. Medicines were stored securely and consistently at the recommended temperature given by the manufacturer and were safely disposed of when no longer required.

People were assisted by suitably trained staff that told us they received training and support which provided them with the knowledge and skills they needed to do their job effectively. People and relatives felt staff were knowledgeable on how to support people effectively and that staff possessed the necessary skills.

We found mental capacity assessments had been completed for people who lacked the mental capacity to consent to their care and welfare. The provider had taken suitable action when they had identified people who did not have capacity to consent to their care or treatment. Applications had been made to authorise restrictions on people's liberty in their best interests.

People's care records contained information relating to their specific needs and there was evidence that the care plans were updated when people's needs changed. People and relatives told us they were involved in developing and reviewing their care plans. People were supported by caring and kind staff who demonstrated a positive regard for the people they were supporting. Staff understood how to seek consent from people and how to involve people in their care. We saw staff interacting with people in a friendly and respectful way and that staff respected people's choices and privacy.

People told us they had no complaints but were confident if they did, that the provider would deal with it effectively. We found where complaints had been raised they were investigated and resolved to the satisfaction of the complainant.

The registered manager carried out audits and checks to ensure the home was running properly to meet people's needs and to monitor the quality of the care people received.

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 told us they felt safe. People were safeguarded from the risk of harm because staff were able to recognise abuse and knew the appropriate action to take.

Risks to people's health and safety had been identified and were known to the staff. This ensured people received safe care and support.

People were supported by suitably recruited staff.

People were supported by staff to take their medicines as prescribed by their GP.

Is the service effective?

Good

The service was effective.

There were arrangements in place to ensure that decisions were made in people's best interest. Staff sought people's consent before they provided care and support.

People were supported by suitably trained staff.

People enjoyed the meals provided and were given refreshments at regular intervals, or when requested. People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration.

People received support from healthcare professionals to maintain their health and wellbeing when it was required.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and respectful.

People's independence was promoted as much as possible and staff supported people to make choices about the care they

received.

People were supported to maintain relationships with their friends and relatives.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People received care and support that was individualised to their needs, because staff were aware of people's individual needs.

People knew how to raise concerns and were confident the provider would address the concerns in a timely way.

Is the service well-led?

Good

The service was well led.

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

People were happy with the care and support they received.

Roxton 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 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 unannounced inspection took place on 17 February 2017 with a return announced visit on the 20 February. The membership of the inspection team comprised one inspector and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone living with dementia.

We asked the provider to complete 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. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

We spoke with nine people, 10 relatives, the nominated individual, the registered manager, the deputy manager and eight nursing and care staff. Because most people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to three people's care and six medication records to see how their care and treatment was planned and delivered. Other records we looked at included two staff recruitment and

training files. This was to check that suitable staff were safely recruited, trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service and a selection of the provider's policies and procedures, to ensure people received a quality service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us the home provided a safe environment for people to live in. One person said, "Yes I feel very safe here." Another person told us, "I know I'm safe here because the girls [staff] keep an eye on me." A relative told us, "All we wanted for [person's name] was for her to feel and be safe, mum has settled right in and she hasn't had any falls since she has been here." Another relative said, "I have no concerns at all about [person's name] safety, there is always staff around to watch out for people." There were a number of people living at the home who were not able to tell us about their experience. We saw that people looked relaxed and comfortable in the presence of staff and that staff acted in an appropriate manner to keep people safe. For example, staff ensured people had their walking frames close by to support them to walk and reduce the risk of falling.

Staff were able to explain to us what could constitute abuse and how they would recognise the signs of distress in people. One staff member told us, "Most of the staff have been here a while and I think we know people well so you get to know them and their ways so if they [people living at the home] suddenly start to behave differently or you notice they act different around a particular staff member that might get you thinking something is not quite right so you would ask them or if you saw something happen you'd tell the nurses or managers." Staff we spoke with knew how to escalate concerns about people's safety to the provider and other external agencies, for example, the local authority, police and Care Quality Commission (CQC). A staff member we spoke with told us, "I wouldn't hesitate, if they [the management and nursing team] did nothing about something I was worried about, I'd come straight to you [CQC]." The provider had procedures in place that showed when a safeguarding incident occurred appropriate action was taken. For example, referrals would be made to the local authority. We saw the provider had conducted investigations, where appropriate and had worked with the local safeguarding team to ensure people remained safe.

The Provider Information Return (PIR) stated risk assessments were regularly completed and reviewed to ensure people's safety. We found that risk assessments had been completed and were individualised for people. One person told us, "I have never fallen over or fallen out of bed; I am frightened of falling out of bed so there are these bars on the bed to stop me." We saw there were a number of people who had been identified at risk of developing sore skin. We saw pressure relieving equipment was available, for example pressure cushions on lounge chairs and wheel chairs, protective heel guards and air flow mattresses were in use to support people. We saw there were body maps that identified where protective barrier cream should be applied to help heal and protect the skin. Where applicable, referrals had been made to the appropriate professionals and we found risks to people's health and welfare were managed effectively. We saw people were supported safely by staff when being transferred from lounge chairs to their wheelchairs, using the correct equipment and techniques.

Safety checks of the premises and equipment had been completed and were up to date. Staff explained what action they would take in the event of a person choking or if there was a fire. The provider safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

The PIR stated that the provider employed sufficient staff numbers to meet people's needs and that staffing levels and shift patterns were regularly reviewed to ensure sufficient staff were on duty each day. People we spoke with told us they thought there was sufficient staff on duty to support people. One person said, "There is always someone walking around." Another person told us, "I don't have to wait long when I ask for help." However, there was a mixture of opinions from relatives and staff we spoke with. One relative told us, "During the week I'd say there is enough staff but they can sometimes be short at the weekends." Another relative said, "The staff are great and I have no complaints. They are extremely busy and sometimes [person's name] can be left in the same pad for longer than they should." Another relative told us, "The carers look a bit worn out sometimes." A staff member told us, "I think there is enough of us on duty," another staff member said, "It's ok until someone phones in sick or on holiday and we have to cover that's when you could do with extra help." Some of the staff told us there was a 'high expectation' for them to provide cover for planned and unplanned absences because the provider did not use agency staff. We raised the issue of staffing with the deputy manager. They confirmed the provider did not use agency staff to cover absences and explained how this contributed to the continuity of care and support people received from staff that were familiar to them and knew people's individual needs. This was supported by conversations with some people, relatives, nursing and care staff. The deputy manager also confirmed additional staff had recently been recruited and they were in the process of completing their pre-employment checks. We found staff was consistently busy, however alarm activations and requests for support were responded to in a timely manner and people were not left waiting for support.

We spoke with staff who confirmed that prior to starting at the service pre-employment checks were carried out. We found that included criminal checks through the Disclosure and Barring Service (DBS). The DBS check helps employers to make safer decisions when recruiting staff and reduces the risk of employing unsuitable people. Records we looked at confirmed the provider had completed employment checks that also included employment and character references.

People we spoke with told us they had no concerns about their medicines and confirmed they received their medicines on time and as prescribed by the doctor. One person told us, "I have the same tablets each day and the staff make sure I have them." Another person said, "I have my tablets at the same time every day." We saw medicines at the home were stored safely and securely. Temperature checks for a fridge that contained medicine had been carried out and these were in line with required temperatures to maintain the effectiveness of the medicine. The nursing staff was responsible for administering medicines and completing the Medical Administration Records (MAR) sheets. We saw nursing staff complete a medicine round; they were discreet and waited with each person to ensure the medicine was taken properly.

We reviewed six people's MAR sheets and found there were people who required medicine to be given 'as and when required'. We found protocols were not in place to provide guidance for staff when people required pain relief or became distressed. Because some medicines are required outside normal medicine rounds, it is best practice to have a protocol in place that provides clear guidance to enable staff to understand when it would be necessary to administer 'when required' medicines. However, the nursing and care staff were able to give us examples of the signs and behaviours that people would exhibit that meant they required their medicine. We were also told that because the provider did not 'use' agency staff, the need for a protocol to be in place may not have been considered because nursing and care staff 'know people very well.' We received notification from the provider following our inspection visit that protocols were introduced and an example was submitted to us as evidence.

We found where people required their medicine to be administered through a skin patch; there was a system in place to ensure the patches were not repeatedly placed on the same area of the body. Changing the position of the patch is important because the adhesive can be an irritant and make the skin sore, red

and itchy. Changing the position of the patch regularly means that the placement area that may be irritated is given time to recover.

Good

Is the service effective?

Our findings

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "The girls are very good, I think they are well trained." Another person told us, "I am very happy with the support I get from the staff, they know me very well." A relative said, "You can't fault the clinical care, the staff seem to know what they are doing." Another relative told us, "The care assistants are very knowledgeable and there appears to be regular training." The staff we spoke with confirmed they received the necessary training to support them in carrying out their roles. We found a number of staff had completed or were in the process of completing their NVQ level 5. One staff member told us, "The training is very good, if you want training in a particular subject and ask [registered manager's name] she will try to arrange it." Another staff member told us, "I can't complain about the training, I think it's good." The provider had indicated in their PIR low numbers of staff had received training in first aid, health and safety and end of life. We discussed this with the registered manager who confirmed they were in the process of finding and arranging training for staff to cover the areas identified in the PIR. We saw refresher training for staff was reviewed with training scheduled for the months ahead. Staff new to the service explained how they completed their training induction and spent time shadowing another staff member for at least two weeks before being permitted to work unsupervised. One staff member said, "I'd been a carer before but still found the training and shadowing good, it helped me to know what to expect and to get used to people's ways." The registered manager explained staff members did not currently complete the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. However, it was noted in the Provider Information Return (PIR) that staff had received training to a minimum of NVQ level 2 with 'many supported to level 3.' The training records we reviewed demonstrated that staff had received training based on the same standards as the Care Certificate.

The PIR stated that staff was allocated a mentor. A mentor is a person who provides guidance and support to a less experienced person. Staff we spoke with confirmed this was in place. Staff also explained they had received supervision although it was not always as regular as they would like. One staff member said, "I can't remember when I last had my supervision but if I have any concerns or I'm not sure of something I will go to the nurses or managers, I always ask if I'm unsure of something." Another staff member told us, "I've not long had supervision." We saw from the staff records we looked at that supervisions had taken place along with observed practices. An observed practice is when a staff member is observed by a senior staff member to ensure the delivery of care and support is effectively practised.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
At this inspection 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 Provider Information Return (PIR) stated that each resident was assessed for their mental capacity and where appropriate, DoLS applications were made. All of the staff we spoke with identified people who would not be permitted to leave the building unescorted or they were required to have a soft or pureed diet because it

would be dangerous to the person if these conditions were not followed. One staff member said, "[Person's name] would love to have a piece of toast but if they did it could cause them harm, we do explain this to them and they seem to understand that it is in their best interest." Another staff member told us, "[Person's name] is at risk of falls and likes to walk without their frame and they just don't see the danger so we have to make sure someone is keeping an eye on them so when they do get up they use their frame or a staff member is walking by them." We saw that some people were closely supervised and had been subjected to a restricted practice, in their best interest, to prevent injury to themselves or others. Applications had been made to the supervisory body and the provider was meeting the legal requirements of the MCA.

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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "We always talk to people even if they can't always talk back to you, it's important you give them that choice just because they can't always tell you doesn't mean they don't know what's going on." Another staff member told us, "I always ask because when you get to know people you understand their needs through their body language or facial expressions." We saw staff encouraged and offered people choices and sought people's permission before supporting them.

People we spoke with told us and we saw they were offered choices at every meal and had access to drinks throughout the day. One person told us, "I had meatballs for lunch and when they [staff] came with pudding I said I was full, the cook is very good." Another person said, "The food is excellent and always plenty to go around." A staff member explained how they visited everyone in the morning with the menu and pictures to ask people what they wanted for lunch. We heard staff explain to people at lunchtime what choices were available. Where possible, staff encouraged people sit at the dining tables and we saw some people were encouraged to walk to the dining area for their lunch. Encouraging people to move to a different location puts emphasis on the lunch time experience and therefore something different and encouraged people to move from their lounge chairs. We found the staff were organised while lunch was served to people. Staff provided one to one support where people required it although we did see one person being offered support to eat by three different staff members rather than being consistently supported by one staff member. The deputy manager provided us with a satisfactory explanation why this had happened. We saw staff encouraged people to eat, asked people if they had eaten enough and meals looked well presented. We saw that people who chose not to eat in the dining room received their meals without undue delay and that meals were plated and covered to keep the food hot. People spoken with told us they enjoyed the food. One person told us, "The food is very nice and you get a choice but I would like to see more fresh fruit offered instead of biscuits all the time." A relative said, "We are always offered a cup of tea but they do seem to offer a lot of biscuits, I'd like to see [person's name] being offered fresh fruit occasionally instead." We spoke with the deputy manager and informed them of this feedback, they said there was fresh fruit available but they would check with the kitchen and care staff to ensure people were being given the choice.

The PIR stated the provider used assessment tools to understand how to plan people's support around their nutrition and dietary needs. Staff we spoke with confirmed people was assessed to meet their individual dietary requirements that ensured people received a healthy and balanced diet. We saw that people's dietary needs and preferences were recorded in their care records and, where appropriate, their food and fluid intake was monitored and reviewed. We discussed with the deputy manager and nursing staff that their fluid monitoring forms were not always consistently completed by staff. For example, some entries contained lines through the time slot while other entries would stipulate 'a sip or ½ a cup of… taken'. It is important to be as accurate as much as possible on what fluid intake people have taken when they have

been assessed to be at risk of dehydration, for example, to reduce the risk of a water infection. The provider sent to us evidence to support a new hydration risk assessment was being introduced and confirmed the way amounts of fluid people had taken was recorded would be discussed with staff at the next team meeting.

We found that people who had been identified as at risk of losing weight had input from healthcare professionals, for example, dieticians and Speech and Language Therapists for support (SALT). A SALT is a healthcare professional that provides support and care for people who have difficulties with communication, or with eating, drinking and swallowing. We saw additional food supplements to sustain and improve people's weight were administered as prescribed and their weights were regularly monitored.

Visiting professionals attended to people to assess and review the person's care and support needs. For example, a GP, podiatrist, tissue viability nurse, community psychiatric nurses, opticians and social workers. People told us if they felt unwell they were seen by the GP. One person said, "I don't see the doctor very often but if I feel poorly they [staff] will always call them [doctors] for me." Staff spoken with were knowledgeable about peoples' care needs and how people preferred to be supported. A relative said, "They [staff] call the doctor when it is necessary." We saw from the care records we looked at that people were effectively supported to maintain their health and wellbeing with additional input from health and social care professionals.

Good

Is the service caring?

Our findings

People and their relatives spoke in a positive way about the staff. One person said, "I enjoy it here it's very good. The girls are great, I don't want them to fuss over me but they do help me when I really need it." Another person told us, "All the staff are very kind." A relative told us, "I can't fault the staff they are all lovely and very caring." Another relative said, "It is a very homely atmosphere, everyone seems to be happy and well cared for." One staff member told us, "I love working here and I enjoy what I do." Another staff member said, "We do our best to make it a home from home for people." We observed positive interactions between the staff and the people who lived at the home. It was clear that staff had built up good relationships with people. For example, we heard one person say to a staff member, 'I love you.'

People we spoke with told us the staff listened to them. Staff explained how they supported people who could not express their wishes. For example, once they got to know people, they could tell by facial expressions and body language whether the person was happy with their care. Staff spoken with explained they would make sure they would deliver care in a way the person was happy with. If the person was not happy, staff told us they would leave the person for a while, then return later to check if the person had changed their mind. We saw staff understood people's communication needs and gave people the time to express their views and treated them with kindness and empathy.

Staff told us how they supported people to make choices and we saw people exercised some choices with regard to their daily routines. For example, one person told us, "I tend to get up late and then stay up late." We asked staff how they encouraged people to maintain some independence. One staff member said, "We try to encourage people to do as much as they can like brushing their teeth, combing their hair or washing their face." Staff demonstrated patience and understanding when people needed encouragement and reassurance. For example, at lunchtime one person left the dining area and started to walk around the lounge with cutlery in their hand. The care staff nearby reacted quickly and distracted the person and encouraged them to take a seat reassuring them that their pudding would be with them soon, whilst at the same time removing the cutlery from their hand. We saw that the person was relaxed and was happy to wait for their pudding.

People and their relatives told us staff involved them in decisions about their care and staff knew the importance of people being involved in these decisions. Our discussions with people confirmed staff understood their needs. People told us they were always cared for in a dignified way. For example, one person said, "I have no cause to get upset with the care staff they are very gentle with me and they wash me very well." Another person said, "I am involved in how I like things to be done for me." A relative we spoke with said, "I watch the staff and if I see anything I am not happy with I will tell them." We saw that staff protected people's dignity when transferring them from lounge chairs to their wheelchairs. Ensuring shirts and skirts covered people appropriately and did not expose under garments. We saw one staff member gently wake one person for their lunch so as not to startle them. One person told us, "The care assistants do respect my dignity and privacy, more than I want them to in a way, when you have had children modesty goes out the window." People's personal appearance had also been supported, for example a number of ladies had their finger nails painted. They told us how much they enjoyed this and proudly showed us their

finger nails. One person told us "I like to have my hair done by the hairdresser." A relative told us, "On the whole I am satisfied mum is getting very good care and they [staff] are looking after her. They are all very good to my mum. She has a nice room, she has her TV and she has some of her personal photos." We were invited into some people's bedrooms and found them to be maintained by the provider and individualised with pictures and personal belongings that were important to the person.

People told us that their family members were made welcome. We saw there was a constant arrival of visitors. A relative told us, "They [staff] don't seem to mind what time you come to visit, I come at all hours and days and am always made to feel welcome and offered a cup of tea." Another relative said, "Friendly staff have encouraged me and made me feel at home when I come to visit. There is open access, and I can visit anytime. Some of the staff I have found to be spot on regards caring for mum. There is no bad attitude and they are never grumpy. I Met the manager on the first visit and everything seems very efficient."

Staff ensured confidentiality was maintained and were discrete when talking to each other in public areas so as not to be overheard. Information held about people was kept safe and secure. People's personal information and records were kept in locked cabinets. Only authorised staff had access to this information.

Good

Is the service responsive?

Our findings

At the last inspection in January 2015 some people were not being engaged in suitable, social activities or stimulation which could lead to social isolation. At this inspection we found there had been improvements made.

The Provider Information Return (PIR) stated the provider had an activities programme in place. We found a recently employed dedicated staff member planned and delivered a programme of activities for people. We saw there was one to one and group activities offered to people. We saw people were invited and some agreed to participate in board games and light exercise. One staff member told us, "The activities have got a lot better since your last visit. Although we have one main staff member that is responsible for activities, because they don't work full-time, we [staff] all have a duty to make sure people have something to do – some staff are better than others at doing this." Feedback we received about how people's leisure and social needs were responded to showed there had been an improvement from the last inspection. One person told us, "Someone comes in each week and we do exercises." Another person said, "I spend a lot of time in bed but the care staff do come and sit with me for about 20 minutes during the day." A relative said, "Only thing I wish they [staff] would do is to try and help with [person's name] brain activity, I know they [people] do activities but the trouble is trying to get and keep mum interested." Another relative said, "The staff do their best to try and sit with people to encourage them with activities but they don't always have the time, it would be nice if they could sit with mum a little more." We were told a 'cinema night' had been introduced with a staff member dressing up as an usherette serving ice creams and other suitable snacks. People told us how much they enjoyed this. We discussed the comments some relatives had told us about the activities. The deputy manager explained the activities were constantly reviewed and updated and confirmed that volunteers had started to visit the home at weekends and they would spend time talking with people. One person told us, "I do look forward to this lovely young lady's visit each week."

Pre-admission assessments were completed by the registered manager to assess whether people's care and support needs could be met at the home. We saw individual care plans were in place which reflected people's support needs and detailed people's medical conditions. People and their relatives told us they had the opportunity to visit and look around the home before they decided to move in. One person said, "I came to have a look round before I moved in and although I'd rather be at home, it is a very nice place with lovely staff." All of the people we spoke with received their care and support in the way they preferred which met their individual needs. Our discussions with people confirmed they had been involved in discussing the planning of their care and they had contributed to their care plans. For example, one person explained the staff would always talk to them about their care and what they would be doing for them. A relative told us, "There is good communication amongst the staff and with us, they [staff] are always quick to let us know when [person's name] needs have changed."

People and their relatives told us staff were responsive to their needs. One person told us, "I fell over once and couldn't reach the buzzer but was able to call out and fortunately someone heard me, I wasn't hurt." A relative told us, "Many of them [staff] know the residents well and are generally pretty quick to react to incidents. A resident walked into the back of me and fell whilst I was standing in the lounge, carers were

there rapidly and the person was assessed by the nurse and helped back into their chair." Another relative said, "We have had a number of meetings with the manager about dad's care, we know it will never be as good as him being at home with mum but things are more settled now and dad seems a lot happier in himself." Staff we spoke with were responsive to people's support needs. They explained to us in detail how they provided care in line with people's wishes. One person told us that their wishes were always listened to by the staff. For example, they preferred to remain in bed and staff respected this decision.

The PIR stated the provider 'welcomed complaints and would provide formal responses as quickly as possible.' People we spoke with told us they had no complaints but if they did, they would speak with the registered manager or nursing staff. Two relatives we spoke with did tell us they had raised some concerns over the laundry with items going missing or other people's clothing being put in their relative's room. They explained they had raised the issues with the provider. We saw from complaints records that issues had been investigated and where appropriate, action taken had been taken. For example, there had been a complaint about the quality of the rear garden path and its safety. The provider explained how they had resolved this and an action plan was put in place to have the pathway re-set to ensure people's safety. With regard to the issues around laundry, the deputy manager explained there had been some problems with the laundry and they would discuss the issues with family members.

Good

Is the service well-led?

Our findings

All the people and the relatives we spoke with were complimentary about the service and that they would speak with members of the management and nursing team if they needed to. One person told us, "I am very happy here." Another person explained, "It is a very nice here and everyone is very kind and I know I can't go home so this is as good a place as any if you have to be held up (laughing)." A relative told us, "We spent time looking around at other homes then someone recommended this place, we came to visit and [person's name] said he like it and he's been here ever since, we are both very happy with the home."

We found there was a clear management structure in place. The provider's management team consisted of a registered manager and a deputy manager. The registered manager and nominated individual, although due to go on holiday the day we visited, made time to come into the service to answer any questions we had. The deputy manager and nursing staff were responsible for the day to day running of the home and the registered manager explained their intention to 'take a step back' and the deputy manager was to submit an application to become the new registered manager. The deputy manager confirmed this was their intention. Staff had a clear understanding of their roles and responsibilities and knew what was expected of them. We saw the deputy manager was approachable and that people and relatives approached her and other staff members freely during our visit. People and relatives spoke positively about the registered and deputy managers.

Staff we spoke with confirmed they felt confident to approach the management or nursing team if they had any concerns or worries. They also told us the deputy manager was involved with people's care. For example, they sometimes worked a shift and provided care to people. One staff member said, "[Deputy manager's name] is good, you can talk to her and she listens and will try to address things." Another staff member told us, "She [deputy manager] helps a lot." Through discussions with staff, people who lived at the home and their relatives it was clear the deputy manager had a good understanding of people's needs and preferences. Staff we spoke with confirmed staff meetings took place and we looked at a selection of minutes from the meetings and we saw meetings had been used to discuss issues around the running of the service and how improvements could be made.

The Provider Information Return (PIR) stated the provider encouraged feedback from people living at the home and their relatives. Satisfaction surveys had been issued to people and relatives within the last six months to gain peoples and relatives views of the quality of the service. We saw that past survey results were displayed on the provider's notice board. People and relatives confirmed to us they had been asked for their views on how the service could be improved. One person said, "We do have meetings." A relative told us, "I have attended residents meetings in the past." There were a number of people who would not be able to contribute to resident meetings because they were cared for in bed or had high support needs that affected their ability to verbally communicate their views. The deputy manager explained in such circumstances the views of people's relatives would be sought but they also recognised the views of the individual people were important and they would look to introduce a revised system for staff members to spend time with each person on a one to one basis to try and directly ascertain the person's views.

Staff told us they would have no concerns about whistleblowing and felt confident to approach the management team, and if it became necessary to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. Whistleblowing is the term used when an employee passes on information concerning poor practice.

It is a legal requirement to notify the Care Quality Commission of any significant incidents or accidents that happen as this helps us to monitor and identify trends and, if required, to take appropriate action. Although we had been notified about some significant events by the provider; on reviewing the incident and accident records, we found there were at least two serious injuries that occurred within the last two months that we should have been notified of. The deputy manager told us there was some confusion over what could be viewed as a 'serious injury'. We explained that serious injuries did not just refer to broken bones but also applied to harm caused to a person that required treatment by another healthcare professional or admission to hospital. Although there had been some inconsistency in notifying CQC, we saw where accidents and injuries had occurred appropriate treatment and observations had been put in place to ensure the person's safety and no long term injuries had been sustained. The provider and management team assured us that in future they would notify us of future serious injuries or contact us if they were unsure and required clarification. We found that, where appropriate, investigations into any safeguardings had been conducted in partnership with the local authorities to reach a satisfactory outcome.

The most recent CQC reports and ratings were displayed in the hallway entrance to the front of the home. The PIR we requested had been completed and submitted on time. It contained information relevant to the service and the improvements the provider planned to make. These were consistent with our findings and what we were told by people, relatives and staff. At the end of our site visit we provided feedback on what we had found. The feedback we gave was received positively with clarification sought where necessary.

A range of audit checks were carried out to monitor the quality and safety of the home. These included audits looking at the arrangements for people's medicines, risk assessments, recruitment, care plans and health and safety. By having quality assurance systems in place, this protected the safety and welfare of people living in the home. We saw the audit checks were regularly completed and were up to date.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the registered and deputy managers had been open and honest in their approach to the inspection, co-operated throughout and acknowledged the identified areas for development.