Kargini Care Services Limited

Grasmere Nursing Home

Inspection report

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Date of inspection visit:
23 August 2017
24 August 2017

Date of publication:
28 September 2017

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 23 and 24 August 2017 and was unannounced. Grasmere Nursing Home provides accommodation, nursing and personal care for up to 21 older people who have a physical disability. At the time of our inspection there were 18 older people living at the home. People had various needs including physical frailty requiring personal care and nursing support with all activities of daily living. Some people were living with dementia. The ambience was warm and inviting. The accommodation is provided over three floors with a mezzanine area on the first floor. Several of the bedrooms have en-suite facilities. All rooms on the first and second floors can be accessed by a passenger lift. The mezzanine area can be accessed by a platform lift and there are stair lifts located on several staircases around the home. The home was clean and tidy and maintained to a high standard and people's bedrooms had been personalised. There was access to attractive gardens to the front of the building and a small patio to the side for people's use. The nursing home is located in a residential area in close proximity to local shops and Worthing seafront.

There was a registered manager in post who joined us throughout our inspection. 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. They had been in post since October 2015.

At the last inspection on 20 July 2016 we identified one breach of Regulations associated with how the staff managed prescribed medicines. We found risk assessments was an area which required improvement as they did not always contain the necessary details and guidance needed to ensure risks to people were mitigated. We also identified care records failed to capture how best interest decisions had been made on behalf of people who lacked capacity to do so for themselves. Following the last inspection, the provider wrote to us to confirm that they had addressed these issues. At this visit, we found actions had been completed and the provider has now met all the legal requirements to ensure the home was safe and effective.

Significant improvements had been made to how medicines were managed. This included how medicines were stored and records of stock levels maintained. Homely remedies were administered to people as recommended and records of when they had been opened and administered were accurate. The registered manager had implemented guidance for 'when required' medicines. This included medicines used for pain relief. However, audits to monitor medicine systems were not always effective. This included where this guidance could be developed further. We have referred to this in the Well-led section of this report. In addition, there was a range of other health and safety audit processes to measure the overall quality of the service provided to people and to make improvements when needed.

Since our last inspection the registered manager had developed risk assessments to ensure risks to people's health and welfare were minimised and consistency in care was provided. There were also detailed

personalised mental capacity assessments on behalf of those who were assessed as lacking capacity to make specific decisions. The staff had worked in accordance with current legislation relating to the Mental Capacity Act 2005 and the Deprivation to Liberties Safeguards (DoLS).

People and their relatives told us their family members were safe at the home. Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk from harm.

Staff knew people well and kind, caring relationships had been developed. People were treated with dignity and respect. Care plans reflected information relevant to each individual and their abilities, including people's communication and health needs. People were provided with a balanced diet, plenty of opportunities to eat and drink between meals and flexibility surrounding the support they needed. Staff were vigilant to changes in people's health needs and their support was reviewed when required. If people required input from other health and social care professionals, this was arranged.

People were offered activities to attend within the home. All complaints were treated seriously and were overseen by the registered manager. People and their relatives were provided opportunities to give their views about the care they received from the service. Some people chose to use these opportunities to become more involved with their care and treatment. Relatives were also encouraged to give their feedback on how they viewed the service. Staff understood their role and responsibilities and valued the support and training they were provided from the registered manager and other staff within their team.

The registered manager demonstrated a 'hands-on' approach and knew people well. They had embedded caring values throughout the home. The registered manager understood their responsibilities associated with being registered with the Commission.

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.

Staff were trained to recognise the signs of potential abuse and knew what action they should take if they suspected abuse was taking place.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient staff to meet people's needs.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had completed training in a range of areas which supported them to care for people effectively. They had regular supervision meetings and attended staff meetings.

The registered provider was working within the principles of the Mental Capacity Act 2005.

Some people were provided support to maintain a nutritional balanced diet and people had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

Positive, caring relationships had been developed between people and staff.

People were encouraged to be independent and to express their views and to be involved in decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care from a staff team who responded to their needs.

The service routinely listened to people and their relatives.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

One aspect of the service was not well-led.

There was a range of health & safety audits in place to measure the quality of care provided to people. However, medicine audits were not effective in identifying the shortfalls we found during our inspection. The registered manager took prompt action.

The culture of the home was open, positive and friendly.

People and staff knew who the registered manager was and felt confident in approaching them.

Grasmere Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 24 August and was unannounced. The inspection team consisted of an inspector, a nurse specialist 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. This expert had experience in the care of older people and people living with dementia.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including health and social care professionals involved in the service for their feedback.

We spoke with five people who lived at the home and four visiting relatives to gain their views on the care received. We observed how staff interacted with people in the communal areas within the home. This included the lounge, dining area and in their individual rooms when invited. We also spoke with two care staff, one senior nurse and the registered manager who is also a registered nurse separately. We observed the lunch time meal being served and spoke with the cook about their role.

We reviewed three staff files, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records, activity plans and surveys undertaken by the service. We observed medicines being administered to people and checked the corresponding medicine records. We looked at care records related to five people; these included care plans, risk assessments and daily notes.

Good

Is the service safe?

Our findings

At the inspection in July 2016 we found the provider was in breach of a regulation associated with managing medicines. We had identified issues associated with how stock balances of medicines were maintained, over the counter homely remedies were stored and recorded and a lack of guidance for staff on when to administer 'when required' medicines such as pain relief to people. The provider took action and sent us an action plan to inform us how areas of risk were being managed to reduce the impact on people. At this inspection, we found improvements had been made by the provider and the regulation was now met. For example, stock balances of medicines kept in the home were clear and accurate and followed a safe system and ensured medicines were returned to the pharmacy when needed. We also found all records relating to all medicines administered including homely remedies reflected what people had been given. Homely remedies are over the counter medicines to treat people with minor illness's or ailments.

The registered manager had also implemented guidance for staff on 'when required' medicines within medication administration records (MARs) in response to the last inspection. Staff were able to tell us how they ensured a safe practice when administering 'when required' medicines and we observed them doing so.

We observed that the Medication Administration Records (MARs) were completed on behalf of each person by the registered nurse on duty each time someone was supported to take their medicine. This evidenced that people received their medicines as prescribed. People told us they were happy with the medicine system and felt confident with how they received their medicines. One person told us they knew they received medicines for, "High blood pressure". We observed the registered nurse administering medicines during the lunchtime period with confidence and using a personalised approach. One person experienced difficulties with hearing so the registered nurse wrote down what they were having on a piece of paper the sensitive approach used meant the person knew what medicine they were taking. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Medicines were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. Topical creams such as ones to prevent skin integrity issues were administered by care staff whilst delivering personal care and then recorded within new electronic system using tablet which is a portable computer. During our inspection we discussed with the registered manager how the a new electronic system had failed to capture the written guidance which had previously been used within the old method. By the end of our inspection the registered manager had returned to the more traditional method as felt it was a safer system as it was easier for the care staff and nurses to follow.

During our inspection we noticed the MARs file was kept on top of the medication trolley in the office which had the door open and was not routinely locked. Due to the confidential information about people contained within it we discussed it with the registered manager. The registered manager said they wanted to continue to keep the door open, for visiting relatives to feel comfortable to approach the nurse on duty so would move the file to a locked cabinet.

At the last inspection we identified risk assessments were in need of improving. We found at this inspection

risks to people were managed so that they were protected from harm. Risk assessments provided information, advice and guidance to staff on how to manage and mitigate people's risks. Risk assessments covered areas such as how to support people to move safely and how to manage people with skin integrity issues. When potential risks had been highlighted for people the necessary guidance was provided in the person's care record. We found risk assessments were updated and reviewed monthly and captured any changes. For example, one person required support with how they ate and drank. A speech and language therapist (SaLT) had been involved and their guidance was embedded within the person's risk assessment to ensure staff team knew how to support the person safely with this aspect of care.

People told us they felt safe living in the home we observed people were relaxed and comfortable. One person said, "Very safe, I feel safe it is a happy place to be". Another person said, "I am well looked after here and they (staff) are good". Relatives described how assured they felt about the care provided to their family members. One relative said, "[Named person] has been here for only four weeks, we are very impressed". Another relative told us, "They stop and chat to residents and us".

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager or one of the senior nurses or another registered nurse in the first instance and failing that would refer to the whistleblowing policy for advice and guidance.

Accidents and incidents were reported appropriately and documents showed the action that had been taken afterwards by the staff team and the registered manager. This also included an analysis of any persons that had experienced a fall. The records showed that appropriate professionals had been contacted and subsequent support provided such as the introduction of specialist equipment. This helped to minimise the risk of future incidents or injury.

People and their relatives told us that there were sufficient numbers of suitable staff to keep people safe, rota's we checked confirmed this and we observed safe staffing levels during our inspection. When people needed support with personal care, their meal or help with refreshments in between meal time's staff were able to meet people's requests. Staff were able to spend time chatting with people in between supporting them with personal care. One person said, "They (staff) are very good in that they will be here quickly". Another person said staff were, "Always very quick if I need them". A third person said, "I have got the cord to pull (call alarm) if I need to and they come quickly". Staffing levels had been assessed based on people's needs and rotas were then completed by the registered manager. In the morning of our inspection there were four care staff on duty, a senior nurse and the registered manager, who was also a registered nurse. There was also a domestic staff member, a cook and a kitchen assistant. During the afternoon there were two care staff to meet people's needs alongside a nurse and throughout the night one nurse and one care staff supported people. The registered manager and senior nurse worked flexibly and covered care staff absences themselves or with regular agency staff therefore reducing the impact to people. One staff member told us, "There is enough staff, the [registered manager] covers with agency, we have never been without enough staff". They told us how the four staff in the morning were split into two teams to cover all areas of the building to ensure people's needs were being met. However, they also shared the teams were flexible and supported the other team when needed. The registered manager told us staff tended to remain working at Grasmere Nursing home and they did not experience a high turnover of staff. The records we read and staff we spoke with confirmed this which encouraged people to build positive relationships with them and meant staff knew people well.

Staff recruitment practices were robust and thorough. Staff were only able to commence employment upon

the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Good

Is the service effective?

Our findings

At our last inspection in July 2016 we identified the provider needed to improve how best interest decisions were made on behalf of people who lacked capacity to make specific decisions. 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).

At this inspection we checked that staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager had dramatically improved this area and captured detailed mental capacity assessments within people's care records. The registered manager showed us she had used resources from the Social Care Institute of Excellence (SCIE) which had influenced a personalised approach. Consent to care and treatment was sought in line with legislation and guidance. Out of 18 people living at the home the registered manager had applied for six standard authorisations on behalf of people. The registered manager demonstrated they understood current legislation regarding the MCA and explained they were able to assess a person's capacity at the initial assessment stage. They continued to tell us how important it was that decisions were made in people's best interests involving health and social care professionals and if appropriate relatives. Care records showed how consent from people had been captured and capacity assessed and where deemed necessary a DoLS application completed. Training records confirmed staff had attended training in both MCA and DoLS. Staff were able to share some knowledge on the topic and provided assurances they were aware of its importance.

People received effective care from staff who had the skills and knowledge they needed to carry out their roles and responsibilities. People and their relatives we spoke with were complimentary about the staff. They told us of the confidence they had in the abilities of staff and said they knew how to meet their needs. A relative told us that staff had, "Good communication". Another relative said, "They (staff) go an extra mile". A third relative said their family member was, "Well taken care of".

People received support from staff that had been taken through a thorough induction process and attended training which enabled them to carry out their care worker role. The mandatory training schedule for all staff covered core topic areas including moving and handling, continence care, risk assessment, first aid, infection control and safeguarding. The registered manager accessed face to face sessions and workbook based training for all the staff team and retained evidence of training attended within their staff files. Refresher training was provided to ensure staff routinely updated their knowledge on particular subjects. In addition nurses attended clinical training such as catheter care and wound management. The registered manager told us they would be updating their catheter training on October 2017 as they supported a person with this need. Staff told us they were happy with the level of training they were given and they attended a

different course every six months and it was on going. They were able to approach the registered manager if they felt they had an additional training need. One staff member told us the training provided was, "Very good, two weeks ago we did our fire training".

The registered manager told us how they encouraged a team work ethic therefore existing care workers who may have been working at the home for longer were helpful in supporting newer staff. The induction consisted of a combination of shadowing shifts and the reading of relevant care records and home policies and procedures. Nurses attended administering medicines training. Care staff were supported by the registered manager and other registered nurses using observations to assess their competency before performing their tasks independently within areas such as moving people safely. This also included nurses and more experienced staff supporting new staff on how to apply prescribed topical creams. Topical creams, such as skin barrier creams to prevent pressure wounds, are prescribed medicines which are often applied when a person receives their personal care. Support was provided from nurses and the registered manager to new care staff with the administration of topical creams. However, we identified there was no formal training for care staff undertaken to apply topical creams. Despite this care staff were able to tell us how they applied topical creams, safely and effectively and if they had any concerns they would highlight them to one of the registered nurses. During our inspection the registered manager reviewed the training plan and medicine policy to include formal medicine training which included topical cream application to the training plan for all care staff in addition to nursing staff. We have referred to this further in the Well-led section of this report.

Supervisions and appraisals were provided to the staff team. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Staff told us and records confirmed they received supervision every three to six months, sooner if needed and they were encouraged to discuss all matters relating to their role within these sessions. Items discussed were agreed and carried through to the next meeting. Staff also told us they did not have to wait for planned meetings as the registered manager was approachable and applied an 'open-door policy'. In addition staff meetings provided opportunities for the staff to come together as a team. Minutes from a meeting in May 2017 showed how the staff team had discussed the role of the CQC and the introduction of an infection control champion. The Mental Capacity Act 2005 (MCA) had been discussed and how this impacted people who lived at the home.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. All staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. One person said, "I get a low sugar diet". Staff including the registered nurses and registered manager completed food and fluid charts on behalf of people to monitor what people were eating and drinking. Weights were recorded and monitored. Registered nurses were able to explain what action they would take if they were concerned about a person's weight which included informing the GP and increasing their observations of the person and what they were eating. This ensured people's nutritional needs were regularly monitored for any changes. People had access to plenty of drinks when they wanted one. A staff member told us when they entered a room they did a, "Visual check" to ensure people had what they needed. One person told us, "I have water and juice in my room that is available when needed".

There was a cook available to organise and provide meals seven days of the week, this meant other staff were able to attend to personal care needs people had. On day one of our inspection we saw people enjoying their lunch; it was a sociable experience for those involved and people talked to each other and staff throughout and music played in the background. Some people chose to eat in the dining area however some people due to their needs or through choice ate in their bedrooms. We observed staff sitting next to people and supporting them flexibly depending on their level of need to eat their meal. One person told us, "They come and ask me what I want for lunch". Another person said, "Each day there is a different menu". A

third person said, "The food is quite good no complaint about that". In October 2017 the Alzheimer's society were running a dementia workshop for the staff team. The registered manager told us they would use the opportunity to seek further advice on any other visual aids to support people within the home living with dementia such as whether a pictorial menu would be helpful.

At the last inspection we observed a visiting hairdresser perming a person's hair in the dining room whilst people were eating their lunch. This was not observed as a positive experience for people and a visiting relative at the time due to the smell of the perming lotion and the space the hairdresser took. Since the inspection, the provider had taken significant action and converted a storage room upstairs into a hairdressing room. The registered manager proudly shared the room with the inspectors and told us, "The residents chose the wall paper". They added people were also going to be involved in choosing which pictures should be hung on the walls of the new room.

People told us and records confirmed people living at the home had routine access to health care professionals. This included chiropodists, dentists, opticians, district nurses and GP's. Staff told us they would tell one of the registered nurses and/or the registered manager if a person had any health issues immediately and they would then contact a GP. One person told us how they were visited once a month by a district nurse. Another person said, "They (staff team) are very good when I need one (district nurse)". A third person told us a chiropodist visited them, "Every six weeks". Handovers between staff on duty were thorough and included discussions surrounding all aspects of a person's health and well –being. This included if a person required further support from a health professional external to the home such as a GP.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. People confirmed their positive experiences of the staff team including the registered manager. One person said, "They (staff) are very good and very caring".

We observed numerous occasions of positive support provided by staff to people. Staff bent down to address people at their own eye level and maintained good eye contact. This included when nurses administered medicines to people, they bent down to people and waited patiently until they had finished swallowing their medicine. Staff spoke with people calmly and warmly and ensured they had everything they needed. We observed how staff interacted with people engaging in conversations important to the person such as about their family members or television shows. One staff member said, "I love Grasmere, it feels like one big family". They described how, on entrance to a person's bedroom staff would always, "Introduce ourselves", they added, "They (people) all seem quite happy".

During a handover between the morning staff and afternoon staff information of importance about people and how they presented during the shift was shared between those staff who attended. The attention to detail was noted in discussions surrounding a person and captured how staff knew people well.

Staff encouraged people to express their views and they were actively involved in making decisions about their care. People were provided with opportunities to talk to staff including the registered manager about how they felt on a daily basis. Resident meeting opportunities were organised to take place every three months. We read a copy of the minutes of a meeting held in August 2017. We noted seven people had attended the meeting with the registered manager. This meeting included discussions about how people felt about the activities they had attended within the home, the meal time menu and the introduction of a new staff member who was going to be working nights. The registered manager told us they were pleased as more people had started to attend the meetings as it had influenced people being more involved in their care and the environment they lived in.

People were encouraged to be as independent as possible by the staff. Staff described to us how they encouraged people to take part in their own personal care, enabled them to make choices and decisions about what they wore each day, how and where they wanted to spend their day, what time they wanted to get up and what time they wanted to go to bed. One person said, "Yeah I choose my own clothes". Another person said, "They ask me what I wish to put on". A third person said, "They come in and ask me what I want for my lunch". One staff member said, "We get them to do as much for themselves as they can".

People were mostly treated with dignity and respect. When people were being supported with personal care in their bedrooms by staff a sign read, 'care in progress' was displayed on the bedroom door. We asked staff how they promoted privacy, dignity and respect. One staff member said, "I try and make it a supporting role as it maintains their dignity and independence". Staff told us how they made sure curtains were drawn and blinds closed within bedrooms before starting supporting a person to wash or undress.

People told us staff knocked on their bedroom doors before entering and we observed when bedroom doors were shut staff knocked, waited for a response and entered. One person said, "They always knock before coming in". Two people occupied bedrooms which were directly leading from the lounge and dining room. Staff told us if any support was being provided they would always close the door behind them and we observed this in practice. However, on occasions when doors were already open staff were observed not knocking. One person told us, "My door is always open so there is no need to knock, they are very friendly here". We discussed this with the registered manager. By the second day of our inspection she had met with the staff team and fed back our observations and reminded them whether a bedroom door was closed or open it was respectful to knock before entering at all times.

Good

Is the service responsive?

Our findings

People lived in a home where staff were responsive to their individual needs. We observed people receiving personalised care. People told us they were happy with the care they received and it met their needs. Bedrooms were personalised to suit people's preferences. Staff demonstrated they had a good understanding of people's personal histories and what they liked and disliked. One person told us, "They are very good here". Another person said, "If you ask for something they will do their utmost to solve it".

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. The provider had recently moved from traditional hard copied care plans to an electronic system. Care plans were reviewed monthly by the registered manager although they had recently handed over care planning responsibilities to the senior nurse we spoke with. People and their relatives told us they were involved with planning their care and signatures from people and/or their relatives were present within the reviewed section of the care record. They included information provided at the point of assessment to present day needs. The care plans provide guidance on how to manage people's physical and/or emotional needs. This included guidance on areas such as communication needs, continence needs and mobility needs. Staff had access to all care plans via the use of tablets so could refer to the information they required at any point. Staff told us they found the new care plan format easy to read and follow and an effective working tool. They also told us they could approach the registered manager and registered nurses with any queries associated with how care should be given. One relative described how their family member lived with dementia and how supportive the staff team had been and said, "They are very good".

All staff we spoke with could provide details on how they supported people with their personal care needs. They knew how people liked things done for them. Mostly care plans were accurate and reflected people's needs. A section named 'Lifestyle choices' provided details on when a person may like to get up in the morning or a whether they liked to remain in their bedrooms or preferred a more social communal area of the home. However, they did not always capture the level of detail which may prove helpful for new staff or staff supporting people who were new to the home with regards to support with washing themselves. For example, this part of the care plan did not capture whether a person preferred a flannel or a sponge or whether they used a shower gel or a bar of soap. We discussed this with the registered manager who responded promptly. Shortly after the inspection we were sent copies of this aspect of the care plan which showed how the registered manager had included what staff were already doing in practice.

Daily records were also completed about people by staff during and at the end of their shift. This included information on how a person had spent their day, what kind of mood they were in and any other health monitoring checks. These daily records were referred to by staff throughout their shift as they were accessible via the use of the tablets.

People were provided with stimulation and were offered various group and 1:1 activities to be involved in at the home however people were able to decline to join if they so wished. The registered manager told us how they were always introducing different external entertainment groups and based their decisions on whether

people who lived at the home enjoyed them. On the first day of our inspection we observed a music session in the lounge where a person sang to people who had chosen to join in. The registered manager told us it was a popular session. Other sessions included armchair exercises, reminiscence and other music sessions such as a person who played music from the 1950's and 1960's. Some people received their care in bed or preferred to spend time in their bedrooms. To avoid social isolation they were provided opportunities for staff to spend time with them if they preferred to have company. This included doing their nails, reading a newspaper to them or having a chat. A staff member told us, "We are always checking people in their bedrooms to see if they are alright". People had also been involved in developing vegetable patches outside in the patio area. This included the growing of cabbages and tomatoes. The registered manager said people had enjoyed joining in and they would be continuing with this project.

People told us staff responded to their concerns and queries promptly and addressed anything that was worrying them. One person said, "There is nothing to complain about in this home". Relatives told us they would go to the nurse in charge if they had any concerns and could name the nurses including the registered manager. Complaints were looked into and responded to in a good time. There was an accessible complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the registered manager and the staff team. There were no formal complaints open at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

A range of audit processes were in place to measure the quality of the care delivered however the medicine audit carried out monthly by the registered manager was not always effective. The registered manager had made significant improvements since our last inspection regarding the systems in place for managing medicines. However, the medicine audits had not identified how guidance for staff relating to administering 'when required' medicines could be developed further. For example, one person had been prescribed a medicine to help relieve their anxiety in the form of a tablet. We were told and records confirmed the medicine was rarely used. There was written guidance for nursing staff in place however, it did not define what support should be given to the person prior to the stage of administering the medicine. By the second day of our inspection the registered manager had sought advice from their local pharmacy and another provider. Shortly after our inspection they had addressed this issue and sent the inspectors a copy of a revised medicine care plan including a revised 'when required' guidance document. The revised guidance incorporated how the person should be reassured prior to the use of the anti-anxiety medicine. This included asking the person if they were hungry or thirsty or whether they were too hot or too cold. The written guidance also included conversation topics the person enjoyed which often included talking about their family members. The registered manager stated this may reduce their anxiety which meant the medicine may not need to be used.

During our inspection, we noted the medicines policy required updating in line with the local authorities medicine policy and The National Institute for Health and Care Excellence (NICE) guidance, reference to this had not been made within the monthly medicine audit. The registered manager agreed and told us they would be updating this. By the second day of our inspection they had reviewed the local authority's medicine policy. They told us they felt confident on how to update their own policy in line with this to ensure their practices were effective.

The medicine audit had also not identified care staff had not received formal training regarding how to apply topical creams to people. Staff were able to tell us how they carried this out safely and people were happy with the way they received topical creams. Please see the Effective section of the report where we referred to this further. The provider must ensure systems to assess the quality of the care provided, including the management of medicines are effective and fit for purpose to ensure consistency of care is provided to all people .

The registered manager had also completed audits in areas such as accidents, incidents, care plans and complaints. Measures were put in place when a highlighted area of concern was identified. Due to the nursing needs of people the registered manager kept a clear audit trail of admissions to hospital or visits to or from a GP and the reasons for them. For example, there was a check on how many people had experience a urinary tract infection or a chest infection. This enabled the registered manager to see if there were any consistent themes and whether the home was doing everything they could to minimise the risks to people living there.

People and relatives expressed positive views of the home and the care that staff provided and said they

would recommend the home to others who were looking, One person said, "I would recommend to a friend". The culture of the home was an open one and people were listened to by the staff including the nursing team and the registered manager. During the course of the inspection, laughter and pleasant exchanges were observed between staff and people. This showed trusting and relaxed relationships had been developed. One person said, "I think it is one of the best places".

The registered manager demonstrated good management and leadership throughout the inspection and made herself available to people using a hands on approach. We observed the registered manager working amongst the staff team guiding and leading other staff on duty. They understood their role and how to work alongside outside agencies such as the local authority safeguarding team and the Care Quality Commission. They knew of the importance of notifying the Commission and when they were legally required to do so. Any shortfalls we highlighted during our inspection were addressed or they were able to provide a reasonable rationale.

Staff felt supported by the registered manager and felt they could go to them as their office door was always open to them. Staff also felt supported by the nurses and other care staff. One staff member told us, "If I have a problem I can go to any of the nurses". They added, "They are open, approachable and very supportive". Another staff member told us the home was, "Well managed and well run". Staff were aware of their role and responsibilities. They understood their own duty of care to the people they supported living at the home and had taken time to get to know them and how their needs should be met.

Views from people on the care they received were gathered through informal discussions with care staff, registered nurses and managers at resident meetings. Relatives were also invited to share their views on the home. This occurred via a combination of formal satisfaction surveys, which were sent out twice a year, discussions over the telephone and face to face meetings with the registered manager. Relatives told us that they remained involved with their family members care and were kept updated with any relevant information from the home. In July 2017 72% of people returned their survey to be reviewed by the registered manager. We read some of the responses which included comments such as, 'Good food could not be better', 'Mum is a different person' and 'honest and open environment'. In February 2017 the home received other positive comments from people and their relatives such as, 'The staff are always friendly and welcoming' and 'There was a sense of unity amongst the staff to give residents the best care'.

During our inspection the registered manager was able to describe examples of support they and the staff team had provided to ensure relatives of people felt involved in their family members care. The registered manager was flexible and enabled relatives to visit throughout the day and evening and applied an open door policy which relatives appreciated. One relative said, "I am happy with all here".