Ealing Manor Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

We inspected this service on 15 and 16 November 2018. The inspection was unannounced.

At our previous inspection on the 18 September 2017 we found a breach of the regulations in Good governance. This was because not all risks were being identified and appropriately mitigated by the registered person.

Following the last inspection, the provider had completed an action plan to improve the key questions of 'is the service safe, responsive and well-led?' to at least good. They told us measures would be in place by 8 January 2018. During this inspection we found the measures had been put in place and there was a good standard of risk assessment with guidance for staff that was detailed and thorough about minimising the risks.

Ealing Manor Nursing Home provides nursing care for up to 33 older people and younger adults with a physical disability. It 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. At the time of our inspection 32 people were living at the home.

There was an experienced registered manager 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.

During the last inspection we found that there were not sufficient activities for all people living in the home to enjoy. At this inspection we saw this had been addressed. There was evidence of varied activities and people who remained in bed had regular staff interaction throughout the day.

During this inspection we found that some records were not being kept in a robust manner for people's ongoing safety. This was because there were not always weekly fire alarm check recordings that demonstrated the alarms had been tested and were in working order. In addition, deep cleaning of the premises were not recorded so their regularity and effectiveness could be evidenced during audits and checks.

There were some infection control and some medicines management issues that were identified during the inspection. These were addressed by the registered manager on the day of inspection.

There was a programme of redecoration and this had refreshed the look of the premises. However, some window restrictors and other implements had been removed during the redecoration work and had not been replaced. This was brought to the registered manager's attention and they were replaced the same

day.

People and their relatives described staff as caring and kind. We observed care was offered in a polite and respectful manner. People were supported to be as independent as possible by staff.

The registered manager and staff could recognise signs of abuse and reported concerns to the appropriate authorities. The registered manager held reflective meetings when errors had occurred to promote good practice and to help ensure mistakes did not reoccur.

Medicines were administered appropriately and although we identified a few minor errors the registered manager audited monthly and addressed any errors with the nursing staff.

Staffing levels were assessed by the registered manager who ensured there was a suitably skilled staff team. Staff absence was covered by known bank staff. Recruitment processes were safe as checks were undertaken to ensure staff were of good character before they were employed. Staff were provided with an induction and ongoing training to equip them to undertake their role.

The registered manager worked in line with the Mental Capacity Act 2005 and applied for authorisations to deprive people of their liberty appropriately when this was indicated and people lacked the capacity to decide about their care and treatment. Also in line with legislation and good practice, they assessed people's care needs prior to offering them a service.

People told us they enjoyed the food served and had their choice of meals. Drinks were served on a regular basis.

People found the registered manager very visible and approachable. They felt they could raise concerns and that the registered manager would take appropriate action.

The registered manager kept their own knowledge updated and worked in partnership with health and social care professionals for the benefit of the people living at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not always safe.

Staff had received infection control training. We found some infection control concerns and these were addressed immediately by the provider on the day of inspection.

Medicines were administered to people in a timely manner. We found some minor recording errors that the manager said they would address.

The registered manager had undertaken an assessment of the risks to people and put measures in place to mitigate those risks identified.

The registered manager assessed staffing levels to ensure there were enough staff to meet people's needs. Staff were recruited in a safe manner following the provider's procedures.

The registered manager demonstrated they held group reflective sessions when there was an error or practice concern identified. They and the staff team worked together to find ways of improving the service and preventing further mistakes.

Is the service effective?

Good

The service was effective.

When people required support to eat and drink this was provided appropriately by staff. People told us they enjoyed the food served and we saw staff supporting people to eat in a sensitive manner.

The registered manager undertook initial assessments to ensure they could meet people's care needs.

The registered manager was working in line with the Mental Capacity Act 2005 to help protect people's rights.

Staff received training and supervision to equip them to undertake their role.

Is the service caring?

Good

The service was caring. People and relatives told us staff were caring and kind.

People's care plans contained guidance for staff about how people communicated their choices.

Staff encouraged people to retain their independence and this promoted people's self-respect.

Is the service responsive?

Good

The service was responsive. People had person centred care plans that gave clear guidance for staff as to how they wanted their care provided.

People had end of life care plans and staff had received training to provide end of life care.

People and relatives told us they knew how to complain and felt any concerns would be addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not always well led.

There were checks and audits in place but some weekly recordings such as fire alarm testing was erratic and it was not recorded when deep cleaning had taken place.

People, relatives and staff spoke positively about the registered manager. They found them approachable and supportive.

The registered manager met with registered managers from other providers in the area to share their learning and keep up to date with changes in health and social care.

The registered manager and staff worked in partnership with health and social care professionals and the commissioning bodies for the benefit of people using the service.

Ealing Manor 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.

The inspection team consisted of 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.

This inspection took place on 15 and 16 November 2018 and the first day was unannounced. During our inspection, we looked at thirteen people's care records. This included their care plans, risk assessments, medicines administration records and daily notes. We spoke with seven people using the service and five people's friends and relatives. We also observed how people were being cared for and supported. 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.

In addition, we reviewed three staff personnel files. This included their recruitment, training, and supervision records. We spoke with two care workers, two nurses, the activity co-ordinator, the maintenance person, the chef, the registered manager and the director.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they found the home was kept clean. Their comments included, "My [family member] likes this place, it's very clean, she likes the food," and "They are always in cleaning my room."

There was a cleaning schedule for staff to follow and there were no malodours in the home. The registered manager told us, 'deep cleans' were undertaken of the communal areas on a three-monthly basis by the maintenance person, who confirmed this was so. The registered manager told us the cleaner undertook regular deep cleaning of people's bedrooms. However, these were not recorded. There was personal protective equipment such as gloves and aprons available for staff to use. We did find on the first day of inspection the laundry room had a dirty floor and there was a mop bucket with used water outside the door into the garden and some disposable gloves had been thrown onto the ground. We brought this to the attention of the registered manager and we noted this was addressed that day and on the second day of our visit these areas were clean.

When we walked around the home we noted some practices that did not promote good infection control. These included, a missing toilet roll holder. This meant that people were touching the toilet rolls when they used them and was an infection control hazard. The registered manager explained the room had been decorated and the holder had been removed and was going to be replaced. The toilet roll holder was replaced the same day.

We also saw some items such as wash basins and a bedpan were placed on the floor of people's bedrooms which might increase the risk of the spread of infection. The registered manager told us that the basins had just been used and along with the bedpan were waiting to be removed and stored appropriately. However, it is not good infection control practice to put items such as these on the floor.

The staff had received yearly mandatory infection control training and just recently watched a video and had an informal discussion about infection control. However, staff were not always following the provider's uniform policy to promote good infection control. The uniform policy identifies best practice of, 'bare below the elbow,' with the exception of a plain 'wedding' band ring. Several staff were observed to be wearing jewellery and one staff had long sleeves. We brought this to the attention of the registered manager who agreed to address this with the staff team.

People and relatives told us they received their medicines on time and were offered 'as required' medicines for pain relief. Their comments included, "I believe the staff are giving out the medicine on time," and "I am getting medicines on time," and "Yes, I can get pain killers whenever I ask for them."

Medicines were stored in a locked room with most of the medicines inside a locked cupboard. Although some laxatives and eye drops were not in locked cupboards but were stored in the locked room or in the unlocked fridge inside the locked room. We brought to the attention of the registered manager that all medicines should as far as possible be stored in a locked fridge or cupboard. Both the room and fridge temperatures were recorded daily to ensure they were at a temperature that was safe for the medicines

storage.

We looked at people's medicines administration records (MARs) and for the most part medicines were recorded and signed for appropriately. However, we did find a couple of recording errors that included one medicine being signed for when it was not due to be given. We spoke with the nurse and they confirmed they had not given the medicine but had signed in error. A second error had occurred when a medicine had not been signed for by the nurse the morning of our inspection. They confirmed they had given the medicine to the person and intended to sign the MARs. In addition, creams were prescribed for one patient and had not been signed for. The nurse reported to us that the cream was no longer required. However, they had not use a relevant code in the MARs to identify that this was the case. Controlled drugs were counted and checked daily by the nursing staff and were recorded appropriately

We brought these recording errors to the attention of the registered manager. They shared with us their monthly medicines audit they undertook to ensure the medicines were administered appropriately. We saw that errors had been identified in previous audits. The registered manager explained they queried any errors they identified with the nurses and discussed with them to promote best practice. In addition, the pharmacy supplying the medicines undertook a yearly audit on behalf of the home to ensure medicines practice was robust.

During our previous inspection in September 2017 risks to people were not always identified and where these were identified measures were not always put in place to mitigate these. People did not have individual personal emergency evacuation plans (PEEPs). Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by 8 January 2018. At this inspection PEEPs were available for staff and the emergency services to reference. PEEPs recorded what level of support people needed if there was a need to evacuate the home. People who required a high level of support to mobilise where clearly highlighted. Factors that might be an additional risk such as an oxygen cylinder present in the bedroom were also recorded appropriately.

The registered manager assessed people to identify risks to their safety and people's records contained guidance for staff to mitigate those risks. Risks identified included, breathing and circulation, maintaining a safe environment, eating, drinking and weight, skin integrity, cleansing, hygiene, mobility, elimination, communication, sight and hearing, sleeping, comfort and physical health, social needs, hobbies and activities, religious and cultural needs, and medicines. Each identified area had an associated care plan. The measures in place for staff to follow were thorough and person centred.

We observed that appropriate equipment had been provided to reduce the risks to people and included for example, a special bed that could be lowered right down, walking frames, hoists and wheelchairs. All people we saw in their bedrooms had a call bell within reach, except for few people who didn't have the capacity to use a bell and this was risk assessed appropriately.

People told us they felt safe in the home. Their comments included, "I like this home, I feel safe enough," and "They [staff] are really kind, soft and gentle with me. Everything is good."

The registered manager and nurses and care staff could tell us how they would recognise signs of abuse and what actions they would take. One care worker told us, "Any bruise or any mark seen we have to report it to the nurse. We must tell them immediately. If any [person] says anything [of concern]. I would report it to the [registered manager]. I would report it to senior staff and they would start an investigation."

The registered manager had appropriately recorded and reported safeguarding alerts to the local authority

and had notified the CQC as legally required, since our last inspection. They told us there were good communications systems in the home and all incidents or concerns were reported to them immediately or discussed at the three daily shift handovers. They explained they and the nurses reviewed people's daily notes and accidents and incidents records to check all potential safeguarding adult concerns were reported by the staff.

The registered manager told us they had an established culture at the home of meeting with the staff group to reflect on the care given and what they could do to improve their practice. They discussed that this always happened when they had provided palliative care to people and no matter how well they thought the end of that person's life had been managed they always looked at ways to improve. In addition, they showed us records of a reflective supervision session with the staff team following the fall of a person living at the service. During the session they looked at ways in which they could prevent a reoccurrence to the person and others.

During our inspection we observed that staff responded promptly to people's call bells and gave assistance when it was required. We did not observe people waiting for long periods of time or becoming distressed. The registered manager told us they assessed staffing needs to ensure there were enough staff on duty to meet people's varied needs. They explained should people need extra support, for instance if they became very unwell, they would approach the funding body for one to one support at key times in the day or night. Staff confirmed they thought there were enough staff to meet people's care needs. One care worker said, "Yes there are enough staff. It's team work. We help each other."

Staff worked in two teams, a team of two care staff with a nurse on the different floors during the day. This meant there was always two nursing staff on duty as well as the registered manager who was also a registered nurse. There were two care staff and one registered nurse on duty at night. A care worker told us, "If someone [staff] is ill they do provide cover." The registered manager confirmed that they used bank staff and did not usually use agency staff, "as people like the familiar bank staff faces." The registered manager was, 'hands on' in her role and offered practical support to staff when necessary.

In addition, there were other supporting staff who provided services during the day. This included, a designated person who served breakfast and following breakfast undertook laundry duties. There was a chef to oversee all catering and serving of meals. An activities co-ordinator worked each week day from 1pm until 5pm and came in at other times on occasions to provide activities. A full time cleaner and a part time maintenance person worked three days a week and was also available at short notice. The director worked from the home each week day and therefore had an oversight of the service and was available to give advice if required.

The provider undertook safe recruitment of staff. Records reviewed demonstrated that staff had been interviewed for their post and appropriate checks were made to confirm their identity and aptitude for their role. Checks included criminal record checks, proof of identity and right to work in the UK. References were obtained prior to the offer of employment being confirmed.

Good

Is the service effective?

Our findings

People who had specific dietary and eating support requirements had clear guidelines in their care plan that stated what support they required. There was a consistent staff team and staff spoken with demonstrated they knew how to assist people in the appropriate manner.

We found that all people were weighed or had upper arm measurements to help monitor their weight and nutritional status. All care records contained a nutritional screening tool to identify risks to people and all had been reviewed within the month of inspection. People whose records demonstrated a change of weight were monitored by staff and appropriate actions were taken. For example, one person whose review demonstrated they had lost weight over several months had been referred appropriately to the dietician.

We found there was no one who had food and fluid intake charts. We brought this to the registered manager's attention. They explained that when a person's nutritional screening tool indicated they were at risk they would then use a recording chart to monitor their fluid input and output. They confirmed at the time of our visit there was no one who required this level of monitoring.

People and relatives told us, they generally liked the food served. Their comments included, "I like food, it's really tasty", "It's not what I would choose for myself. I would like a sirloin steak but it's ok," and "They love the food here and they always eat well." People confirmed they were given a choice of meals each day and that the chef went around the home mid-morning when serving coffee and supported each person to look through the menu choices. The chef also told us they went around to all the people in the home with the days menu and recorded their menu choice each day. People confirmed they could change their mind if they wished and an alternative would be offered.

We found that people in the lounge area were being helped to eat in an appropriate manner when they required support. We also observed people who choose to have their lunch in their bedroom. Their meals were served from a trolley by staff. We checked and found that food was served as people's care plan stated, for instance pureed. Food was still hot and people confirmed they had their choice of meals.

We observed that a choice of hot and cold drinks were served throughout the day and with meals. One care worker told us, "We take drinks frequently to people., We know who is not drinking or eating so we check them frequently and try to feed them and we try to give water." They continued to say, "I encourage one person who does not like to drink, I say, just drink for me please and they will have a little." We heard staff encouraging people to drink in the lounge area.

The registered manager told us how they assessed people prior to offering a place at the home. They said, "I love when they come and visit so they get the feeling of the home. I prefer them to come so I insist at least the family if not the person visit. They will often bring their mother or father to see the home and view the room they want." Initial assessments were completed and health and social care professional's assessments reviewed to ensure they could meet people's needs prior to offering a service. Care plans that were developed following the initial assessment were detailed and person centred.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We saw that when there was a reason to believe that people were being deprived of their liberty the registered manager had applied to the statutory body for DoLS authorisations appropriately. The registered manager told us how they monitored the DoLS authorisations to ensure they were reviewed in a timely manner. They had attended a forum for registered managers and had with other registered managers refreshed their knowledge about DoLS and shared their learning in the forum.

People we spoke with told us that staff usually asked for consent before they offered care. We observed instances of staff offering people choice. This included offering clothes protectors at lunch time and they sought consent prior to helping people who wanted to wear them. We also observed that care staff asked people if they would like to go for lunch before supporting them to mobilise and asked if they wanted to join in activities. Staff confirmed they had received MCA training. One care worker told us, "We will give them their choice. If they can't make a decision by themselves, say if they forget immediately, then we help."

People's relatives told us they were kept well informed by staff of changes in their family member's health. They confirmed that staff contacted health care professionals on behalf of people in a timely manner. One relative told us, "[Family member] uses wheelchair, they need some exercise so a physiotherapist comes and visits for them." People's care notes reviewed reflected that the staff were working with many social and health care professionals for the benefit of the people living at the home. These included, social workers, GP, tissue viability nurse, speech and language therapist, palliative care team, physiotherapists, opticians, chiropodist, dietician and the wheelchair service.

Although, Ealing Manor Nursing Home was not a purpose-built care home it had been made accessible for people with mobility restrictions. There was a lift for easy access to the ground, first and second floors of the home. There were communal facilities including bathrooms and shower rooms on each floor and a large lounge area on the ground floor. There was also a small lounge should people wish to have a quiet space to talk with their family. There was a large accessible garden and room for car parking.

Smoking was not allowed inside the home and people and visitors were reminded of this. One person told us, "The best thing here is I can go and smoke in the back garden." People who wanted to smoke could do so in the garden where there was a comfortable and safe shelter.

People and relatives were positive about the skills and knowledge of the staff. Care staff told us that they received an induction prior to commencing their role and had completed online training and attended training at the home. Induction training included, manual handling, infection control, safeguarding adults and end of life care. Yearly refresher training and ongoing training was also provided. This included food hygiene, safeguarding adults, first aid, moving and handling, end of life care, fire safety and eye care training provided by a visiting optician. The nursing staff and some care workers had also attended specialist training at a local hospice to have access to best practice in end of life care.

Nurses and care staff said they were well supported by the registered manager and the director who they

described in positive terms. One care worker told us, "Everyone [registered manager and [director] are very, very helpful. They are like my parents. Where ever they can help they do." There was evidence of individual formal and informal supervision and group supervision so staff were supported in their roles.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff. Their comments included, "The staff are fabulous, but very busy", "Some care workers are better than others. Generally they are good with me," and "The staff are very friendly and very courteous to everyone." Also, "Staff are very kind, helpful for everything."

The registered manager told us they had a stable staff team and nursing staff who were familiar with the people in their care. They described this helped build a good working relationship with people. A care worker told us, "They [people] are not here with their family, we spend a lot of time with them. It is our responsibility to make them happy. I try to do my best to do that. I smile, I talk and I even dance. I talk with them to make them happy… When I talk with them I ask lots of questions. Did you sleep well? How are you today? I encourage them to speak back to me."

We observed that staff were kind and caring in their manner with people. They used people's preferred name and responded when people were not engaged in an activity or looked bored or anxious. They anticipated when people might require support and asked politely if they might help.

People's care plans contained detailed guidelines for staff about how people communicated their choices. For example, how to interpret one person's facial expressions. The care plan stated how staff might misinterpret the person's expressions because of how the person responded to them. There were listed strategies for communication that included encouraging the person to engage in conversation using favourite topics, repeating what they had said and giving time for them to respond and writing down information or questions.

People were encouraged to remain independent. We observed staff being sensitive with people. For instance, people who wanted to mobilise independently were supported to do so. They were not rushed but given time to do so with the supervision they required. If people needed help to cut up their food this was offered and people were provided with eating aids to enable them to eat unaided by staff. Staff monitored and were proactive in offering support when it was required. A care worker described to us how they encourage people to be independent as they felt it was good for their confidence and self-respect. They said, "Whenever I give help I try when possible to encourage them and say, you can do it."

People and relatives told us staff were respectful of their privacy and knocked on bedroom doors before entering. One relative said, "They speak to her like she is their mum and always respect her privacy." Staff demonstrated they were aware of the need to keep people's information in a confidential manner.

Good

Is the service responsive?

Our findings

During our last inspection in September 2017 we found that not all people were offered activities and that people on the two upper floors were not engaged in regular staff interaction. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by 8 January 2018. During this inspection we found that this had been addressed. The activities coordinator showed us photos and records that demonstrated they had been providing a variety of activities for people to enjoy. There was a weekly programme of events displayed. Whilst the event planned did not take place on one day of inspection, a bingo session did take place and many people joined in. One person told us, "I play Bingo, you know I am quite lucky."

We spoke with people who did not always like to join in planned activities. They told us, "I don't like to participate in activities. I also often go out shopping," and "I really don't like to take part in any activity, sometimes I read a newspaper." A visitor told us, "My friend doesn't like to sit in the lounge. They like watching TV and reading." We observed that the two upper floors were livelier than on our previous inspection. This was because when we checked at intervals throughout both days staff were visible and could be heard talking with people in their rooms. In addition, the activities co-ordinator and the chef also visited people and engaged them in conversation throughout the day.

The home welcomed people's visitors and encouraged them to stay and join meals and activities. Two visitors told us "There are celebrations of festivals such as Christmas, and Easter in the home," and "Last year they had a very nice Christmas party and families were also invited." People's personal special anniversaries were also celebrated including birthdays.

People had person centred and detailed care plans. These had been reviewed on a regular basis to reflect people's changing circumstances. The care plans contained background information about people and referred to important events in their life including where they had been born, grew up, marriage and children. People who were important to the person were also named. This included, family members, partners and friends. This information helped the staff understand the person in the context of their life. Care plans explained what was important to the person. This included their diversity support, for example, religion or culture and how they liked to celebrate these important areas of their life. There were visitors to the home that supported people to observe their individual religious practices. People's care plans also contained information about their hobbies and what activities they liked and how staff could best engage them in enjoying these activities.

People told us that they felt their care was good and personalised to their needs. Care plans stated clearly what support people required from staff in their everyday life activities and what they could do for themselves. For example, one person's care plan stated clearly, they required two staff to mobilise. The equipment required was specified and it was stressed that staff must explain to the person what was happening always.

The home offered end of life care for people and had end of life care plans in place to support people and to

identify their choices. The GP was working with the home to identify when people wanted a Do Not attempt Cardio Pulmonary Resuscitation (DNACPR) in place if there was a medical emergency. When people were identified as requiring end of life care the staff worked in conjunction with the GP and the palliative care team. The nursing staff and care staff had received end of life training and some staff were accessing further training with a local hospice to increase their knowledge and skills in this area.

There was a complaints policy and procedures that were shared with people and their relatives. People and relatives told us they would feel comfortable raising a complaint and felt assured it would be addressed appropriately. One relative said, "I can approach the manager with any concerns I have." There were no complaints recorded since the last inspection. The registered manager explained that when there was a concern raised they had addressed the matter immediately. They gave us two examples of when this had occurred and demonstrated how they had made changes in the provision of care to meet both complainants' satisfaction.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2017 we found a breach of the regulations in good governance. This was because the registered person did not always have effective systems to assess, monitor and improve the quality and safety of services provided in the home. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by 8 January 2018. During this inspection we found that risks to people's safety were being assessed by the registered manager.

However, during this inspection we also found that some checks were not being completed as they should have been on a weekly basis.

Fire alarms testing records were maintained in an erratic way. We found this because there were three fire alarm tests and/or fire drills in August but only one test and /or one fire drill in September and one test in October. However, two tests had taken place appropriately in November 2018. The director told us categorically that the fire bells were tested every week however, this was not recorded.

We found that there was a programme of redecoration in the home and this had refreshed the look of some communal areas such as bathrooms, toilets, corridors and some bedrooms. During the painting of window frames, window restrictors had been removed from some of the windows and had not been replaced when the work was completed. We raised this with the director and registered manager and the restrictors were replaced the same day by the maintenance person.

In addition, deep cleans for bedrooms and communal areas were not recorded and we had observed some poor infection control practices that had not been picked up by senior staff. The registered manager agreed to address these shortfalls in recordings.

Notwithstanding the above concerns there was also some good fire prevention practices. There were recorded regular fire drills. Two recorded in June, one recorded in both August and September. Fire training sessions for staff had taken place several times throughout the year. A fire risk assessment was undertaken yearly. All fire prevention equipment had been serviced and eight fire extinguishers had been replaced. Two fire evacuation blankets had just been purchased for the upper floor stair cases with training planned in their use.

A whole building inspection was undertaken by the director on the 28 September 2018. Checks such as the yearly gas certificate and electrical portable appliance testing had taken place in 2018. A five-year electrical installation check had been undertaken in 2016. Walking aids and bed rails safety checks were undertaken weekly and hoists were serviced on a regular basis.

People's care plans were audited monthly as were medicines, falls and pressure ulcer care. Each floor's allocated staff team and nurses took a lead in areas overseeing continence care, tissue viability, medicines and dietary need.

People and relatives spoke in positive terms about the registered manager. Their comments included, "I know the manager, she is ok", "[Registered manager] is very nice and helpful," and "I can approach the manager with any concerns I have." We observed that the registered manager interacted politely with people and their relatives, always welcomed them and responded to them. People and relatives told us that the management team was visible in the home. The registered manager was often out on the floors monitoring care and their office was close to the main entrance and they were therefore accessible for people and relatives.

People and relatives were asked their views of the service. The survey for 2018 had just commenced and we saw that questionnaires were being sent out. The results of the survey for 2017 were displayed on the notice board in the entrance to the home. The registered manager described how they analysed the results of the survey. If the scores had changed or there were lower scores than the previous year they discussed with staff how they could improve the area of concern.

Staff told us that the director and registered manager were supportive and approachable. "One care worker said, "I feel like here is my second home. I am very, very happy in my job...If I had a problem I would tell [registered manager], we work like team work, we help each other." Lines of communication in the home were good with three handovers each day to the oncoming shift. Staff were encouraged to contribute their views in reflective meetings where they discussed best practice.

The registered manager kept their own knowledge updated. They had completed their revalidation for the Nursing and Midwifery Council. We saw that there was positive feedback from people and family members in the revalidation submission. The registered manager was also attending a course called My Home Life Group. This was a forum where registered managers of care homes met and talked about how they could improve the quality of care. They undertook projects for instance about DoLS and shared their learning with the group. The registered manager described this had been helpful and they had the opportunity of visiting other care homes and meeting other providers in sharing good practice.

The registered manager worked in partnership with health and social care professionals and with the local commissioning bodies on behalf of people living in the home to help ensure people received safe care.