Rushcliffe Care Limited

Thorpe House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 December 2017 and was unannounced.

This was the third comprehensive inspection carried out at Thorpe House Nursing Home.

Thorpe House Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 50 people in one adapted building. On the day of our visit, there were 43 people using the service.

The service had a registered manager. 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 and associated Regulations about how the service is run.

Following the last inspection in October 2016 we asked the provider to complete an action plan to show how they were going to become compliant with the regulations relating to staffing and person centred care. During this inspection we found that the action plans had been implemented and had driven improvements in all areas of care people received. There were enough staff deployed to meet people's needs and care was provided in a person centred way.

The registered manager provided an open and learning culture which involved staff, people who used the service and their relatives to feedback about the service and have their comments responded to. The registered manager had used people's experiences to analyse the quality of their care and had changed the way staff provided care and monitored the quality of the service closely.

Staff understood their roles and responsibilities to safeguard people from the risk of harm. Risk assessments were in place and were reviewed regularly; people received their care as planned to mitigate their assessed risks.

Staffing levels ensured people's care and support needs were safely met. Safe recruitment processes were in place. People received care from staff who had received training and support to carry out their roles. People were supported to have enough to eat and drink to maintain their health and well-being.

People were supported to access relevant health and social care professionals. There were systems in place to manage medicines in a safe way.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff demonstrated an understanding of the Mental Capacity Act, 2005 (MCA). Staff gained people's consent before providing

personal care. People were involved in the planning of their care which was person centred and updated regularly.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted. People had developed positive relationships with staff. Staff had a good understanding of people's needs and preferences.

People were listened to, their views were acknowledged and acted upon, and care and support was delivered in the way that people chose and preferred.

People using the service and their relatives knew how to raise a concern or make a complaint. There was a complaints system in place and people were confident that any complaints would be responded to appropriately.

We made a recommendation that the provider seeks advice on how to improve communication with people who have a sensory loss.

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 received care from staff who knew how to safeguard people from abuse.

People's risks were assessed and reviewed regularly or as their needs changed.

There were sufficient qualified staff to support people to stay safe. People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures.

People received their prescribed medicines as planned. Staff followed procedures to help prevent and control infections.

People could be assured that staff continually learnt from incidents and improvements were made when things went wrong.

Is the service effective?

Good

The service was effective.

People received care that was delivered in line with current legislation, standards and evidence based guidance.

People were cared for by staff who had received the training and support they required to carry out their roles.

People were supported to eat and drink enough to maintain a balanced diet.

People were supported by staff who worked well across organisations to ensure safe admission, discharge and transfer of care.

People's needs were mostly met by the adaptation design and decoration of the premises.

People's consent was sought before staff provided care. Staff understood their responsibilities in relation to the Mental

Capacity Act 2005 and DoLS.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

People were supported to be involved in planning their care.

People's privacy and dignity were maintained and respected.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs and had plans of care that were updated as their needs changed.

People had information on how to make complaints and the provider had procedures they followed to manage and learn from complaints.

People were supported to plan and make choices about their care at their end of life.

Is the service well-led?

Good

The service was well led.

There was a registered manager who understood their roles and responsibilities.

The provider had a clear strategy and vision to deliver high quality care.

The provider had procedures in place to monitor the compliance and quality of the service and had systems in place to take action to improve where necessary.

People and their representatives were involved in developing the service.

Thorpe House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 comprehensive inspection took place on 11 December 2017 by one inspector, a specialist nurse 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 was the third comprehensive inspection since October 2014. The last comprehensive inspection was 13 October 2016 where we rated the service as Requires Improvement; there were two breaches of the regulations. We asked the provider for an action plan to explain how they were going to become compliant. We received the action plans that demonstrated that the service would be complaint with all the regulations by 31 March 2017. We contacted the health and social care commissioners who monitor the care and support of people receiving care from Thorpe House Nursing Home who told us they had visited the home in May 2017. They carried out an audit where the service scored 92%; they told us they did not have any concerns about the home.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with six people using the service and four relatives. Most people were not able to speak due to their dementia, we spent time observing their care and how staff interacted with them.

We also spoke with eight members of staff including the registered manager, the provider, the compliance officer, two nurses, two care staff and kitchen staff.

We looked at the care records for four people who used the service and five medication records. We also examined other records relating to the management and running of the service. These included five staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, complaints, incidents and accident reports and quality monitoring audits.

Good

Is the service safe?

Our findings

During the last comprehensive inspection on 13 October 2016 the provider had not ensured there were enough staff deployed to meet people's needs, this was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice which meant the provider had to explain how and when they were to become compliant with Regulation 18. The action plan submitted by the provider demonstrated they would be complaint by 31 March 2017. During this inspection we assessed whether the provider had systems in place to ensure there were always enough staff deployed to meet people's needs.

During this inspection there were enough experienced staff to keep people safe and to meet their needs. One person told us, "I think that there are enough staff. They work very hard. We see the same staff all of the time." The provider had systems in place to calculate the number of staff required according to people's dependency. Following the commissioner's quality monitoring visit in May 2017, they recommended that the registered manager maintain close monitoring of the staffing levels due to the high dependency of people using the service. During this inspection the dependency remained very high; most people (33 people) required nursing care and we observed at least 13 people requiring all of their care in bed and/or help with eating and drinking. The registered manager continually monitored the staffing levels to ensure they could meet people's care needs.

Staff rotas were planned in advance; they demonstrated that there were enough nursing and care staff allocated on all shifts to care for people in the communal areas and in their own rooms. Staff told us they were busy, but had enough staff to meet people's needs. One person told us, "There's always someone here to help me." One member of staff told us, "We are always allocated to the lounge or to assist people in their rooms, it works well." We observed that staff were available to people when they needed care and people in the communal areas were supervised.

The provider sometimes used agency care staff; there were four vacancies for care staff. The registered manager told us they were in the process of actively recruiting care staff. There were no nursing vacancies.

The registered manager followed safe recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Nursing staff provided evidence of their registration with the Nursing and Midwifery Council (NMC) and the provider had systems in place to ensure their registration was maintained.

People told us they felt safe living at the service. One person said, "I really do feel safe here." Three relatives told us their family member was safe at the service. One commented, "[Name of relative] is definitely safe here, all the carers are good." Staff demonstrated they knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. Staff told us they would report any concerns to

their line manager. One nurse told us, "I would make the person safe and report it to the manager or if necessary to CQC or safeguarding." The registered manager had raised safeguarding alerts appropriately and had systems in place to investigate any concerns if required to do so by the local safeguarding authority.

People's risks were assessed and reviewed regularly, for example moving and handling or their risk of falls. Risk assessments reflected people's current needs and staff were provided with clear instructions in care plans to mitigate the assessed risks. For example one person required a hoist to move, staff had clear instructions about the size and type of sling to use to move them safely. Another person was prone to falls; they had a low bed and a crash mat next to their bed at night in case they rolled out. The risk assessments and care plans were reviewed regularly or as people's needs changed.

There were fire risk assessments and fire safety procedures in place to check that all fire safety equipment was serviced and readily available. Staff had received training in fire procedures, including nursing staff who received fire warden training. Each person had been assessed for their mobility in the event of an evacuation. Staff told us and records showed they had practiced the fire procedures. The provider carried out regular environmental checks and maintenance of equipment such as hoists, radiators and window restraints. They completed regular checks on the temperature and cleanliness of the water supplies.

There were appropriate arrangements in place for the management of medicines. Nursing staff had received training and demonstrated they were knowledgeable about how to safely administer medicines to people. One person told us, "My medication is given at the right time and regularly." Records showed that people received their medicines at the prescribed times. People could ask for pain relief; staff provided medicines as required such as Paracetamol and recorded the reasons and the effects. People's medicines were reviewed by their GP at regular intervals, or as their needs changed. Nursing staff had arranged for the GP to review one person's medicines, their relative told us, "My [relative]'s medication has been reduced recently. This is because it seemed to be making her a bit sleepy." Some people required their medicines covertly; where people received their medicines without them knowing, usually disguised in food. People receiving their medicines covertly had undergone an assessment and agreement by their GP as it was in the person's best interests; the arrangements had been made in accordance with the Mental Capacity Act 2005. Nursing staff had clear guidance on how to administer covert medicines safely.

People were protected from the risks of infection as the provider had infection control procedures that staff followed. There were procedures in place for cleaning schedules and these were monitored for effectiveness. People told us the home was clean, "It's always clean here, including the rooms." Relatives also told us, "I have no concerns about the cleanliness or hygiene here." Staff followed procedures to help prevent infections such as washing their hands and using gloves and aprons. People told us and we observed that staff used gloves and aprons when providing personal care or changing bed linen. One person told us, "They always wash their hands." Relatives told us, "I have witnessed the staff washing their hands. They wear aprons too." The registered manager carried out three monthly infection prevention audits and the results of these were shared in staff meetings to improve standards. Staff had received training in infection control and food hygiene; the service had a five star food hygiene rating from the local authority. Five is the highest rating awarded by the Food Standards Agency (FSA). This showed that the service demonstrated very good hygiene standards.

The registered manager strived to make improvements to the service by using lessons learnt from reported events and complaints. The registered manager analysed information they gathered in relation to falls, accidents, complaints and safeguarding alerts to understand how these had occurred. They shared the information with staff at meetings where they discussed possible solutions and learning from these

incidents. The registered manager had carried out an in-depth analysis of the falls within the home. They had identified that the patterned carpets, overcrowding in communal areas and the lack of grab rails had contributed to people falling. They had submitted their findings to the provider who had changed the environment to help prevent falls; this included a change to the flooring, installation of grab rails and rearranging the communal areas to reduce crowding. The registered manager told us, "We can now easily observe people and help prevent falls." The numbers of falls had significantly decreased since the improvements to the environment. The registered manager had shared their learning with other managers within the organisation to help prevent falls throughout the provider's homes.

Good

Is the service effective?

Our findings

During the last comprehensive inspection on 13 October 2016 the provider had not ensured there were enough staff deployed to meet people's needs, this was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. We issued a requirement notice which meant the provider had to explain how and when they were to become compliant with Regulation 9. The action plan submitted by the provider demonstrated they would be complaint with Regulation 9 (3b) by 31 March 2017. During this inspection we assessed whether the provider had systems in place to ensure people received the support they needed to eat their meals.

People were supported to eat and drink enough to maintain a balanced diet. Staff were allocated to people who required assistance to eat and drink. People received their meals in a timely way. People had been assessed for their risk of not eating or drinking enough to maintain their health and well-being. Where people had been assessed as at risk of losing weight or choking, they were referred to health professionals such as their GP, dietitian and Speech and Language Therapist for further assessment and advice. Staff followed the health professional's advice. For example where people were at risk of choking due to swallowing difficulties staff ensured people received thickened fluids as recommended and stayed with people as they ate. Some people required high protein foods and extra snacks and drinks to help maintain their health; we saw that these were provided as planned.

People's individual dietary needs were met. People could choose what they ate and when. Most people told us they particularly enjoyed the breakfast, one person said, "For breakfast I have a full English, this is the best meal of the day. It's really good. I have cereals, egg & bacon and other bits and bobs with toast." We saw that most people in the dining room were eating a cooked breakfast. Where people could not speak for themselves, staff would use information from their care plans to ensure people received food they liked, or asked their relatives. One relative told us, "The food is very good. My [relative] has to have her food liquidised. I choose her meals for her."

People's care was assessed to identify the support they required. Each person received a pre-assessment of their needs before moving in, to enable the service to support them effectively. Most people required nursing care; there were standards and guidelines in place to manage people's nursing needs which were evidence based. For example, all nursing staff received additional training in tissue viability and followed evidence based guidelines to help people's wounds heal and prevent pressure ulcers. The provider had introduced specific training for all staff in the recognition of sepsis in line with national drive to raise awareness. Sepsis is the body's overwhelming and life-threatening response to infection. The training ensured that information was available to staff about what symptoms to monitor and how and when to access medical care for people with suspected sepsis.

People received care from staff that had the skills and knowledge to meet their needs. All new staff had an induction where they received training in core areas such as health and safety, moving and handling, infection control, nutrition, end of life care, dementia awareness, understanding the mental capacity act and safeguarding of vulnerable adults. New staff received close supervision and shadowed more experienced

staff and were assessed for their suitability and competency during their probation. The provider had a specific training programme for nursing staff which were competency based for example in medicines management, catheterisation and taking blood samples.

The provider employed nurses who completed their nurse training outside Europe (EU/EEA). These nurses can only provide nursing care whilst being supervised by a nurse registered with the Nursing and Midwifery Council (NMC). Once the overseas nurse has completed an Objective Structured Clinical Examination (OSCE) which assesses them against the current UK pre-registration standards; they can apply to register with the NMC and provide nursing care unsupervised. The provider supported the overseas nurses to gain the experience and competencies to pass the OSCE; this had helped the provider to recruit and retain nursing staff.

There were systems in place to provide on-going support to staff and they confirmed they received regular formal supervision. One nurse told us, "We have supervision on a regular basis, it helps eliminate bad practice." The provider ensured there was additional support for staff at all times. One nurse told us, "There is an on-call system where senior managers are available in case of emergencies and to deal with issues such as staffing and disciplinary matters." Staff confirmed that in addition to supervisions, the registered manager was always around to speak to or provide advice. One staff member said, "The manager is very approachable, her door is always open."

Staff worked together within the service and with external agencies to provide effective care. Staff provided and received effective handover of information between shifts which included changes in people's care and care plans were updated in a timely way. Staff provided key information to medical staff when people were transferred into hospital so their needs could continue to be met.

People's needs were mostly met by the adaptation, design and decoration of the premises. The first floor had a small dining room and lounge. They were at opposite ends of the building to each other. Not all people could use either the dining room or lounge as they were too small to accommodate them, and they were so far apart that most of the time was spent moving people between the two rooms at meal times. People's rooms were spacious and the corridors were kept clear for ease of access. The building required regular and frequent maintenance to maintain the levels of safety. The provider had already identified these issues and told us of their plans to rebuild the home on the same site to replace it with a new purpose built home more suitable for people's needs. In the meantime, the provider was committed to ensuring the building remained safe and fit for use.

People had access to healthcare services and received on-going healthcare support. Staff monitored people's clinical observations regularly and referred people for medical care promptly when people became unwell. Staff worked closely with GPs to provide prescribed care to manage people's illnesses in the home, such as providing oxygen or antibiotics. People were helped to attend health screening and specialist appointments or carry out screening in the home. For example, staff assisted people to carry out the home bowel cancer screening. Some people were supported by the mental health in-reach team for occasional aggressive and agitated behaviour. The In-reach team provides a multidisciplinary assessment and specialist support to people living with dementia who live in a care home. The registered manager worked closely with the public health nurse and the environmental health officer in April 2017 to contain an outbreak of diarrhoea and vomiting. People or their legal representatives were asked for their consent to have flu vaccinations and these were provided in conjunction with the GP practice.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Our observations showed that people were encouraged to make decisions about their care and their day to day routines and preferences. The registered manager and staff understood their roles in assessing people's capacity to make decisions and people told us they were always asked about consent to care and treatment. People received their care as planned in their DoLS authorised assessments. For example one person had a specially commissioned tilt chair following an assessment by the Occupational Therapist. There was a care plan in place for the chair supported by a DOL's due to the restraint aspect of the chair.

Good

Is the service caring?

Our findings

People received care from staff that they knew. People were happy with the care and support they received. One person told us, "They [staff] are brilliant with me. They're marvellous. Nothing's too much trouble here."

Relatives were satisfied and pleased with how staff cared for their family members. One relative said, "They [staff] take good care of [Name of service user]. I have a good relationship with the staff; I feel that they know me."

Staff were knowledgeable about the people they were caring for. Staff knew people's preferred routines and the family and visitors that were important to people. Staff worked with people's relatives to support them to continue to have a role in caring for them. One person told us, "My visitors come at any time. They are made to feel welcome." One relative who helped to provide care told us, "I feel welcome as a visitor. I have a good relationship with the staff." The registered manager told us that people were encouraged to maintain relationships that were important to them. Staff had received training in equality and diversity; staff respected people's wishes in accordance with the protected characteristics of the Equality Act. For example people were helped to maintain their relationships with their partners or spouse no matter their age, race or sexuality.

We observed that staff treated people with warmth and kindness. Where people had fallen asleep in the communal areas, staff gently woke people up to offer food and drink and check they were feeling alright. Staff interacted with people in a polite and respectful manner and care was carried out in a dignified and person-centred way. People chose when they wanted to get up in the mornings. One person living with dementia spent the morning asleep in bed, when he was ready, he was helped to wash and dress and join others in the communal area where he interacted with others and was helped to eat and drink.

People's privacy and dignity were respected. One person said, "If my door is shut they [staff] knock on the door. I am encouraged to be independent. I do as much for myself as I can." A relative told us, "When they are doing personal care they always draw the curtains and I have to stay outside." People were encouraged to be as independent with their care needs as they could. Another person told us, "I'm supported to be as independent as I can be but there is a lot I can't do."

Even when people could not communicate their needs, staff ensured that people's likes and dislikes were known. For example one person had a notice on their door which read, "When I'm in my room I would like my door left open." We saw that their door was left open when not receiving personal care.

People's rooms reflected their personalities and previous lives. People had photographs and items of meaning in their rooms to make each room individual. One relative told us, "[My relative] has twinkly lights in his room; he has his pictures and a TV."

There was a person centred approach in how the service was run. People were supported to make decisions

and express their views about their care. They could have access to an advocate if they felt they needed support to make decisions, or if they felt they were being discriminated against under the Equality Act, when making care and support choices. One person told us, "I ask the staff here for advice, but my family are my advocates. I definitely have a good relationship with the staff here, excellent I would say."

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance and staff were provided with training about the importance of confidentiality. Information about people was shared on a need to know basis. We saw that people's files were kept secure in filing cabinets and computers were password protected to ensure that information about people complied with the Data Protection Act. Handovers of information took place in private and staff spoke about people in a respectful manner.

Good

Is the service responsive?

Our findings

During the last comprehensive inspection on 13 October 2016 the provider had not ensured there were enough staff deployed to meet people's needs, this was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. We issued a requirement notice which meant the provider had to explain how and when they were to become compliant with Regulation 9. The action plan submitted by the provider demonstrated they would be complaint with Regulation 9 (3b) by 31 March 2017. During this inspection we assessed whether the provider had systems in place to ensure people received the support they needed to engage in meaningful activities.

There was a member of staff employed specifically to co-ordinate people's preferences for activities. Some people did not respond well in company, so the activities co-ordinator ensured they spent time on a one to one basis to engage with people in activities they were interested in. People told us they were very happy with the activities co-ordinator, one person said, "The activities lady is very good. I'm not able to hold things in my hands so I'm not able to do things that require me to hold a pencil. I enjoy story time, which is on Thursday morning, bingo and gardening." Another person told us, "There's music. A lady comes some days and we listen to her talks. We go into the garden; we've done all the gardening, and tomatoes. Last week I went to [supermarket], I enjoyed that."

People's care records were very comprehensive which included information about people's lives which helped staff to relate to them; staff talked to people about their interests and their families. For example one person liked music, which was a frequent activity in the home. One relative told us, "[My relative] joins in with the activities when there's music to entertain."

People were helped to be involved with the local community. Two local supermarkets had schemes to reach out to people, which people using the service were involved in. For example one supermarket helped to facilitate people meeting in their cafeteria once a week to meet friends. Another supermarket helped to provide supplies for the recent fete. People from the local church helped people to be involved in their cake club. The registered manager was liaising with the local primary school to involve people using the service in the music at the school.

People had the opportunity to plan future events such as the Christmas Fair. There was a residents association which met regularly to plan and organise chosen outings, secret Santa presents and how they were planning to decorate the home at Christmas. At the time of inspection the reception area of the home was decorated with a winter town scene made up of dolls houses covered in fake snow which was very attractive. The activities co-ordinator had helped people to be involved in creating the scene and decorating the home.

People received individualised and person centred care that met their needs. People had comprehensive care plans that provided staff with detailed information of how to care for them. Where people required pressure relieving equipment, they were assessed for their particular needs. For example one person had an air mattress which was calibrated using their weight and body mass; they had good skin integrity and no

pressure sores. Staff ensured that people received the support they needed to mobilise safely. People's needs met their preferences, for example one person liked to smoke; staff facilitated this person to have a cigarette in a safe environment.

Some people could not use their call bells to summon assistance; staff visited their rooms at regular intervals to check on their welfare. A high number of people could not communicate their needs verbally. Although there were some picture charts available to people in their rooms to indicate their needs there was not a system in place to explore other possibilities of communication where people had a sensory loss, such as their loss of hearing.

We recommend that the provider seeks advice from a reputable source about how to improve communication with people who have a sensory loss.

People or their legal representatives were involved with their care planning. One relative told us, "I was involved with [my relative's] care planning and his risk assessment. He gets all of the care as planned." Another person told us, "We were involved in the planning and have consented to [my relative's] treatment; we have power of attorney."

People felt confident that they could make a complaint. One person told us, "I would feel comfortable to make a compliant. I don't have any complaints though." Information on how to make a complaint was displayed in people's rooms. People had the opportunity to raise any concerns informally with staff or managers, or formally in writing. One person told us, "If I had a complaint I would tell a member of staff." One relative told us they felt confident in raising a complaint, they said, "I have no complaints. If there are any issues I deal with them immediately. My suggestions are generally well received." The provider had procedures in place to record and respond to people's concerns. Complaints had been responded to in a timely way. Points for learning were shared with staff at team meetings to help prevent future complaints.

People had the opportunity to discuss with staff what it meant to be at the end of life. People had expressed their own preferences in how they wanted their care to be provided when they were at end of life; this was recorded in their records and reviewed as and when people made their preferences known. Staff had received training in providing care to relieve symptoms for people when they were at end of life. Nurses told us and we saw that people had advanced care plans in their records. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care.

Good

Is the service well-led?

Our findings

There was a registered manager who had managed the home since February 2013. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager understood and carried out their role of reporting incidents to CQC.

The service had an open culture where staff had the opportunity to share information; this culture encouraged good communication and learning. The registered manager explained, "We analyse everything, feedback from staff and complaints help us to improve the service." Staff told us that the registered manager and senior staff were approachable. The service had improved since the last inspection; the registered manager had developed and worked through effective action plans to develop the standard of care.

The provider had supported the registered manager to complete the action plans and shared the good practice and improvements with other managers of their other homes. The compliance officer and directors took notice of the registered manager's opinions and could see benefits of the actions they had taken. The registered manager received peer support from the other homes' managers at regular meetings.

The registered manager had driven improvements in the care that people received by constantly assessing, monitoring and evaluating the quality of people's care. They had carried out thorough investigations into incidents and accidents and changed the environment and staff practice to reduce these incidents. They had implemented changes in how staff provided people's meals; they had a project where staff tasted the food and introduced a system to identify people who required additional assistance; by placing a red mat under their plates. All the changes that had been implemented had been embedded into everyday care.

The registered manager's approach to management was very 'hands on'. They regularly provided care alongside staff and knew people using the service and their relatives well. This had led to a good insight into people's needs and how the care was being provided. The registered manager had an open door policy for everyone which had proved essential in improving care, as they had responded to people's experiences. They had a notice on their door which advertised a time each week that relatives could visit to discuss anything they wished. The registered manager told us, "Sometimes relatives just want to discuss what dementia is and how to communicate better."

People could talk to the registered manager at any time, as they were visible in the home. One person said, "If I wanted to speak to [the manager] I would ring my call bell and ask to speak to her, or I would see her walking by and so I would speak to her that way." A relative told us, "I know the manager very well. She is a lovely lady and she is very supportive. I can speak to her anytime." People were represented at the residents association, relatives knew they could attend, but some had chosen not to. One relative said, "I can be involved with this care home because they have meetings for me to go to." Relatives meetings were held regularly, these were repeated on different evenings to ensure that relatives could attend.

Staff meetings were informative and encouraged staff to make suggestions and talk through ideas to improve care. The registered manager told us, "I am proud of the staff; we have achieved a lot by using their ideas and developing better ways of providing care." The minutes to these staff meetings showed that staff were encouraged to challenge each other if they saw poor practice and discussed feedback from people who used the service and their relatives.

The provider had implemented quality assurance systems that were effective in identifying areas that required improvement, such as the environment. Plans were in place to rebuild the home on the same site to provide a building and environment fit for purpose now and in the future. Other quality monitoring of staff training, care plans, risk assessments, nutrition and infection prevention were effective in maintaining a safe environment and good practice.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.