Hamberley Care 2 Limited

Nesbit House Care Home

Inspection report

Orpington By Pass
Badgers Mount
Sevenoaks
TN14 7AG

Tel: 01959581350
Website: www.hamberleycarehomes.co.uk

Date of inspection visit:
02 June 2021

Date of publication:
14 July 2021

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

About the service
Nesbit House is a residential care home providing nursing and personal care for up to 60 people. Peoples' needs were varied and included those living with dementia or requiring nursing in bed. The service was arranged across three floors with one floor dedicated to people living with dementia. At the time of the inspection only two floors were in use and there were 26 people living in the service.

People's experience of using this service and what we found
People told us they felt safe in the service. One person said, "I feel very safe because things are well organised here." Without exception, relatives told us they felt their loved ones were safe. One relative said, "[Loved one] is undoubtably safe there. They were very good during COVID and locked down early." Staff completed safeguarding training, and this was up to date. People received safe care and treatment, medicines and risks were both managed safely.

People and their relatives were involved in decisions about their care and their dignity and privacy was respected. People were encouraged to be independent. One person said, "I can make my own choices and get up when I want." Another person said," I am very much independent and can do what I like."

The registered manager had an open-door policy and staff had a lot of confidence in the management team. One person said, "The manager is great. It is very well run and organised." A relative said, "They have a good manager there, he will always make time for you. I would definitely recommend it." There were robust quality assurance processes in place to monitor all aspects of the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 09/08/2019 and this is the first inspection.

Why we inspected
This was a planned inspection based on timescales for unrated services.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Nesbit House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector 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.

Service and service type
Nesbit House 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the service was registered. This included information the provider sent us about issues related to the service. We sought feedback from the local authority and professionals who work with the service and no concerns were received. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information when planning our inspection.

During the inspection
We spoke with eight people who lived in the service and eight relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, head of quality (for Hamberley Homes), clinical lead, maintenance person, nurses and care staff (Homemakers). We reviewed a range of records, this included five peoples' care records and multiple medication records. We looked at four staff recruitment files. A variety of records relating to the management of the service were reviewed, including policies, procedures and audit records.
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, meeting notes and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated good. This meant that people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Staff were knowledgeable about safeguarding, knew what to report, who to report to and if necessary, how and when to escalate any concerns. Staff told us and records confirmed training in safeguarding was up to date; the service was 100% compliant with safeguarding training.

● Records showed that staff recorded and reported allegations of abuse to the appropriate safeguarding authorities. Safeguarding records were completed; the registered manager cooperated with investigations and actions, outcomes, notification of closure and lesson learned were recorded.

● People and their relatives felt safe in the service. One person said, "I definitely feel safe. I feel right here. Perfectly happy. I felt well protected during COVID." A relative said, "Oh yes. She is safe there. I cannot fault it; it is amazing there. They are like family and support us too. They have been very strict with COVID." Another relative said, "Mum is very much safe there."

Assessing risk, safety monitoring and management

● Care plans and risk assessments were comprehensive and up to date. They had enough information to enable staff to provide safe care to people. There were detailed instructions for staff to minimise risks, for example falls, choking or skin damage. Daily records of care were up to date and accurate.

● People received safe care and treatment. Staff knew people well and told us they had enough time to read the care plan and they contained enough detail to enable them to support people in the right way. One person said, "The staff understand me." A relative said, "When you go in you notice the simple things like when Mum's legs hurt; they dealt with her."

● Environmental risks were managed, including fire risks, electrical, water and equipment safety. Records of checks were comprehensive and well organised. Most staff had up to date fire training and the service had designated fire marshals. Individual Personal Emergency Evacuation Plans (PEEPs) were in place with copies kept in a fire grab bag at reception for ease of access. There was a debrief session after all fire drills allowing staff to reflect and learn from the experience. Radiators were guarded to protect people from burns and window latches were restricted to minimise the risk of falling. People living in the service and their relatives told us they were happy with the security.

Staffing and recruitment

● There were enough staff deployed to meet peoples' needs. The electronic care planning system had an integral dependency tool to support the registered manager's decisions about staffing levels. Rotas confirmed that the right number of staff were on duty. Call bells were answered quickly, and response times were discussed at the daily meetings. One person told us, "There is always somebody around." Staff told us there were enough staff. One staff member said, "Staffing is always good. People feel safe." Another staff

member said, "Nothing is rushed."
● Staff had been recruited safely. Records were maintained to show that checks had been made on employment history, references and Disclosure and Barring (DBS) records. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people working with people who use care and support services.
● Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their personal identification number to confirm their registration status. Nursing staff were required to update their registration annually.

Using medicines safely
● Medicines were managed safely in accordance with national guidelines. Medicines were ordered in a timely manner, were stored in appropriate temperature-controlled conditions and disposal was safe. Medicines were administered by nurses and other staff who had received additional training in the management and administration of medicines and had been deemed competent to carry out this role. Training and competency records were comprehensive and up to date and where competency checks had lapsed the person was not permitted to administer medicines.
● Records of medicine administration was held on an electronic system. The system has an alert process which included, missed doses of medicines and low stock levels. There were clear guidelines in place for staff to administer 'as required' medicines, for example pain relief. When these medicines were used, staff recorded whether the medicine had the desired effect. Medicines were reviewed monthly. One person told us, "They do my medicine and stay with me whilst I take it."
● Medicines were audited regularly. Medicine errors were reported and recorded appropriately and investigated by the clinical lead or registered manager. Professional advice was sought if necessary and actions put in place to prevent recurrence. For example, a patch chart was put in place after a recent error. Outcomes of any errors were recorded, and lessons learned shared with the team.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● There was a robust electronic system in place for recording accidents and incidents. Staff knew what to do if someone had an accident. Accidents and incidents were investigated, and investigation records were thorough. There was evidence of actions taken to prevent recurrence, for example, low rise beds, bed rails, crash mats and increased monitoring. Lessons learned were shared amongst the staff team at meetings and through written messages; these were shared more widely by the regional management teams.
● Monthly analyses of accidents, incidents and key clinical indicators, for example weight loss, wounds or infections, were carried out to identify trends and reduce risk of recurrence, for example trends in falls or

pressure ulcers. These were discussed at regular clinical support group meetings and documented.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Peoples' care plans and risk assessments were comprehensive and detailed; they contained enough information for staff to know about peoples' individual choices and wishes, and how to support them in the way they wanted. Care plans were reviewed and updated regularly, usually in liaison with people and their relatives. One person said, "Every few weeks they discuss my care plan." A relative said, "Now we can visit we always have a catch up and discuss her care plan."
- Peoples' assessments included needs relating to equality, diversity and human rights. National Institute for Clinical Excellence (NICE) guidance was referred to, for example, NICE guidance for hydration.
- There was provision in place to support and reassure people living with dementia and those that are nursed in bed. One relative said, "They always explain what they are doing and have a lot of patience. There is enough staff and it is nice they hold her hand. They care for her like she was one of their own."

Staff support: induction, training, skills and experience

- Nurses and care staff had received training and had the knowledge and skills they needed to safely provide care. Staff told us that they had received appropriate training and that training updates were arranged for them. An electronic system alerted staff when training updates were due and regular messages were sent from the registered manager when reminders were needed. One staff member had been assigned as a 'training champion' with the responsibility of ensuring training was completed. The staff training matrix demonstrated that training was up to date.
- Staff had regular supervision and felt supported by an approachable team of nurses and managers. The clinical lead was responsible for doing supervisions with the nurses.
- Nurses attended clinical meetings and had regular clinical supervision meetings. Nurses worked within the Nursing and Midwifery Council's Code of Conduct and re-validated every three years in accordance with regulations.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink safely in line with recommendations received from Speech and Language Therapists (SaLT) and dieticians. People were protected from risks of choking with modified food and fluids following assessments by SaLT and nutritional plans were reviewed regularly. Some people had feeding tubes in place; care plans and risk assessments gave specific instructions for staff on how to maintain these safely and detailed which tasks should only be done by nurses.
- The chef or a member of the kitchen staff attended daily meetings to ensure they were kept up to date with any changes. They also discussed birthdays or other special occasions. The service had a recent nutritional audit undertaken by an external party which showed improvements since the previous audit;

there was an action plan in place based on their findings, for example for people on food intake charts a recommendation that staff record the actual food eaten and portion size.

● Menus were on display and before meals were served, show plates were prepared and shown to people to support them with making their choice. There were enough staff to support people who needed assistance to eat and drink, either in the dining room or in their rooms. A range of hot and cold drinks were offered throughout the day. Some people chose to have a cooked breakfast, and everyone was offered two hot meals each day. The service offered 'night bites' routinely. People were always able to choose alternatives to the meals offered, for example, cauliflower cheese, jacket potato or cheese and crackers.

● Most people and their relatives were complimentary about the food, telling us the menu was varied and they got choices. One person said, "The food is excellent, plenty to eat and very tasty." Another person said, "It is nice food, plenty of choice and you can have more if you like." A relative told us, "There is always plenty of choice and they go out of their way to make what people like."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Where people required support from outside healthcare professionals, this was organised by staff. Doctors visited the service weekly to address any issues and review peoples' needs, care and medicines. One person said, "They would call a doctor if I needed one. I get all the support I need." The service worked with a range of health care professionals, such as Speech and Language Therapists, dieticians and tissue viability nurses. Relatives were kept up to date with any health-related issues. One relative said, "They keep me informed of how she is and of her health." Another relative said, "They organise everything medical."

● Personalised care plans contained health assessments and records of professionals' meetings with other health care professionals. The clinical lead updated care plans weekly after the doctor's visit and kept a log of everyone who had seen the doctor. Any actions agreed during the visit were sent to the doctor for confirmation. Information was shared with others, such as hospitals, if people needed to access their services.

Adapting service, design, decoration to meet people's needs

● We saw people walking around the service safely, either unaided or with different mobility aids. There were key coded locks on doors for peoples' safety, for example, to prevent people on the upper floor accessing stairs unassisted where it was not safe for them to do so. We saw people enjoying the gardens.

● Peoples' rooms were personalised with photographs, ornaments and things that were important to them, such as blankets and cushions. Rooms had memory boxes outside. One person said, "I am happy with my room and they have put pictures up for me. The handy man is very good." Another person said, "I have a nice room and have pictures up of my family. I have everything I need here, and I am very lucky to be in such a nice place."

● Relatives agreed the rooms were good quality and always well presented. One relative said, "Everything there is top quality and the furnishings. Her room is gorgeous, she has lights on around her bed. She has her own chair and pictures up." Another relative said, "There is a handyman that does whatever you want, he will put up pictures for you."

Ensuring consent to care and treatment in line with law and guidance

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service complied with the MCA. There were decision specific MCA assessments in place which were completed correctly and subject to regular review. The decisions people were being assessed as being able to make were clear and there were instructions for staff to support people with these decisions. Where people were unable to make decisions there were clear reasons documented. There was evidence that a best interest meeting had been held involving a manager from the service, healthcare professionals and relatives. Decisions made following best interest meetings were clearly documented.
● The registered manager had made appropriate DoLS applications to the local authority and there were systems in place to keep these under review.
● Care was provided in the least restrictive way. Consent was documented in peoples' care plans and people told us, and we observed that staff obtained consent from people before offering them support.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staff were caring and respectful and treated them as individuals. One person said, "The staff are all very kind. They know exactly what they are doing and understand me well." One relative said, "They are so loving and caring for her mental wellbeing." Another relative said, "Very satisfied; could not be given any better care if she was on a five-star luxury liner. Ten out of ten. They look after her not out of duty but because they care."
- Staff and people knew each other well. Staff were patient with people and gave them time to respond to questions; talking with them at their own level. Staff knew peoples' preferences, but still offered choices, for example, when offering drinks. A relative said, "The staff are very caring. We are very impressed; it is everything we could have hoped for and more." Another relative said, "The best thing is they are excellent care providers and it is beautifully kept."

Supporting people to express their views and be involved in making decisions about their care

- Peoples' care and support plans were developed with them and their relatives. People were encouraged to share their lived experiences so that staff could get to know them. Peoples' daily routines, for example what time they like to get up or go to bed were documented along with their likes and dislikes.
- Care plans documented peoples' personal goals and desired outcomes. One relative said, "They ask her what she would like to wear, and they help her choose." People were able to make their own decisions, for example one person told us they could get up whenever they wanted, and another person said they could have breakfast in bed if they wanted to. Care plans detailed whether people wanted their doors open or closed whilst they were in their rooms.

Respecting and promoting people's privacy, dignity and independence

- People were being treated with dignity and respect; their privacy was protected, and they were encouraged to be independent where possible. We saw bedroom doors were closed whilst people were having their personal care needs tended to by staff. Staff were sitting with people and talking to them. Staff told us that they liked that they could sit and talk to people without feeling under pressure.
- Staff recognised and responded to individual needs and promoted independence. For example, offering a person tea the staff member said, "Let's go and make it together." A relative said, "I have not come across any poor members of staff. They respect her privacy and dignity." Another relative said, "Mum tells me they are kind to her. The staff are so good, and they talk to the relatives and ring us up. They even let us Skype her when we were on holiday. They have so much respect for her."
- People's confidential information was kept securely on electronic password protected systems and accessed only when required and by those authorised to do so.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were highly personalised and reflected peoples' choices and wishes. There was an 'about me' section which contained information about their life and lifestyle, their hobbies and interests, what job they used to do, their childhood memories, religious or cultural needs, their likes and dislikes and places and people important to them. Care delivery was person-focused and responsive. Staff were kind and considerate. One relative said, "The staff are so kind and caring. She loves it, it's like a hotel." Most people and their relatives knew the care staff and managers by name.
- There was a well-being and lifestyle lead who took responsibility for ensuring the well-being of people and staff. They organised and planned large events in the service and put together the daily activities programme. They held meetings with people in the service to ascertain what they might have done for a job, where they have travelled to, what their interests were and what was important to them. This enabled a more personalised activity programme to be developed, which was delivered by the home makers (care staff).
- People living in the service were encouraged to take the lead on certain activities. For example, one person ran the scrabble club and was the bingo compere. The activities programme was varied and included national days, for example, national cheese day, national pink day and world gin day. There were also activities dedicated to pampering, spa's and films.
- People told us there was a lot to do and a lot going on. One person told us, "We play bingo and I have made nice friends." Another person said, "I join in the activities; I like bingo and scrabble. I like to go out into the garden when it's hot." A relative agreed, "Activities are brilliant, they have lots going on and encourage her to join in. They have spa afternoons and do their nails." Another relative told us, "They have integrated well with the local community. They have the clergy there and take people to church. They take them for a walk and to the garden centre."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Communication needs were clearly documented within care plans. There were specific instructions for staff to follow, for example, one person required staff to wait after questions to allow them time to absorb the information and provide their response. Another person's communication plan said to be prepared to repeat questions or information twice to ensure understanding.

● Information was available in accessible formats, for example, pictures or easy read, if this was required. The Nesbit House survey was provided in an accessible format. Menus could be displayed as pictures, but the service also used show plates to aid personal choice.
● Staff communicated with people appropriately, were softly spoken where they could be and showed patience and respect. Some people were living with hearing loss or sight impairment. Staff made sure spectacles and hearing aids were used properly to support better communication.

Improving care quality in response to complaints or concerns
● We reviewed records of complaints. The registered manager had a proactive approach when receiving and responding to concerns about the service. Complaints were thoroughly investigated, and the outcomes and actions shared with the complainant in a timely manner. Complaints were reviewed by a regional quality manager and sometimes complaints were escalated to the regional team for investigation and response if more appropriate.
● Lessons learned were shared within the service at staff meetings and through written communications. Action plans were developed in response to complaints through the electronic system and actions were monitored by the registered manager and the regional manager until completion and closure.
● Most people told us that nothing could be improved. People we spoke to and their relatives knew how to raise concerns if they had any and were confident that something would be done if they did so. One relative said, "They listen to our views and do act on things."

End of life care and support
● The service was able to provide end of life care which enabled people to remain in the service if needs increased and not have to move to a new service.
● Care plans included end of life plans; they had clear instructions which included any preferences, visitors, cultural or religious needs and funeral wishes. The care plans also detailed the need for extra care to maintain personal and dental hygiene; to maintain skin integrity and to continue to explain every action as hearing is the last sense to leave the body. These plans had been made in partnership with peoples' relatives or representatives.
● Staff worked with district nurses, hospice nurses and GPs to provide end of life care when required. Medicines were available to them to keep them as comfortable as possible.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The values of the organisation were on display throughout the service. The registered manager fostered a positive culture within the service where people felt empowered and involved. The registered manager had an open-door policy. Staff said the culture was open, friendly and with a homely atmosphere. One staff member described the culture as, "Home from home." Another staff member told us there was a good team ethic, people were treated as equals, supported and listened to. They said, "This is the nicest environment I've ever worked in." Staff told us morale was good and it was a happy place to work. Staff said the management team were all approachable.
- Relatives were impressed with how the service was run and said that it was well organised with a nice atmosphere. One relative said, "There is nothing to improve. The best thing is the general care and ambiance of the place, it has a caring and homely feel." Another relative said, "We love it, it is welcoming, homely and professional." Several relatives commented on the 'fantastic front of house'.
- Staff were invited to meetings and were encouraged to participate. Staff said they felt included and if they made any suggestions they were listened to and sometimes changes were made, for example, amendments to some head office documentation.
- Services providing health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. This is so we can check that appropriate action has been taken. The registered manager had correctly submitted notifications to CQC.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. The provider understood their responsibilities.
- Relatives told us, and records confirmed that staff were in regular contact with them. Relatives said that they were told, for example, if a doctor had been called. Relatives received regular newsletters, emails and telephone calls. One relative said, "It is faultless and from reception nothing is too much trouble. I have good contact and can call anytime." Relatives confirmed that they were informed if things happened, for example, skin damage or a fall.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was a clear management structure, nurses and care staff understood their responsibilities to meet regulatory requirements. They had access to policies and procedures to help them consistently provide people with the right assistance. Staff told us the registered manager and nurses were supportive and they were treated as equals. People and their relatives told us they thought the service was managed well. One person said, "I know who the manager is and would talk to the manager if I needed to complain."
● The registered manager met daily with heads of each department, to ensure that key information about people's safety and messages were shared in a timely way. Daily handover meetings were held to ensure that staff on duty had up to date information about the people they were supporting. Specific health and safety meetings took place regularly. All meetings were accurately documented and included any specific actions required.
● The provider had a robust electronic quality monitoring system. The system was used for all reporting, including accidents, incidents, complaints and grievances. There was an in-built mechanism for by-passing the registered manager, for example, if the complaint was about them. The system was monitored by the registered manager locally and by regional and national quality assurance teams. Action plans were generated specifically for each incident and an alert system ensured that actions were followed up and dealt with in a timely manner.
● A range of audits were undertaken, for example, in medicines, infection control, care plans, health and safety and clinical indicators. The registered manager and clinical lead told us, and records confirmed that regular meetings took place where key clinical indicators were discussed, such as wound management, weight loss or falls. Action plans were in place to ensure that issues were addressed and reviewed, for example, referrals to dieticians or tissue viability nurses. Care records were comprehensive and up to date.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People living in the service were encouraged to contribute to the organisation of activities, for example running clubs and events. People and their relatives told us that they were asked their opinion about things, such as food, activities and the way they were supported.
● The service had recently undertaken an inclusive and accessible quality survey for people, relatives and staff. There was an overwhelming positive response from people about the environment, facilities and feeling of safety and 90% of people said that staff helped them feel part of the community. 80% of people said their families were involved in their care. Of the staff, 96% said the manager was approachable and 79% felt they contributed to the running of the home. A 'Talkback Action Plan' was developed as a result of surveys of staff and people, detailing what the issue was, what the service planned to do to address the issues, who was accountable for the action, a due date and progress notes.
● Relatives told us they had been to meetings before the COVID restrictions and felt that they were able to share their views openly with the registered manager. One relative told us, "Before lockdown they had a special room for children to play in and colour. They go the extra mile."

Continuous learning and improving care
● The registered manager and the provider demonstrated a clear commitment to continuous improvement. Proactive action plans were in place following audits or incidents which were monitored to ensure completion. Nurses attended clinical meetings where clinical risks, such as weight loss or wounds, were discussed. The registered manager or clinical lead undertook night visit checks periodically.
● Lessons learned from incidents, accidents or complaints were shared with the local team and escalated to regional and national managers. After incidents staff were encouraged to reflect on their practice for self-development and service improvement. Records showed that actions had been taken following incidents, such as extra monitoring being put in place after falls, or ensuring beds were at the lowest level to reduce the risks to people.

● Reflecting and learning from a recent medicine error led to a medicines review and a positive outcome and improved health and wellbeing of the person. Other actions following this incident included targeted retraining, reflective accounts, updating of care plans and changing system security features.

Working in partnership with others

● The registered manager worked in partnership with local health teams during the COVID-19 pandemic to ensure people were receiving appropriate care and support. The manager had a good working relationship with local safeguarding and commissioning teams.

● Managers and nurses liaised regularly with other health professionals, including GPs, tissue viability nurses, dieticians, physiotherapists and speech and language therapists.

● Doctors visited weekly and undertook reviews for the people living in the service and people we spoke to and their relatives knew about this.