HC-One Limited

Victoria 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 5 September 2017. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

The service was last inspected in June 2016 and at that time required improvement. We found breaches of Regulations 17 good governance and regulation 18 staffing. This was because staff had not received supervision on a regular basis and best interest decisions were not recorded in care plans. Following our last inspection the provider sent us an action plan, which detailed the action they would take to make improvements at the home.

At this inspection we found that staff were now receiving regular supervision and best interest decisions were fully documented in care plans.

Victoria House Care Centre is a purpose built care home providing personal and nursing care to older people and older people living with a dementia. It is located close to the centre of Stockton-On-Tees, within easy reach of local amenities.

There was a registered manager in place who had been registered with the Care Quality Commission since 2015. 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.

Risks to people arising from their health and support needs and the premises were assessed, and plans were in place to minimise them. Risk assessments were regularly reviewed to ensure they met people's current needs. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use.

There were enough staff to meet people's needs. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. Staff were now given effective supervision and a yearly appraisal.

Staff understood safeguarding issues and were aware of the whistleblowing policy [telling someone] if they had concerns.

Staff received training to ensure that they could appropriately support people, and the service used the Care Certificate as the framework for its training. Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and clearly understood the requirements of the Act. Best interest decisions were made appropriately with the person and family fully involved. This meant they were working within the law to support people who may have lacked capacity to make their own decisions. The

manager understood their responsibilities in relation to DoLS.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they had a choice of food and everyone enjoyed what was on offer. Where people had a percutaneous endoscopic gastrostomy (PEG) in place and was nil by mouth. A PEG is a procedure to place a feeding tube through the skin and into the stomach to give the nutrients and fluids needed. Along with advice from the dietician and SALT team the service was offering taste spoons or oral food tasters. An oral food taster or taste spoon is where an empty spoon is dipped in custard or yogurt for example; all the excess is allowed to fall off the spoon leaving a very thin covering.

We saw evidence in care plans to show the service worked with external healthcare professionals to maintain people's health.

We found the interactions between people and staff were kind and respectful and people were offered choice throughout the day.

Procedures were in place to support people to access advocacy services should the need arise. At the time of inspection no one was using an advocate.

Complaints were acted on using the guidance of the services complaints policy.

Staff had a clear understanding of people's needs and how they liked to be supported. People's independence was encouraged without unnecessary risks to their safety. Care plans were well written and specific to people's individual needs. However, people's life history was missing from four of the six files we looked at.

The manager was a visible presence at the service, and was actively involved in monitoring standards and promoting good practice. People, relatives and staff felt confident in the manager. Feedback was sought from people, and relatives to assist in this. The service had quality assurance systems in place.

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 remains safe.

Is the service effective?

Good

The service was effective.

Staff were now fully supported with supervisions and appraisals.

Staff had an understanding of promoting choice and gaining consent. The manager and staff knew their responsibilities under the Mental Capacity Act.

People were provided with a healthy diet.

Staff at the service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service was responsive.

Best interest decisions were now fully documented in peoples care plans.

People had access to a wide variety of activities.

There was a clear complaints policy which staff at the service adhered to.

Is the service well-led?

Good

The service remains well led

Victoria 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 September 2017. At the time of our inspection 57 people were using the service.

The inspection team consisted of one adult social care inspector, one specialist professional advisor and two experts by experience. A specialist professional advisor is someone who has professionalism in this area such as nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR in a timely manner.

We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information as part of our planning.

During the inspection we spoke with 11 people who lived at the service and 11 relatives. We looked at six care plans and Medicine Administration Records (MARs). We spoke with 8 members of staff, including the manager, the deputy manager, nurses, nursing assistants, care staff, activity coordinator and the cook. We looked at seven staff files, including recruitment and training records and records relating to management of the service. We also spoke with one visiting healthcare professional.

We also completed observations around the service.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe living at the service. Comments included, "Yes, the staff are very helpful, you get whatever you need." another person said "They [staff] just make me safe."

Relatives we spoke with said, "Safety is really good, there is a buzzer to get in and I wait for staff to let me in." Another relative said, "I have no problems with safety, all doors are coded and there are plenty of staff." And another relative said, "I can go home knowing my [relative] is safe." A visitor said, "The home is a nice home, I was a Matron for forty years, the person's needs are the first consideration, everything they want they get. My friend needs total care; they are very safe I have no concerns."

We saw medicines were administered and stored safely.

Medicines that were liable to misuse, called controlled drugs were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly. The temperature of treatment rooms were checked daily and were within recommended limits.

The service had protocols for when required medicines (PRN) and these were individual to each person, explaining why and how each PRN should be administered and when to be repeated.

Medicines training was up to date and we saw evidence of competency checks on staff to ensure they were competent with the administration of medicines and other areas. Competency checks were carried out every six months. Medicine audits took place monthly by the manager and a daily check by suitably qualified staff took place on five people's medicines, to check quantities and recording.

We asked people if they received their medicines on time. One person said, "Yes they [staff] are nice, the nurse does my medicines for me, I have injections." Another person said, "The nurse gives me my tablets properly."

We saw risks arising from people's health were assessed and a detailed plan was in place to mitigate the risks. Risk assessments were in place for people's mobility needs, diet and nutrition, bed rails and lap belts on wheelchairs. Risk assessments were reviewed on a monthly basis or more frequently if needed to ensure they reflected people's current needs.

Risks to people arising from the premises were assessed and monitored. A fire and general premises risk assessments had been carried out. Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. Records confirmed that monthly checks were carried out of emergency lighting, fire doors, water temperatures and shower descaling. This meant the provider was ensuring equipment was safe.

A Personal Emergency Evacuation Plan (PEEP) was in place for each person, documenting the support people needed to leave the premises in the event of an emergency. This showed that the provider had taken

appropriate steps to protect people who used the service against risks associated with the home environment.

We saw the provider's business continuity plan, which detailed what to do in the event of having to evacuate the premises due to an emergency such as flooding or fire. The plan also stated what to do in the event of staff shortage or loss of electricity. This showed us that contingencies were in place to keep people safe in the event of an emergency.

Accidents and incidents were recorded accurately and analysed regularly in relation to date, time and location to look for trends. Although no trends had been identified recently, records showed appropriate action had been taken by staff.

Staff we spoke to had a good understanding about safeguarding. One staff member said, "We have had training on safeguarding, I would feel comfortable to report any concerns I had, it would be no problem to me at all."

We observed there were enough staff on duty. On each floor (up and down) there was a nurse, a nursing assistant and five care staff. People, relatives and staff all said there was enough staff on duty at all times. The manager used a dependency tool to calculate how many hours were needed. The service did not use agency staff.

Robust recruitment procedures were in place to ensure suitable staff were employed to work at the service. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service (DBS) check was carried out before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with children and adults. The manager said they request updated DBS checks every three years.

We found the service was clean and tidy. Staff had completed training in the prevention and control of infection. There was personal protective equipment (PPE) available such as gloves and aprons.

Good

Is the service effective?

Our findings

At our last inspection in June 2016 we found that staff were not supported by supervisions. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

At this inspection we saw evidence to show supervisions were now taking place and the manager had a supervision matrix to show when a staff member's next supervision was. The service's supervision policy stated that they were to take place six times a year and we saw the service was on track for this. For new staff they received a welcome supervision to ascertain training needs, explain the induction and training requirements and discuss safeguarding and whistleblowing procedures. New staff also received supervision six weeks after starting to see how they had settled, if they are getting to know the routine and to check on their training.

Staff also received a yearly appraisal. For the appraisal staff had to complete a document rating themselves stating whether they thought they had exceeded, achieved or needed further development. Staff needed to bring evidence to the appraisal meeting to support their self-rating. During the appraisal training was looked into and how the staff member wished to further develop. The manager said, "Staff are provided with amazing opportunities to develop with HC One."

New staff undertook a twelve week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that are expected. New staff were assigned a mentor and stayed working on one unit of the service till they felt comfortable. New staff were also supernumerary for two weeks before being added onto the rota. The manager said, "This is very individual and depends on how they staff member is doing and if they have had previous experience in care."

We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff told us they received training that was relevant to their role. We confirmed from our review of records that staff had completed training which included safeguarding adults, food safety in care, MCA and DoLS, nutrition and hydration and person centred care. One staff member said, "We use e-learning and come in our days off, which is fine because we get paid." A relative said, "Our relative was being hoisted today by two carers, they looked as though they knew what they were doing."

We saw evidence that people were weighed either weekly or monthly to monitor their health. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team. Weight records we looked at showed everybody had put weight on in the last six months. This meant the service was meeting people's nutritional needs.

At meal times staff supported people discreetly where needed, cutting food up and offering tabards to cover and protect their clothes. Staff were very attentive, constantly talking to people and encouraging them to

eat as well as offering plenty of drinks. Staff knew people's likes and dislikes. For example, one person had sandwiches and one staff member said, "I don't think [Person's name] is not too keen on them sandwiches, they may like an omelette instead." A request for an omelette was made to the kitchen and it arrived promptly. There was also useful documentation available for staff. For example, 'give [person's name] drinks at the end of the meal as they mix the drinks with their food.'

Drinks and biscuits were readily available at snack stations throughout the day. People were also provided with smoothies in the morning and afternoon. One person continually walked around the unit and staff said it was difficult to get them to sit and eat a meal. We were told and saw that staff continually offered this person food throughout the day. One person said, "Staff are always going around with tea and coffee." This meant that the service was ensuring people's health through nutrition and hydration.

One person had a percutaneous endoscopic gastrostomy (PEG) in place. A PEG is a feeding tube which passes through the abdominal wall into the stomach so that water, feed and medicines can be given without the need for swallowing. Along with advice from the dietician and speech and language therapist (SALT) team. staff at the service were offering taste spoons or oral food tasters. An oral food taster or taste spoon is where an empty spoon is dipped in custard or yogurt for example; all the excess is allowed to fall off the spoon leaving a very thin covering. This was being offered to the person three or four times a day to allow them to still enjoy the taste of food without the complications. The deputy manager said, "We are trying to think of different tastes to offer instead of custard."

People were complimentary about the food. Comments included, "The food is perfect," and "I get enough food and regular drinks. If I want a sandwich I tell the kitchen and they make me one." And "The food is very good and very good choices."

Relatives said, "We do spot checks and intentionally arrive at meal times to see if [person] is getting their food pureed, which they always do." Another relative said, "The food is well prepared, looks presentable, they get a choice with well-balanced portions." And "[Person's name] has put weight on." Another relative said, "The food is nice, sausage and mash, pork or chicken dinners, pudding and custard. There's always something [person] can eat, Friday is fish and chips, and Sunday they have a buffet tea. Dinner is really nice."

We observed a board in the kitchen which provided details on people's special dietary requirements such as diabetic, pureed or food that needs to be mashed with a fork. This meant the cook was fully aware of each person's dietary needs. The cook said, "We fortify foods and drinks for people who require additional calorific content, these include smoothies made with whipping cream and butter and milk in potatoes." And "We have flash meetings every day and I received information on new admissions and their diet requirements. People have their weight taken on admission then weekly if there are concerns, with full input form the dietician and SALT team."

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 supported living settings are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The manager and staff had an understanding of the MCA and the DoLS application process. At the time of our inspection there were 33 people subject to a DoLS authorisation.

We saw evidence of best interest decision being made for people who required bed rails, lap belts on wheelchairs and medicine administration. We saw the manager had spoken to the person at different times of the day to ensure their understanding was not variable. These attempts at different times of the day were to gauge understanding and demonstrate the person was unable to retain information. A best interest meeting was set up with the person, the care team and family.

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as their doctor, the district nurse, dieticians, speech and language therapist, dentists and opticians. During the inspection we spoke with one visiting external healthcare professional who said, "Staff here are knowledgeable about the residents and the care is very person centred. We all work as a team, if staff have any concerns they will contact me and I will give advice or arrange a visit." One person who used the service said, "The optician and the dentist come here, everything is on hand."

The service had a refurbishment plan in place. New dining furniture and curtains had been ordered for an upstairs dining room. On one of the units upstairs all the walls were painted. There was a painting of a bus riding through the countryside and also poems written along the wall. The deputy said, "We wanted it to be a journey, where they got on the bus and travelled." The manager said, "All our staff received a bonus at Christmas and decided to pool it together to commission an artist to do the paintings." The manager was arranging for the other unit to be decorated to make it more dementia friendly.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and friendly staff. One person said, "You have seen for yourself, the staff are lovely." Another person said, "Nothing is too much trouble, they [staff] say 'we will get it for you.' They [staff] are all caring." And another person said, "I am happy here, they look after you well, they are good."

Relatives spoke positively about the care provided and told us they were made to feel welcome whenever they visited. One relative said, "Staff are brilliant and very caring." Another relative said, "Staff know who my relative is and they are very helpful and friendly."

Staff knew people well and we observed warm, positive and caring interactions between staff and people who used the service. For example, there was friendly chatter amongst people and staff which made the environment appear homely. People shared jokes with staff and staff engaged people in conversation by crouching down to speak to them at eye level. Staff worked together to provide a pleasant atmosphere, speaking to people in a thoughtful and respectful manner and were well aware of their roles and responsibilities.

One staff member said, "The residents are just lovely, it is a pleasure to look after them. They all have their individual needs and a sense of humour."

Staff encouraged people to maintain their independence. One person who used the service said, "If I need anything I ask and they [staff] do it but I do try and manage on my own, I make my own bed." One staff member said, "We always encourage them, [person's name] uses a wheelchair but sometimes likes to get up and walk a little." One relative said, "[Relatives name] manages much better now with dressing than they did at home, they are walking better too."

Staff promoted people's privacy and dignity. One person who used the service said, "Even if my door is open they [staff] still knock on it before they come in." Another person said, "The staff always knock on my door, they don't barge in."

Throughout the inspection we observed staff interacting with people in a kind and caring manner. As staff moved around the service they made an effort to stop and talk with people. Staff clearly knew people well, which meant they could have conversations with people that they enjoyed. One person who used the service said, "They [staff] are all kind, they have got to know me, if I don't go to the dining room they say 'we missed you today.' You can have a laugh with them; I know the staff and the other residents well."

At the time of inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. Information on how people could access an advocate and what an advocate does was on display in the reception.

At the time of inspection no one was on end of life care. However staff had received training on this subject.

We also saw some detailed advanced care plans or an explanation if the person did not want to discuss this subject or they were waiting for family input. One relative said, "[Relative] was on the end of life pathway [approaching end of lie] over a year ago and they are still here, that says something about the care doesn't it."

Good

Is the service responsive?

Our findings

At our last inspection in June 2016 we found that best interest decisions were not recorded in care plan. At this inspection we found that all best interest decisions were recorded with full involvement of the person, the care team and the family.

During our visit we reviewed the care records of six people. Records showed people had their needs assessed before they moved into the service. During this assessment staff checked on people's sleeping patterns, mobility, dietary requirements, communication and what support they needed on a daily basis. A pre admission draft care plan was made up so information was available to all staff before admission. This ensured the service was able to meet the needs of people they were planning to admit to the service and to meet the needs of a person directly on admission.

Once the person came to live at the service an admission assessment took place. At this assessment the person's weight, height, pulse, blood pressure, temperature, preference to male or female care worker, arrangements for services such as hairdressing and how they preferred to sleep for example one or two pillows, duvet or blankets. This meant staff at the service were able to provide care that was to the person's wishes and preferences.

Following the admission assessments a full care plan was developed which centred on the person's needs, wishes and preferences. The care plans were extremely detailed with likes and dislikes, how they liked pillows placed on their bed and dining preferences. For example, one care plan stated, tolerates food better off a teaspoon. We saw when people received drinks in cups of their choice, these were either in china cups, mugs, closed bottles with straws or cups with drinking supports.

One person was very particular about their appearance and liked to be smart with their nails painted. We saw the daily notes and activity records for this person recorded they often were taken to town to have a manicure.

The service had books called 'Remembering together' this was where people or relatives recorded their past history, where they worked, favourite holiday destinations, people important to them and memories. Out of the six care files we looked at only two people had these books in place. We discussed this with the manager who said these books had been sent to the families for them to complete. The manager agreed to chase these up as best as they could.

Care plans were reviewed on a regular basis to ensure they accurately reflected people's current support needs. Reviews took place with the person and family members were invited. Daily notes and handovers were used to ensure staff coming onto shift had the latest information on people in order to provide responsive care. One nurse we spoke with said, "I involve all the relatives in the formulation of care plans and ask if they are happy." Relatives we spoke with confirmed they were involved.

At the front of each care file there was a profile with a photo of the person with date taken, preferred name, a

list of things 'I must have' such as mobility aids, important things to me, what do I enjoy doing each day and how do I tell you if I need help or support. This provided staff with a quick reference and reminder of the person.

Once a month the service had a 'resident of the day.' On this day the person had the care plan evaluated, all staff spent time with the person such as the cook, cleaner and care staff to see if they were happy or if more could be done. Their room was deep cleaned and they were the general focus of the day.

People said they were happy with the activities on offer and had choice of whether to join in or not. One person said, "The activities are quite good, bingo, cake making, puzzles, they are adequate they could do a bit more." One relative said, "My [relative] used to sit in their room all day alone but staff encouraged them to come into the lounge. They now speak to staff and other residents."

On the day of inspection people were invited to a cookery class. We observed that people were encouraged and supported by the activity coordinator and carer's to make biscuits and cakes. People were mixing the cake mixture, using the scales and adding ingredients. The session was well attended with a pleasant atmosphere with staff and people chatting and laughing with each other. People enjoyed reminiscing about how they used to bake at home.

The activity coordinator had also developed a newsletter. The newsletter included historic events that had taken place that month, events and trips that had taken place or were about to take place. The newsletter also included dates for the diary of upcoming meetings and shows and a photo gallery.

The activity coordinator said, "I work with a colleague and we cover the full seven days. We change the activities each week and ask the residents what they want and then they choose whether to attend." And "We provide one to one sessions for people who prefer to stay in their own rooms, such as hand massages, crosswords, crafts and conversations. We aim to get round everyone in the week." The activity coordinator went on to say, "I love it, I think we provide an individual person centred service. We tailor the lifestyle to the individual, we are proud of how person centred we are." We saw evidence of this as one person who loved to draw and there were examples of their work in their room along with drawing books, pens pencils and drawing materials.

There was a clear and comprehensive policy in place for managing complaints. This set out what would constitute a complaint, how it would be investigated and the relevant timeframes for doing so. The service had received two complaints so far this year and we could see this had been fully investigated in line with the provider's policy. The main complaint people had at present was laundry going missing. The manager said they addressing their concerns and looking at extending the hours of ancillary staff. The manager also held a 'manager's surgery' for relatives to come and speak to them between 5pm and 8pm on the last Wednesday of every month. The manager said "No one has come to see me as yet but I am there if needed."

One person who used the service said, "I have no complaints about the staff, I can talk to the staff, the lady in charge is very nice. I see her wandering about, I can go into her room, I have no complaints I don't need to see her." Another person said, "I would go to the lady in charge, she is very efficient."

Good

Is the service well-led?

Our findings

People, relatives and staff felt very much supported by the manager. People said, "The manager is nice and good at her job." And "The manager is pretty good." Relatives we spoke with said, "There has been a remarkable improvement in standards within the care home, [manager] has good management skills and an open door policy."

People and their relatives were very complimentary about the manager. We were told by relatives and staff that the team ethic was very strong and they attributed this to the manager. One staff member said, "Since [manager's name] came the changes are immense, it has improved so much."

People who used the service said they were happy living there. Comments included, "It's ten out of ten." "Its nice living here"And"I can't find fault with it."

All the staff we spoke with said they were really happy working at the service. Comments included, "I love it here," and "It's great, love being here and I love them [pointing at the people who used the service]."

Staff we spoke with said, "I see them [manager] every day, they are always visible on the top floor, if I have any problems I can definitely go and knock on their door." Another staff member said, "The manager is brilliant, the best manager we have ever had, they are really fair with all the staff and easy to talk to."

The manager and the deputy manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the operation of the service. The system was aimed at ensuring they provided people with a good service and met appropriate quality standards and legal obligations. The manager carried out audits, daily, weekly and monthly to check areas such as falls, medicines, care plans and staffing levels.

The manager carried out twice daily walk a rounds at the service where they looked to see if people looked well cared for, if call bells were being answered promptly, general cleanliness and they observed the dining experience. The manager also completed spot checks at random times such as during the night, early morning and weekends. We saw evidence of the daily walk a rounds and spot checks.

We saw the manager interacted well with people. Relatives came into the office throughout the day just for a friendly chat. One relative said, "My [relative] has been in seven homes, they have been here for three years and by far this is the best home they have been in." Another relative said, "If I have to ever go into a home it will be this one, it is great and the manager is great."

Staff we spoke with said there was an open and honest culture with the care home. Staff said, "This is a super home, all the staff are fab and the manager is excellent. I have never worked anywhere where there is no blame culture. If staff are happy people are happy."

The manager spoke very highly of their staff team. They said, "I have a good, caring and competent staff

team. I hope I support them well as I believe happy staff means happy residents."

Feedback was sought from people and their relatives through annual questionnaires. The last survey took place in June 2017. Comments included, "I have never felt so happy or cared for in my life before moving here. Everyone is so happy to help and very kind when I struggle" Another person said "I feel at home and comfortable. I feel respected and listened to," and "I have no complaints, everyone is nice and the food is lovely." Relatives did feel more outings were needed. From the relative's feedback an action plan was developed. To address the concern of lack of outings, the manager had put an extra 17 staff on the mini bus insurance so more outings could be arranged. We saw evidence of outings that had taken place following this.

Meetings had took place for people who used the service and their relatives on a monthly basis. However, these had been moved to every two months due to the lack of response. The newsletters now highlighted when next meetings would take place.

Meetings took place every month for staff as well as daily flash meetings. Topics discussed at the monthly meetings were training, significant incidents, hospital admissions, rotas, the dining experience and documentation. At one meeting staff attitude had been addressed due to some concerns about staff during a recent fire drill. The person in charge of the fire drill did not feel staff were taking it seriously enough. At the daily flash meetings all the people who used the service were discussed such as any changes in the person's needs, how they were feeling and what had taken place so far that day.

The service was trying to build links with the community but due to a lot of rejuvenation in the area this was proving difficult. They had arranged for a local supermarket to do afternoon tea for the people who used the service and a local do it yourself store was planning on supporting the home with their garden.

We asked for a variety of records and documents during our inspection. We found these were well maintained, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.