The Royal Star & Garter Homes

The Royal Star & Garter Homes - Solihull

Inspection report

Tudor Coppice,
Monkspath Hall Road,
Solihull,
B91 3DE.
Tel: 0121 711 6330
Website: www.starandgarter.org

Date of inspection visit: 29 July 2014
Date of publication: 09/12/2014

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. The inspection was unannounced.

The service provides nursing and personal care for up to 60 ex-service men and women. The service was provided to older adults, people with a physical disability, younger people and people with dementia. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

At our previous inspection in October 2013, we found there was a breach in meeting the legal requirements for records. We found that paper and electronic records of care did not always match each other, as the provider had recently changed over to new electronic care records.

During this inspection we found hard copies of the care plans and risk assessments mirrored the electronic records. All the staff we spoke with were confident and competent in using the electronic system and could access computer terminals to update the records immediately after delivering care.

The service had won The Pinder Healthcare Design Award for the design of the building. The home was organised into four wings, which enabled people to belong to a community within a community. Each wing had its own lounge, dining space and kitchenette, so people could be self-sufficient within a familiar, homely space. Larger communal spaces on the ground floor enabled people to experience the feeling of going out safely, surrounded by familiar faces. We saw people used the large communal space to take part in group activities, such as, a form of push-table-tennis in teams, to have a cup of tea with their visitors, to read the newspaper or to watch the world go by.

Everyone we spoke with was very happy with the quality of the service and the care and support they received. People talked enthusiastically about the activities on offer and the thoughtfulness of staff. Visitors we spoke with told us they were very impressed with what they saw and heard. The local authority commissioners encouraged other local providers of social care to visit the service because it was an exemplar of good quality care.

Staff told us they were proud to work at the home and felt part of a team with shared goals. The registered manager was supported by a team of senior nurses, administrators, volunteers and an executive team who shared a common objective of creating a caring, family environment. Everyone we spoke with gave us confidence that the service achieved its objective.

We saw some people in the dementia unit dancing and singing with staff and other people being supported by staff to engage in gardening and cooking activities. All the staff who worked at the home were trained in dementia awareness so they knew how to support people with dementia. The service had recently achieved the highest possible score at a Dementia Care Matters (DCM) assessment. DCM is an organisation that specialises in training focussed on the lived experience of people with dementia. The care plans we looked at were person centred and all the staff we spoke with understood the importance of putting the person at the centre of care planning. We saw care plans were regularly reviewed and staff asked other health professionals for advice and support when people's health needs changed.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS). For people who were assessed as not having capacity, records showed that their families were involved in discussions about who should make decisions in their relation's best interests. No one was under a DoLS at the time of our inspection because no one was deprived of their liberty.

People who lived at the home and staff told us they had confidence in the registered manager, who was supported by a hands-on team of three supernumerary nurses. All the nurses and care staff we spoke with told us there were always senior experienced staff around to guide and support them. There were regular meetings for people who lived at the home which meant their views on the quality of the service were known and understood by the registered manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

The service had a comprehensive set of policies and procedures to ensure people's safety. The provider checked staff's suitability to work at the home and staff understood their responsibilities to keep people safe, without restricting their liberty.

The service had appropriate arrangements for managing people's medicines safely and for preventing and controlling infection.

Staff regularly checked the premises and equipment were clean, safe and suitable for people to use.

Is the service effective?
The service was effective.

Good

Staff received training that was appropriate to people's needs and minimised risks to people's safety and well-being. Specialist training for staff was developed by experts in the field of social care and dementia.

Risks to people's nutrition were minimised because all the staff knew about people's allergies, dietary requirements, likes and dislikes.

The service employed a team of other health specialists to ensure people received the treatment they needed promptly.

The layout, décor and signage in the home enabled people to move around independently and safely.

Is the service caring?
The service was caring.

Outstanding

Staff encouraged and supported people to maintain their independence and enjoy their life at the home according to their preferences.

People and relatives were invited to attend monthly meetings to make their views known about the service. Newsletters on display around the home described the actions taken as a result of people's suggestions.

People were treated with dignity and respect and relatives could visit whenever they wanted to.

Records showed that people were encouraged to make advanced care planning decisions in case they became too poorly to make their wishes known at a later date.

Is the service responsive?
The service was responsive.

Good

Summary of findings

People's care plans were regularly reviewed and updated when their needs changed. People were involved in discussing their treatment options and were supported to maintain and improve their health.

The provider's complaints policy was made known and available to everyone. People were confident any complaints would be listened to and responded to appropriately.

People's needs and wishes were known to other service providers because staff accompanied and supported them when they accessed external health care services.

Is the service well-led?

Good

The service was well led. People's views on the quality of the service were valued and their suggestions were acted on.

The provider's senior management team set the standards for quality by checking the quality of the service every week. The quality assurance system included checks that people were happy with the service, that the premises and equipment were maintained, clean and safe to use and that staff demonstrated appropriate skills and behaviours.

People who lived at the home were supported by a team of people who constantly strived to adopt best practice under the guidance of experts. The registered manager's plans to continuously improve the service included the appointment of lead health care assistants and link nurses for specialist areas of clinical care.

The local authority commissioners assessed the service as exemplary

The service was accredited to relevant nationally recognised schemes which promoted a learning culture.

The Royal Star & Garter Homes - Solihull

Detailed findings

Background to this inspection

The inspection team included two inspectors, a specialist dementia nurse and an expert by experience in dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. We looked at the statutory notifications the manager had sent us and information received from relatives and other agencies involved in people's care. We reviewed information we received from the local authority commissioners and the provider's information return. This is information we asked the provider to send us to explain how they are meeting the requirements of the five key questions: is the service safe, is the service caring, is the service effective, is the service responsive and Is the service well-led?

During our inspection we spoke with nine people who lived at the home and three relatives of people who lived at the home, to find out what it was like to live there. We observed how staff cared for and supported people in the communal areas of the home.

We spoke with the registered manager, six care staff, three nurses, three physiotherapists, the housekeeping supervisor, an activities co-ordinator, maintenance staff, two volunteers and the cook, to find out what it was like to work at the service.

We reviewed five people's care plans, daily records and medicine administration records to see how information about people's care needs was known to staff. We looked at information in the kitchen to find out how the cook knew about people's dietary requirements, allergies, likes and dislikes.

We looked at records the housekeeping supervisor kept to find out about the measures in place to minimise the risks of infection. We looked at records kept by the maintenance staff to find out about the measures in place to ensure the premises and equipment were maintained effectively.

We reviewed three staff files to check staff were recruited, trained and supported to deliver care and support appropriate to each person's needs. We looked at the results of the quality assurance checks to find out how the registered manager minimised risks to people's health and wellbeing.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us they felt safe at the home because of the way they were treated. Relatives told us their relations were well looked after and the staff made them, “Feel wanted.” Relatives said, “The home is always clean and tidy" and “The care given is wonderful.” A volunteer told us, “It’s a really worthwhile place. You get to know them all well.”

The service had effective procedures for ensuring that any concerns were appropriately reported. All the staff who worked at the home received safeguarding training. Care staff told us they would report any concerns to a senior or nurse, because they were confident the concerns would be taken seriously and acted on. None of the people or relatives we spoke with had any concerns about their safety. No referrals had needed to be made to the local authority safeguarding team during the 12 months prior to our inspection and no concerns had been raised by relatives or other agencies.

Care staff we spoke with understood their responsibilities under the Mental Capacity Act 2005. The care plans we looked at included mental capacity assessments. For those people who were assessed as not having capacity, their records named the person who should take decisions in their best interests. Records showed that for people assessed as lacking capacity to sign their consent to care and treatment, an advocate or family representative signed on their behalf.

We saw that people or their representatives had signed their consent to using equipment that kept them safe, but that restricted their freedom. For example, people signed their consent to using a lap belt when using the provider’s transport on trips out. One care plan showed the person was assessed as needing rails at the sides of their bed to prevent them from falling from the bed. Their relative had signed to say they consented to the use of bed rails because, without consent, this action would be considered as a deprivation of liberty. No one was under a Deprivation of Liberty Order (DoLS) at the time of our inspection because no one was deprived of their liberty.

People were safe from the risks associated with care and treatment because they had a plan of care in place that was relevant to their individual risks. People’s needs were assessed before they moved to the home and an initial care plan was written. For example, risks were assessed for people’s mobility, nutrition, skin condition, communication and cognition. When the person arrived at the home, staff spoke with and observed the person to find out whether any further assessments or treatments were needed. A nurse then completed risk assessments based on their conversation and a physical check. One care plan we looked at recorded the person had been assessed by an in-house physiotherapist and referred to the in-house speech and language therapist (SALT) after their initial meeting with the nurse.

We saw there was a high ratio of staff to people who lived at the home. A member of care staff told us, “We are very lucky. There are four care staff and one nurse in the morning and three care staff and one nurse in the afternoon for fifteen people” and “We have time to go to the park with people and we have extra staff for trips and for staff meetings.”

We saw that the nurse and care staff team were complemented by two activities coordinators, a team of volunteers and four supernumerary nurses. We saw the two in house physiotherapists and one assistant physiotherapist treated a physiotherapy session as an opportunity to socialise with people. We saw lots of people smiling and laughing with the physiotherapy staff. This meant staff had time to get to know people well so they would know straight away if a person’s needs or abilities changed.

The registered manager checked staff’s suitability to deliver personal care to people who lived at the home. In the three staff files we looked at we saw records of the checks made before staff were employed. The registered manager obtained two written references, photographic identity documents and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that holds information about criminal records.

The registered manager told us that the recruitment process included a face to face interview, psychometric and written tests. This meant the manager was able recruit staff who displayed the skills and behaviours appropriate to people’s needs.

The volunteers’ co-ordinator explained that the assessment and induction programme for the 50 volunteers was as robust as the programme for staff. Volunteers were subject to checks on their suitability to

Good

Is the service safe?

work with people who lived at the home, taught how to use equipment safely and were allocated a buddy to mentor them before they could be confirmed as ready to support people with activities.

People were safe from the risks associated with medicines because nurses followed the provider's policy and procedures for medicine administration. We saw the locked clinical room, where medicines were kept was tidy and well organised. All the medicines we looked at were within their expiry date. Nurses checked the temperature of the room and the medicine fridges every day, to make sure medicines were kept at the recommended temperatures.

People's medicines administration records (MAR) included their photograph so staff could be confident they administered the right medicines to the right people. The MARs that we looked at were signed by designated staff and were up to date for the prescribed medicines. Staff had accurately recorded if medicines were not administered, so we could tell, for example, when people were temporarily away from home.

A physiotherapist assistant told us they knew what equipment people needed, for example, the type of hoist and size of sling, because it was recorded in their care plan. They said an external health professional assessed and advised on the appropriate sling size and, once the sling was obtained, it was electronically tagged for the person by their room number. This meant that people were supported safely using appropriate equipment.

We spoke with a member of the maintenance staff, who explained their role in minimising risks to people who lived at the home and others. They minimised risks through a planned maintenance programme and equipment servicing agreements. For example, we saw service agreements for the collection of clinical waste, gas safety, electrical and water testing. We saw records of their regular checks of the fire alarm system, hoists, lifts, pressure relieving mattresses and call bells.

The member of maintenance staff told us that fire training was provided to all staff during their induction and regular refresher training throughout their employment. They said the fire evacuation drill was practiced through a series of unannounced tests for day and night staff. We saw records the maintenance staff kept of false fire alarms. They told us about their improvement plan. They told us they planned to analyse the causes of the false alarms to identify whether any preventative action could be taken.

One person told us, "My room is lovely and clean, they do a good job." We observed the premises and equipment were clean and well maintained. We spoke with the housekeeping supervisor who explained the policy and procedures they followed to prevent and control the risks of infection. We saw staff wore aprons and gloves appropriately to protect themselves and others from the risk of infection. We saw the laundry was well organised so that clean and dirty washing was separated. Laundry staff we spoke with explained the process for washing and storing soiled linen separately, to minimise risks of contamination.

We saw copies of the detailed daily and weekly cleaning schedules that housekeeping, laundry staff, nurses and care workers signed when they had completed their designated tasks. The schedules included the frequency of cleaning bathrooms, curtains, carpets and under beds and emptying vacuums, for example. The housekeeping supervisor showed us records of the checks they made of the cleanliness of the home. We saw they recorded any issues of concern and actions taken to improve. For example, when shower chairs showed signs of wear, the supervisor reported to the nurse that new shower chairs should be ordered, to prevent and minimise the risks of infection.

Good

Is the service effective?

Our findings

Care staff we spoke with told us they felt prepared to work after they had completed their induction programme. They told us they received training and shadowed experienced staff until they felt confident to work independently. We saw training was appropriate to staff's role. For example, during induction, staff were trained in falls awareness, and nutrition, delivered by the in-house specialists.

Care staff told us they were encouraged and supported to consider their own personal development. Ninety-five per cent of care staff had achieved nationally recognised qualifications at level two and 50% had achieved a level three in healthcare. Staff told us their recent dementia training from the Dementia Care Matters (DCM) was useful and allowed them to reflect on and improve their practice. One member of care staff said, "It inspired me to think ahead, to plan and master the new techniques."

Nurses were observed annually by senior nurses to check their competence in clinical procedures, such as, catheter care, pressure sore prevention, chronic disease management and dietary interventions. This meant people were supported by staff who were appropriately trained and skilled.

We saw the administrator's records of staff's training dates, which meant they knew when to book staff on refresher training. Care staff told us, "We have annual training in moving and handling, infection control, safeguarding, food hygiene and first aid" and "We get a letter to remind us when it is due." One member of care staff told us, "We learnt about the butterfly programme with Dementia Care Matters. We learnt some techniques and how to, "Follow their journey." We saw a member of care staff using this technique effectively when one person became agitated during the afternoon.

Some people told us they ate in their own rooms because they wanted to. We saw most people went to the dining room for lunch. Everyone we spoke with told us the food was good. Two people said, "I really enjoy the food and there's plenty of it" and "I like the choices and the food is good." A table was set up just outside the dining room with a cloth, cutlery and both meal options, so people had a visual reminder of the menu. All the tables in the dining room had white tablecloths, menus, cutlery laid out, jugs of four different drinks and condiments, for people to help themselves. Vegetables were served in separate dishes which promoted independence and encouraged people to make their own decisions about their nutrition.

Staff took people's orders and served their meal at the table, which meant everyone ate at the same time. For people who were on a soft diet, the individual ingredients were served separately on the plate, which meant the person could savour the individual flavours. The cook told us they knew about people's dietary needs and preferences because the nurses found out at the initial assessment. We saw a board in the kitchen listed people's needs and their choices for the day. The cook told us they planned the menus according to people's suggestions.

At lunch time we saw ten staff sat at different tables giving one-to-one support to people who needed assistance to eat. We saw other people were supported to eat independently by the use of adapted cutlery and lipped plates. The cook knew people's needs for adapted plates, cups and cutlery to enable them to eat independently because the in-house speech and language therapist had told them of their recommendations. The staff providing one-to-one support also encouraged other people to eat and offered alternatives to anyone who was not eating. This meant staff knew who had eaten well and who might be at risk of poor nutrition.

Everyone we spoke with told us they were happy with the health care they received. A relative told us, "The physios are very good at getting [Name] up and about." We saw members of the physiotherapy team championing physical activity, such as team games and armchair exercises, throughout our visit. We saw people responded positively and engaged enthusiastically in one to one and team activities.

People told us they were supported to access additional health services when they needed to. Chiropody services were available free of charge to make sure the service was available to everyone. A dentist and optician visited the service every month.

There was a dedicated physiotherapy suite and in-house physiotherapists, dietician and speech and language therapists. Nurses were encouraged to take a lead role in clinical issues, such as diabetes, tissue viability and stroke care, to help them develop their own area of expertise and to improve the quality of care available to people.

Good

Is the service effective?

Nurses we spoke with told us they were supported by a four full time supernumerary nurses who were always available for advice, guidance and practical support. The registered manager had arranged for a GP to attend at the home twice a week, which ensured any health concerns were addressed promptly. This meant people received treatment when they needed it.

Relatives told us, “It (the service) is very appealing, very spacious here” and “I was very impressed when I came to visit, before (name) came here.” Two volunteers told us, “It’s absolutely wonderful” and “The space here is ideal, it’s a great facility.”

The home was designed to offer people alternative venues and experiences to maintain their interest and promote independence. There were permanent venues and ‘pop-up’ areas, designed to capture people’s attention, to offer an alternative activity, to interest them in a creative activity or to promote memories. Each area was organised or staged to ensure a real life experience that people could inhabit whenever they wanted to. We saw a library, a cinema, hairdresser, gym and pop-up potting shed and Indoor park area, complete with a water feature and bird song.

We saw people were positively affected by their environment, which was designed as four distinct domestic scale units with many different areas. We saw that wherever people chose to spend their time, quietly looking at artefacts designed to stimulate memories, walking around the garden, in the dining area with art and craft work or in their own rooms, there were always care staff, nurses and support staff within sight and sound of people.

Outstanding ☆

Is the service caring?

Our findings

People we spoke with told us the staff were thoughtful and they enjoyed living at the home. One person said, "Good food, good choice, very good choice of activities." Volunteers told us, "It's absolutely wonderful" and "It's extremely rewarding being here." Relatives told us they visited whenever they liked and felt welcome.

We saw staff were attentive and professional in their approach to people and knew them well. Staff helped people to create life history books or memory boards, if they wanted to. People's bedroom doors displayed the insignia of the regiment they had served in which meant staff knew some topics of conversation that would be of interest to the person. For people who were spouses of people who served in a regiment, we saw they had chosen a symbol or picture they liked because it represented how they felt about themselves.

People told us they were involved in discussing their care and treatment plans. We saw people's care plans included their likes, dislikes and preferences. Recognised risk assessment tools were used to assess people's needs and preferences for eating, bathing, dressing and personal grooming. Care plans included the signs of well-being and signs of ill-being so care staff knew when people needed some focussed support. Care staff told us each nurse was a key worker for five people and health care assistants were co-key workers for two people, which meant they knew people well. A member of care staff told us, "It is like a family."

We saw staff engaged with people in a person centred way. Staff smiled a lot, used positive language and ideas to engage people in a way that was centred on the person. Staff described how they engaged with people to maintain their interest in their surroundings, but not to overburden them with information. A member of staff explained the intention was to, "Create a positive moment." A member of care staff in the dementia unit told us, "We dress up in our nightclothes at bedtime to show people that it is bedtime. It makes bed time more visible

In the dementia unit we saw people were actively engaged in domestic activities, such as mixing a pudding. Staff wore brightly coloured tops and belts with pockets. A member of care staff showed us some of the small items they carried around in their pockets to attract people's attention, stimulate memories or offer a sensory experience when people appeared agitated or distressed. Staff handover in the dementia unit was staggered so people were not disorientated by an abrupt change in the faces of staff around them.

In each unit we saw there was a flip over display with photos and a personal profile of all the staff who worked at the home. This meant that people could get to know about the staff and would feel familiar with the many faces they saw in such a busy environment.

We saw people used the communal spaces to meet with their visitors, to have a drink and a conversation and to read the newspapers. The receptionist and administration staff knew people's habits and routines well. They advised us which people liked to spend time in the communal areas and why. The receptionist understood people's need to maintain their routine to preserve their sense of identity.

Most people came to the reception area independently just before lunch was served. We saw some people took part in a pre-lunch activity of push-table tennis. The physiotherapists had adapted the rules of the game to accommodate six people with a pusher instead of bats, so the ball stayed mostly on the table. We saw people were invigorated by this activity by the time lunch was served.

Throughout our visit we saw that people were treated with dignity and respect. Staff knocked on people's doors and called out their names before entering their rooms. All the staff we saw smiled and spoke with people by name. Laundry staff put people's clean clothes away while people ate lunch in the dining room to minimise interruptions to people's privacy. Support staff in the reception area knew people's daily routines and made sure their preferred tables and chairs were available at their usual time.

We found that people were used to their wishes being respected without fear of recrimination. For example, one person we spoke with for a short while was confident enough to tell us they would, "Prefer to read their paper now," rather than continue our conversation.

A nurse told us they used advanced care planning for people who people who were very poorly, so they knew how they would like to be cared for and treated if they became too poorly to communicate their wishes. Advanced care planning included people deciding which treatments they would not like and nominating a person who should

Outstanding ☆

Is the service caring?

make decisions on their behalf in the event they became too ill to make decisions. The registered manager told us they were supported by McMillan nurses and followed the Gold Standard Framework guidelines to deliver end of life care.

Good

Is the service responsive?

Our findings

One person who was on a short term stay told us, “I’m very satisfied with the situation here. I would like to stay longer.” Another person said, “There’s always something going on, I’ve had to tell my family not to call in the morning, as I’m never in my room.”

A list of activities and events were displayed in the lift and in the communal areas on each unit, so everyone knew what was available. There were two activities coordinators and 50 volunteers to support people to engage in whichever activity or event they chose. There were newspapers, books and audio books for people who preferred solitary occupations.

One person told us they had regular contact with their family with the support of staff. They told us sometimes staff took them out on day trips. We saw people were busy and engaged in activities with visitors or in conversations with staff throughout the day.

The provider had a complaints policy which was included in the information pack given to help people to decide if they would like to live there. The policy was included in the welcome pack when people moved in. People told us they had not raised any concerns or complaints about the service. A member of care staff told us, "I have never heard a complaint about the care.”

We saw records of the regular meetings for people who lived at the home. People discussed the food and activities and made suggestions that would improve their experience of living at the home. We saw people’s opinions were listened to and changes implemented in response. For example, people had asked for longer tabards to protect their clothes at meal times and for the lift buttons to be coloured so they would be easier to distinguish. Minutes of the subsequent meetings for catering and maintenance staff showed that the catering team had searched for a supplier for the tabards and the maintenance team planned to investigate the options for coloured lift buttons.

We saw people were encouraged to take control of their own health needs when they were able to. One person who was rolling putty told us, “We have plenty of things to do, this is exercise for our hands and it’s good for us.” Another person told us they felt, “Better” after the physiotherapist had spent time supporting them to exercise their shoulder and stroking their hand. One person told us they had used a wheelchair when they first moved into the home, but, with support from the physiotherapy team, they were now able to walk around independently.

Staff told us people were never transferred to another service, such as into hospital, on their own. Staff told us they always escorted people to make sure they were supported and had someone who knew them well who could speak on their behalf when needed. Transfer documentation was also sent when people were transferred to another service, to ensure the person's medical details were available to the receiving service.

The home was designed to offer people alternative venues and experiences to maintain their interest and promote independence. There were permanent venues and ‘pop-up’ areas, designed to capture people’s attention, to offer an alternative activity, to interest them in a creative activity or to promote memories. Each area was organised or staged to ensure a real life experience that people could inhabit whenever they wanted to. We saw a library, a cinema, hairdresser, gym and pop-up potting shed and indoor park area, complete with a water feature and bird song.

We saw people were positively affected by their environment, which was designed as four distinct domestic scale wings with many different areas. We saw that wherever people chose to spend their time, quietly looking at artefacts designed to stimulate memories, walking around the garden, in the dining area with art and craft work or in their own rooms, there were always care staff, nurses and support staff within sight and sound of people.

Good

Is the service well-led?

Our findings

All the people we spoke with were enthusiastic about the service and told us how happy they were living at the home. One person told us the service was better than they could have expected. Another person told us, “Everything is fantastic.” Relatives we spoke told us they had, “No problems” with the service and “The care given is wonderful.”

The manager told us people were invited to visit the home before they decided whether they would like to live there. They were given an information booklet which explained the philosophy of care, the provider’s policies and how people would be supported to maintain their independence.

Staff told us they knew they were doing a good job because people who lived at the home and relatives told them and they had regular one-to-one supervision meetings with a nurse. Care staff told us they felt part of a team because there was always a nurse on duty for advice and guidance. A team of three supernumerary nurses , the home manager, deputy manager, practise development nurse and lead nurse, supported the nurses on duty.

All the staff we spoke with told us they enjoyed their work. One member of staff told us they were, “Very, very happy here." Two members of staff told us they were proud to work for the service. Care staff said, “I’m so glad I work here. It’s very nice”, “We are lucky because there are so many staff on each wing” and “This is the best home I have worked in.”

Staff told us they liked the manager and had confidence in the management team because they were approachable and listened to their concerns. Staff understood their responsibilities for putting people first. They told us they would not hesitate to whistleblow if their concerns were not taken seriously and acted on.

We attended a shift handover meeting between staff. Staff on the incoming shift were given clear guidance about people’s needs and risks to their health and emotional wellbeing by the outgoing shift staff. An agency nurse told us, “We have handover with the head nurse. We go through person by person. We learn about sore skin, signs of pain, breakfast and medicines” and “I can always know what I need. I never have a problem with finding things out.”

Staff told us everyone was involved in the quality monitoring system. We saw some of the results of the continuous programme of checks and audits undertaken by various members of the staff team. Housekeepers undertook checks of the cleanliness of the premises, maintenance staff undertook regular checks of the fabric of the building, the fire prevention system and specialist equipment. Nurses undertook medicines audits and the cook undertook food hygiene audits. Records of staff meetings, team meetings and unit meetings showed that the results of the audits were discussed with relevant staff and actions agreed to minimise the risks of a reoccurrence.

Minutes of the regular team meetings that we saw, showed that the relevant teams discussed the results of the audits and improvement actions were agreed for any issues that were identified.

People and relatives were invited to attend monthly meetings to make their views known about the quality of the service. Newsletters were sent to relatives and were on display around the home. The newsletters described the actions taken as a result of people’s suggestions, so people knew their opinions were listened to and responded to.

The registered manager told us they had only received one complaint in the previous 12 months and they had resolved that to the complainant’s satisfaction promptly. The local authority commissioners told us no-one had raised any concerns or complaints with them about the service.

The registered manager told us the provider’s senior management team and several external agencies, such as the infection control community nurse, the local authority commissioners and a community pharmacist audited the service. This meant the service was able to measure their performance by externally agreed standards.

The commissioners of services had completed a ‘Service users experience and care planning audit’ earlier in the year and reported they had no concerns. The infection control community nurse had found no issues during their most recent inspection.

The service had achieved the highest level award by the local environmental health agency. Staff told us they were proud that the service had been awarded the highest possible rating from Dementia Care Matters at their recent inspection.

Good

Is the service well-led?

The provider had won the Pinder Healthcare Design award (more than 60 beds category) in 2009 for the design of the home. The service was an accredited member of initiatives in care, such as, Skills for Care, the Dignity in Care and Ladder to the moon. This showed commitment by the provider to learn from the experience and knowledge of others to enable the best possible outcomes for people who used the service and staff.

The registered manager told us there plans to continuously improve the service included lead nurses for specific clinical conditions. The service had lead health care assistants for infection control and dementia and planned to introduce lead nurses for diabetes, tissue viability, and stroke by April 2015. This meant that designated staff would act as champions for best practice in discrete areas of care as part of their personal professional development.