Care Quality Commission

Popular Care Ltd

Wilton House Nursing Home

Inspection report

Wilton Drive
Darlington
County Durham
DL3 9RE

Tel: 01325353701

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05 June 2018

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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

The inspection took place on 23 May and 5 June 2018 and was unannounced. We last inspected the home in April 2016 and awarded the service an overall rating of Good.

At this inspection we found the service remained Good.

This inspection was partly prompted by an incident which had a serious impact on a person using the service. The information shared with CQC about the incident indicated potential concerns about the management of risk. Specifically, the risk associated with nutritional needs. We reviewed the systems, policies and procedures put in place by the provider following the incident to check if these were effective in managing risk.

Wilton House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 37 people across two floors. At the time of the inspection 30 people were being supported in the home, 18 of which required nursing care.

The service had a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Risks to people with nutritional needs were assessed regularly with associated care plans to provide support and guidance for staff to follow. People who required specialist diets were provided with the correct consistency meals. Policies and procedures supported this.

Risks to people and the environment were assessed and plans put in place to mitigate against them. The provider had a business continuity plan in place for staff guidance in case of an emergency. People had Personal Emergency Evacuation Plans (PEEPS) in place which were updated regularly providing support and guidance for staff in case of an evacuation situation.

Staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Where lessons could be learnt from safeguarding concerns these were used to improve the service. Accidents and incidents were recorded and monitored as part of the provider's audit process.

Care plans were personalised to include people's likes, dislikes and preferences. Care plans were reviewed on a regular basis and updated when changes in need were identified.

The provider ensured appropriate health and safety checks were completed. We found up to date certificates were in place which reflected fire inspections, gas safety checks and portable appliance tests (PAT) had taken place.

Staff received regular supervision and an annual appraisal. Opportunities were available for staff to discuss performance and development. Staff mandatory training was up to date. Nurse's training for specialised techniques were not easily located in staff records. The registered manager addressed this issue at the time of the inspection. We found additional refresher training and competency checks for nurses had been organised.

Recruitment processes were in place with all necessary checks completed before staff commenced employment. Staff received an induction on commencement of their employment. The provider used a dependency tool to ensure staff levels met the needs of the people living in Wilton House.

People's nutritional needs were assessed and we observed people enjoying a varied diet, with choices offered and alternatives available. Staff supported people with eating and drinking in a safe, dignified and respectful manner. People were supported to maintain good health and had access to healthcare professionals when necessary and were supported with health and well-being appointments.

People and relatives felt the service was caring. Staff provided support in a respectful manner ensuring people's privacy and dignity was promoted. Where possible people were supported to be as independent as possible.

People enjoyed a range of activities both inside and outside the home. The service had positive links with the community with people accessing the theatre, local centres and shops.

The provider had a complaints process in place which was accessible to people and relatives.

Staff were extremely positive about the registered manager. They confirmed they felt supported and could raise concerns. We observed the registered manager was visible in the service and found people interacted with them in an open manner. People and relatives felt the management approach in the home was positive.

The provider worked closely with outside agencies and other stakeholders such as commissioners and social workers.

The premises were well suited to people's needs, with ample dining and communal spaces. Bedrooms were personalised to people's individual taste. Bathrooms were designed to incorporate needs of the people living at the home. The garden area was accessible to people.

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.

The provider had policies and procedures in place to keep people safe in relation to nutritional needs and specialist diets.

Clear and up to date information was provided to kitchen staff for people who required their meals to be of a specific consistency.

People who were at risk of choking had risk assessments in place which were reviewed regularly. Risk assessments contained control measures for staff support and guidance to reduce the risk.

Staff understood the definition of abuse and how to report

concerns. The provider had systems and processes in place to learn from safeguarding incident

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Care Quality Commission

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

The inspection was prompted in part by notification of an incident which had a serious impact on a person using the service. The information shared with CQC about the incident indicated potential concerns about the management of risk.

The first day of this inspection took place on 23 May 2018 and was unannounced. This meant the provider did not know we were coming. We also visited the home on 5 June 2018 also unannounced to finalise our inspection.

The first day of the inspection was carried out by two adult social care inspectors, along with a specialist advisor who was a Speech and Language Specialist with the NHS (National Health Service). The second day of the inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with seven people who lived at Wilton House Nursing Home. We spoke with the operations manager, registered manager, deputy manager, three care workers, kitchen staff including both chefs and the activity coordinator. We also spoke with two visitors and four relatives of people who used the service. We also spoke with one visiting health care professional.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of seven people, medicine administration records of ten people, recruitment records of two staff, training records and records in relation to the management of the service.

Good

Is the service safe?

Our findings

Information had been shared with CQC about an incident which indicated potential concerns about the management of risks to people who were assessed as having nutritional needs and requiring specialised diets.

As part of this inspection we reviewed the systems, policies and procedures in relation to nutritional assessments and diet notifications for staff to check if these were effective in managing risk. We looked at the care records of three people who were assessed as being at risk in relation to nutritional needs. Each file we reviewed had a choking risk assessment and a dietary needs care plan in place. Speech & Language Therapist (SALT) report sheets were available. We found information from the SALT report matched the advice provided in each person's care plan and diet notification sheet.

A SALT is a specialist therapist who carries out assessments on a person's swallowing reflex thereby supporting people to reduce the risk of choking by providing guidelines for food and drink consistency. For example, a SALT may recommend a pureed diet or that fluids need to be thickened to reduce the risk of choking.

Copies of dietary care plans and risk assessments were kept in the kitchen. We spoke to the chef about these and when asked, the chef accessed them easily and in discussion demonstrated a good knowledge of people with specific dietary requirements.

The provider had updated their policy and procedures for meeting the needs of people who have nutritional needs. We found the policy was not specific in terms of identifying who was responsible for ensuring that each person was provided with the correct textured food, such as pureed meals. The policy stated, "all staff" were responsible. We discussed this with the registered manager who provided a flow-chart which identified that the chef was responsible for this area.

Following our discussion, the registered manager acted to ensure that the flow-chart was attached to the policy. Following the inspection, we received confirmation that all staff had been issued with the updated policy and flow-chart and a record of every staff member acknowledging that they had read the document was in place. This meant the provider had assured themselves that staff had the information required to provide safe care in relation to supporting people needing specialised diets.

On the second day of the inspection we spoke with the chef who told us they were aware of their responsibilities regarding meal preparation. They told us, "Yes. It is much clearer now, the menu sheet is written in red which stands out more, the staff also check the meal is right as well. The kitchen gets a menu sheet when someone new comes so we know what they need."

We spoke to staff to ensure they had knowledge and information to keep people safe. Staff told us they were aware of people's risk assessments regarding swallowing and knew where to find the information. Staff demonstrated knowledge of the signs and symptoms of choking and aspiration and were clear about

reporting any of these signs immediately to the nurse in charge or registered manager and documenting concerns on the handover sheet.

We found the tea trolley had a laminated sheet attached which contained information for staff on who required thickened fluids and specialised diets. This meant that staff had quick access to information when serving drinks and snacks to keep people safe.

Where people were assessed as being at risk in other areas of their care and support needs, we found appropriate risk assessments were in place. Such as, moving and assisting and skin integrity risk assessments. These were reviewed regularly and contained a clear level of detail for staff to provide control measures to reduce the risk.

People and relatives told us they felt the care they received in Wilton House Nursing Home was safe. One person told us, "Oh heck yes, as safe as I can be." Another told us, "Everyone is looked after we are all safe." One relative told us, "If you need someone [staff] it doesn't take long to find someone." And "staff are always so busy but they've still got time for him. We're quite happy."

We checked the provider's recruitment process. Staff files contained application forms, checks in employment gaps, interview documents and identity checks. New employees had also received clearance from the Disclosure and Barring Service (DBS) that they were able to work with vulnerable adults and that they could do so without restriction. The provider checked nurse's personal identification numbers (PIN) as part of the recruitment process to ensure they were up to date. A PIN is given to nurses to demonstrate they are registered with the Nursing and Midwifery Council and are fit to practice in the role of 'Nurse'.

The service had a range of policies and procedures about keeping people safe, such as safeguarding and whistleblowing policies. The registered manager kept a log of all safeguarding incidents. We saw that appropriate action had been taken following safeguarding incidents. Investigation records were also in place with outcomes and where lessons learnt or changes to policy were required these had been addressed to prevent a reoccurrence. The provider used the local authority's policy and procedures in reporting concerns by completing consideration logs to the local safeguarding team as well as submitting the required notifications to the CQC.

Staff had received training in safeguarding which was refreshed on a regular basis. One staff member told us, "Yes, safeguarding training is done on line." Staff we spoke with understood the importance of reporting any concerns they may have and told us they felt the registered manager would take their concerns seriously. One staff member told us, "I would speak to the manager or person in charge." Staff knew the signs to look out for such someone becoming withdrawn or unexplained bruising. Team meetings and supervisions were used to discuss safeguarding outcomes and to look at any lessons that could be learnt from incidents.

We found medicines were managed in a safe manner. Medicine administration records (MAR) were completed with no gaps or anomalies. Temperatures of the medicine room and refrigerator used to store medicines which needed to be kept at below a certain temperature were recorded daily. People told us they received their medicines when they needed them. One person said, "If I have a pain then I just ask [name], they are very good like that." One relative told us, "[name] gets medicines when needed, very regular."

Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls and kitchen safety. These were reviewed on a regular basis and were accessible for staff support and guidance. Regular audits were completed to cover areas of health and safety such as infection

control, kitchen checks and emergency evacuation procedures.

The registered manager completed a dependency review of people's needs to ensure the staffing levels in the home were at a safe level. The staffing rotas we examined were appropriate to the needs of the service. We found staff were visible in the home and call bells were answered in a timely manner. No concerns were raised by the people, relatives and staff we spoke with.

We found up to date records to demonstrate the provider ensured the maintenance of equipment used by people and in the service, was checked on a regular basis. Certificates were in place to reflect gas safety checks, portable appliance checks, and mobile hoist and sling checks.

A business continuity plan was in place to ensure staff had information and guidance in case of an emergency. People had personal emergency evacuation plans in place that were available to staff.

We observed the housekeeping staff kept the home clean and tidy with scheduled cleaning plans in place. There were no odours and all furniture and furnishings were of a good standard. Infection control policies and procedures were in place. Staff received infection control training and had access to a supply of personal protective equipment.

Good

Is the service effective?

Our findings

Care records demonstrated how a person's physical, mental and social needs were assessed on admission to the home and then on a regular basis. Care records contained information which considered current legislation and national guidance when planning outcomes. For example, nutritional guidance from the NHS regarding nutrition was used in developing eating and drinking care plans with an outcome of providing a nutritionally safe diet.

We reviewed how people were supported with their nutritional needs. People were offered a healthy, varied diet. Observation at lunchtime provided good evidence that the staff were skilled in terms of their approach to supporting the nutritional needs of people. We found appropriately modified textures were provided for each person requiring specialised diets. Meals left the kitchen one at a time and it was clearly communicated to the carers who each meal was intended for.

Clear and sensitive communication was observed both in terms of establishing good rapport with the people and in terms of maintaining the maximum level of awareness in people who needed full support with eating (i.e. explaining when another spoonful was being offered, reminding patient to chew or swallow). Staff were aware of the need to wait for the person to swallow/clear their mouth before more food was given.

People and relatives, we spoke with felt staff were appropriately trained. One person told us, "They do know what to do when I am not well, getting the doctor or the nurse." One relative told us, "I think they are, we have no worries in that respect." Another relative said, "Yes, staff can always answer the questions." and "He likes the food. He has to have soft food because he chokes, they take good care of that. If they bring biscuits they bring him an alternative."

We spoke with a staff member who had not worked in care prior to working at Wilton House, they told us that they had received an induction into their role that included care practices training, observations and shadowing other staff as well as completing mandatory training. We checked staff files and found that inductions were in-line with good practice guidance and staff completed the Care Certificate, a recognised standard for staff beginning to work in a care setting.

Staff had received training in mandatory areas such as personal care, moving and handling, fire safety, health and safety. This was monitored on a training matrix which was colour coded to show when training renewals were required. We saw that training was planned throughout the year to ensure staff knowledge was current. Staff told us they felt the training enabled them to meet people's needs. The provider had maintained their compliance with NHS's Focus on Undernutrition initiative (FoU). FoU is a course developed by NHS dieticians to enable staff to increase their knowledge and understanding of how to identify and treat undernutrition in older adults.

We found that the training matrix did not detail what specialised techniques nurses had received recent training in. We looked at nurses training files and found that it difficult to establish what training had been

completed and when. We spoke with one nurse, they told us, "Yes, I have the skills I need. If not, I'd say if I wasn't happy or competent doing something." They confirmed they had received training in the past for the needs of the people currently in the home, such as percutaneous endoscopic gastrostomy (PEG), diabetes and Parkinson's disease. A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate. We found catheter training had recently been completed.

We spoke with the registered manager about training for nurses. They told us that a new training manager had been appointed to cover all the provider's registered locations. We found a meeting was due to take place the week of the inspection to discuss this role and additional competency checks that would be implemented for nurses. On the second day of the inspection we found the registered manager had sourced and booked additional training as a refresher for nurses.

Staff had access to regular supervision and an annual appraisal. These were detailed meetings that discussed staff performance, training and development and gave staff an opportunity to comment on ways to improve practices in the home. We saw that learning and good practice was shared at these meetings. One staff member told us, "I had supervision last month, I seem to be always having them. I've said a few things and action has been taken." And "We get asked if we are happy with things and told things that are going to happen." The deputy manager said, "I have supervision every other month. I supervise the nurses and some of the care staff. It's all up to date."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated a good knowledge of the rationale for DoLS. We found details of MCA assessments and the decision-making process with people being fully involved. This was reflected in care plans with a clear rationale for action set out to inform both the person and staff. Staff understood the importance of supporting people to make as many of their own decisions as possible. We observed staff supporting people to make decisions regarding whether they wanted to join in activities and what they wanted for lunch.

People told us they had access to health care professionals when they needed them. One person told us, "I get to see the doctor if I am not well." Care files contained records to identify when professionals had been requested by the home. For example, referrals to community nurses, chiropody and GP's. The registered manager told us, "We have links with the diabetic nurses as well as dieticians and occupational therapists."

People had access to communal areas. We found lots of space for activities and for people to spend time together with relatives and friends. Photographs showing people involved in various recreational activities were also on display. The home had a welcoming atmosphere. One person told us, "I like my room, it's just how I want it." They showed us their own room and we found this to be personalised and decorated to their taste.

En-suite rooms were available with hand basins and toilets which were easily accessible for people.

Specially designed baths were available for those who required support to access the bath along with spacious wet rooms. Facilities were large enough to accommodate wheelchairs and other mobility equipment. Signage was in place for orientation.

Good

Is the service caring?

Our findings

People and relatives we spoke with felt the service was caring. One person told us, "I think we are well looked after". Another said, "The care is excellent, she is a smashing lady [pointing to a member of staff], we are all friends together". A third person told us, "The staff are really nice and kind, I couldn't be anywhere better." One relative told us, "Everyone [staff] has had a lovely rapport with people, it's wonderful. Staff do care". Another relative said, "[Name] is really well cared for here."

We found several cards and compliments had been made about the home and staff. Comments included, "[Staff member] is so lovely to everyone", "Thank you to the team, so kind and caring" and "Abundant kindness, care and concern, you can be proud of them [staff], blessed that [name] received excellent care."

We observed genuine relationships between people and staff. There was lots of laughter in the home and people reacted in a positive manner with staff smiling and chatting together. It was clear staff knew people well and understood gestures, body language and facial expressions. One person raised their hand during breakfast and a member of staff immediately went over asking if they wanted a drink. During coffee time one person needed support with their cup. This was done in an unobtrusive manner, enabling the person to maintain their dignity.

During the inspection we saw staff knocked on people's doors before being invited in. We noticed one person did not answer when staff knocked on the door. The staff member slowly opened the door saying, "Am I ok to come in [name]?" Staff ensured doors were closed when they were supporting people with personal care. People were asked if they wished to go to their room when visitors arrived for privacy.

We joined people in the dining room at breakfast time and lunch. We observed staff treating people with dignity. People were asked if they wanted to wear protection for their clothes before being served their meals. We observed staff demonstrating respect for people by asking what they preferred for breakfast and lunch, offering choices and alternatives. Staff supported people to eat and drink in a safe manner and to be as independent as possible. We saw staff ensured people who required specialised cups and adapted cutlery had these readily available. Meals were not rushed, people were given time to eat their meal at a pace of their choosing.

We found independence was promoted by staff in a range of ways. One person liked their clothes set out in an outfit so it was easy for them to get dressed, this was recorded in their care plan. Staff told us they supported people to be independent. One staff member told us, "I give them the face cloth and ask if they want to wash themselves". A relative told us, "They always get [name] to try for themselves."

Staff were aware of people's communicative needs and could meaningfully engage with people. We saw one person used non-verbal behavioural indicators such as facial expressions and gestures. Staff responded appropriately with a gentle stroke of the arm. Staff told us they had taken time to get to know the people they supported by reading care records and spending quality time with them.

Information regarding advocacy services was available to people, relatives and visitors. Advocates help to ensure that people's views and preferences are heard.

Good

Is the service responsive?

Our findings

Staff understood how to deliver person centred care. Person centred care is care that is centred on the person's own needs, preferences and wishes. We looked at seven people's care plans and assessments and saw these were comprehensive and included people's likes, dislikes and preferences. Care plans included information on people's histories, what things they still enjoyed doing, noted the special routines that were significant to people and how people like to be addressed.

The care plans detailed information on how a person wished to be cared for. They covered all the needs that we saw people were assessed as having including area their; communication, relationships, emotional, social and spiritual needs.

For three of the seven people's records we focused on care plans in relation to nutritional needs. We found advice provided by the SALT had been used in the persons' care plans. These had been updated or amended accordingly and dates on the plans evidenced that this happened immediately (same day) following each assessment.

Records showed that people were at the centre of their care and decision were made with them. Staff had worked in partnership with the individual, their relatives and professionals involved in their care to develop a support plan outlining how people needed and wanted to be supported.

Where a person had been recommended to have a modified diet following SALT assessment but had chosen not to follow this advice, Quality of Life decisions had been taken. This was evidenced in the care file in terms of input from the SALT, GP, the person themselves and relevant family members. The care file included information indicating that the risks had been explained to the person and they had understood. Guidance for staff regarding what to do if food was requested that was not advised by the SALT was recorded in the care plan and on the handover sheet (i.e. speak to nurse in charge before proceeding).

We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. We saw that staff were trained in how to offer people the support they needed at the end of their lives. Relatives told us the end of life care provided by the service was wonderful. One relative told us, "We have seen love, care, dignity and respect shown to us and [name] by everyone. The care is everything we had hoped for." And "We are welcome at any time, we've had meals, drinks, such good care from everyone. "Another relative said, "We have had 101% care, any problem has been resolved when I have spoken to [registered manager]. It couldn't be any better."

The home had received several positives comments from relatives whose loved ones had passed away in Wilton House. For example, "Abundant care, kindness, care and concern", and "Blessed that [name] received such excellent care".

We saw that people had access to stimulating and varied activities. We spoke with one of the two activities

co-ordinator who worked in the home who told us that they spent time with people on a one to one basis and planned activities inside and outside the home, which were flexible to meet the interests of the people who wanted to join in activities each day. The activities co-ordinator told us, "I try to think of new things to keep people motivated, there is a singer this afternoon." They also said, "Some people like to go for a walk and on Friday we are going to the theatre." We saw that some people liked gardening and had grown fruit and vegetables that had then been used in the home. The activities co-ordinator also told us, "I like the fact that I can bring in new ideas and I'm not told I can't do that, I'm given free rein."

We observed people and staff sitting together and playing board games and later in the day some people enjoying listening to the singer. A relative told us, "[Person] is involved more, goes to the entertainment. There is a singer on this afternoon. He goes to quizzes, exercises, sits with people he likes, someone comes in and plays the organ, someone takes him for walks and he likes that. They took him to the railway station, he used to work on the railways"

People in the home had links to the local community; local faith groups came into the home to hold services, local school children visited the home at Christmas and people who used the service also had the opportunity to visit the school and the home held a bi-annual fair where people were invited to spend time at the home.

There was a clear policy in place for managing complaints. We saw that complaints received had been fully investigated, an outcome shared with the complainant and their satisfaction checked. One relative who had made a complaint told us that they were "definitely" happy with the way it had been addressed. They had some concerns about their relative's health, they spoke with the registered manager, who arranged for some test to be done and medicines prescribed. They told us, "They've picked up since then." We saw where possible learning from concerns and complaints had been cascaded to staff through staff meeting and supervisions.

Good

Is the service well-led?

Our findings

People and relatives were happy with the manner the service was managed. One person told us, "She is lovely and on the ball, we see her every day." Another said, "Never a day goes by when I don't have a chat or a joke, she is really good at her job." A third told us, "She' a lovely person, always ready to listen." One relative told us, "[Registered manager] is absolutely fantastic, she moved heaven and earth to help." Another told us, "[Registered manager] is very helpful…anything I need to know she tells me." A third said, "Pleasant, cheerful…. a really good. manager".

One health care professional told us, "[Registered manager] is always helpful, very sociable and good at communicating." And "The home is well-organised. They know when to get in touch and when to wait for the round, it's a good balance."

Staff felt the registered manager was open and approachable. One staff member told us, "[Registered manager is for the residents, she's the best we've had. You can go to her with any worries". Another said, "The deputy manager told us, "Staff are very happy here. There is an open-door policy. They can go to the registered manager or me."

We found the provider had a quality assurance system in place. The registered manager and deputy manager completed several audits on a regular basis to cover areas such as care plans, health and safety and infection control.

We spoke to the registered manager regarding care plan audits as we found bedrail assessments had not always been signed. This was addressed by the registered manager who advised documents would be reviewed and signatures obtained as soon as possible.

The registered manager also provided a weekly report to the operations manager which included information such as, amount of accident and incidents and any weight loss. If any trends of themes were identified, plans were in place to reduce risk. The operations manager used this information to inform the monthly monitoring visit they carried out. This meant the operations manager had an oversight of the service.

The registered manager met regularly with the operations manager as well as attending manager meetings with other registered managers from sister homes. This support enabled the sharing of best practice and gave a platform to discuss issues and concerns collectively. The registered manager told us, "I have good support from [operations manager], I know I can speak with her at any time".

We found head office disseminated best practice to the home. The registered manager gave an example of new measuring scoops provided by the manufacture of a prescribed thickening agent which were to be used when preparing thickened fluids to ensure the fluid was at the correct consistency. Each staff member on duty had been made aware by the registered manager and information was readily available in the office.

We spoke with the operations manager who was visiting the home. They advised the learning from the recent incident had been used in developing policies and processes in relation to people's nutritional needs and meal preparation in Wilton House Nursing Home. The learning had also been shared with other homes in the provider's portfolio. This meant the provider was proactive in driving improvement. The registered manager told us, "We learn every day and look at our practices in a different way."

We found minutes of regular meetings held with people and relatives. These were recorded and made available for those who could not attend. The registered manager was reviewing the timing of the meetings with relatives to be more inclusive, for example holding them at different times of the day and evening.

The provider had implemented an 'Employee of the month – Golden ticket' award. People, relative and staff are encouraged to nominate a staff member they feel has gone over and above in their role. A gift voucher and thank you letter are given to the winner. This meant the provider valued staff by recognising their work in the home.

The provider worked with the wider community in supporting people's health and wellbeing. We saw interaction between the home and local schools, churches and community groups. Regular contact was maintained with social workers and commissioners as part of partnership working.

The registered manager ensured notifications were submitted to CQC in a timely manner.