Colville Care Limited

Kite Hill Nursing Home

Inspection report

Kite Hill
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 23 February 2016 and was unannounced. The home provides accommodation for up to 30 older people with nursing care needs. There were 27 people living at the home when we visited. All areas of the home were accessible via lifts and there was a lounge dining room and accessible outdoor space. All bedrooms were for single occupancy and had en-suite facilities.

There was a registered manager in place. 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.

People and relatives were positive about the service they received. They praised the staff and care provided. People felt safe at the home. Care staff knew how to prevent, identify and report abuse.

Staff followed legislation designed to protect people's rights and freedom to help make sure decisions were only taken in the best interests of people, although this was not always documented.

People received personalised care from staff who understood their needs and they were supported to make choices. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. Individual risks to people were managed effectively.

People had access to healthcare services and were referred to doctors and specialists when needed. Reviews of care involving people or relatives (where people lacked capacity) were conducted regularly. Staff recognised that people's needs varied from day to day and responded effectively. The provider had identified a need to increase activities staff and was recruiting to these posts.

Suitable arrangements were in place for managing medicines administered by nurses. Although However, self-administration procedures were not sufficiently robust.

People were also positive about meals and the support they received to ensure they had a nutritious diet.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely. There was an environment maintenance and improvement program in progress.

The provider had identified a need for additional staff at busy times of the day due to an increase in people's needs; they were taking action to provide this. Safe recruitment practices were followed. Staff provided effective care; they were suitably trained and appropriately supported in their role.

Staff treated people with kindness and compassion and formed caring relationships with them and their

relatives. Staff protected people's privacy, promoted their independence and involved them in planning the care and support they received.

People liked living at the home and felt it was run well. There was a clear management structure in place. Staff understood their roles, were happy in their work and worked well as a team.

There was an open and transparent culture. The provider encouraged staff feedback and visitors were welcomed. Complaints, when received, were investigated and responded to. Quality assurance processes were in place to assess key aspects of the service. Where these had identified a need for improvement action had or was being taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was usually safe.

Systems were in place to ensure medicines were managed safely when administered by the nurses. However, self-administration procedures were not sufficiently robust. Individual and environmental risks were managed appropriately.

People felt safe. Staff knew how to identify and report abuse and were aware of how to respond in an emergency situation.

There were enough staff to meet people's needs. The process used to recruit staff was robust and helped ensure staff were suitable for their role.

Is the service effective?

Good

The service was effective.

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people although this was not always recorded.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision and staff meetings.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs. They had access to healthcare services when needed.

The environment was safe and adaptations had been made to ensure it was suitable for people.

Is the service caring?

Good

The service was caring.

People were cared for with kindness, treated with consideration and were positive about the way staff treated them. Staff understood people's needs and knew their preferences which were met. At the end of their life people received appropriate

care to have a comfortable, dignified and pain free death.

People (and their families where appropriate) were involved in assessing and planning the care and support they received.

People's privacy was protected and confidential information was kept securely.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

Staff were responsive to people's needs. People were supported to make choices and retain their independence.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The management team was approachable. People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the registered manager and provider's representative with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

Kite Hill 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 the 23 February 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of older people.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the registered manager completed 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.

We spoke with eight people living at the home and four family members. We also met other people who were unable to comment on the service. We spoke with the provider's representative, ten care and nursing staff, the administration staff member, two catering staff members, maintenance staff and two housekeeping staff. We also spoke with two health and social care professionals who had regular involvement with the home. We looked at care plans and associated records for five people, staff duty records, staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records. We observed a staff handover meeting and care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected in November 2013, when we did not identify any concerns.

Requires Improvement

Is the service safe?

Our findings

We found one person had been self-administering their medicines as they had done at home prior to admission for a respite stay. There was no risk assessment or monitoring of the person's ability to safely self-administer their medicines. Staff had also failed to monitor the medicines in the person's possession or how they were taking these. Shortly before the inspection staff had taken over managing the person's medicines. A check of their medicines showed significant discrepancies between the stock held and the amount received into the home and those which staff had ticked on the medication administration records (MAR) to show the person had taken. Included with the person's medicines was a box of tablets which should have been used by April 2015. These had not been identified on admission. The failure to assess and monitor the person's continuing ability to manage their own medicines or check medicines brought into the home placed the person at risk of not receiving their medicines as prescribed.

Following the advice of the GP, two people were receiving their tablets crushed and mixed with a small amount of food to aid swallowing. The advice of the pharmacist had not been sought to ensure it was appropriate to crush these medicines. Shortly after the inspection we received information from the provider telling us the pharmacist had been contacted to confirm it was safe to administer these medicines in this way.

All other people were supported to receive their medicines safely. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. A medicines audit had been completed in September 2015. The format of the audit was comprehensive and covered all areas of medicines management and found the systems in place were safe.

Medicines were administered by qualified nurses only. Nurses were aware of how and when to administer medicines to be given on an 'as required' (PRN) basis for pain or to relieve anxiety or agitation. Where people had been prescribed PRN medicines, they had a PRN plan which explained when the medicine should be given. A relative said "When I was visiting last week [my relative] said they had back ache. I spoke with the nurse who checked the charts and gave [my relative] some paracetamol". Where people were not able to state they were in pain, a recognised pain assessment tool was in use. This was used to assess and evidence why PRN pain medicine was given, or not, on each occasion. We observed nurses administered medicines competently; they explained what the medicines were for and did not hurry people. There were suitable systems in place to ensure other prescribed medicines such as nutritional supplements and topical creams, were provided to people. Care staff were aware of which routine topical creams should be applied for each person.

We received mixed views about the staffing levels. People said they felt the service needed more staff, especially at certain times of the day. One person said, "Most times [the staff] come as quick as they can". When asked if there were enough staff, the person replied, "No, I don't think, no, I think they could do with more. It's busy in the mornings and a lull in the day, but it gets busy at bedtime. The call bells get answered as quickly as they can". Some staff members felt the service needed a few more staff members to allow them to spend time talking to people. One staff member said, "Not enough staff at the moment due to the high

dependency of residents, they are all 'double-ups' apart from two residents. We could do with extra staff on each floor". The provider told us they were employing new staff members who will provide additional support at the busy times such as mornings and meal times. They had recognised a need for more staff at these times. The provider's representative said that they were not going to admit new people unless they were sure there were enough staff to meet everyone's needs. Absence and sickness were covered by permanent staff working additional hours or the very occasional use of agency staff. This meant people were cared for by staff who knew them and understood their needs.

Although busy, we observed that staff responded to people's needs promptly. As soon as anyone required support there was a staff member available. A relative told us "They always answer the call bell quickly". Staff were allocated to different parts of the home meaning they were usually close by people when they required assistance. Systems were in place to enable staff to be informed promptly when people required them.

Without exception, everyone we spoke with said they felt safe at Kite Hill Nursing Home. One person said, "I feel safe". Another person said "I feel safe; all the carers are lovely they really look after me". Relatives and visitors also reported that they felt the service was safe. One said "All the staff are very nice". Another told us "Yes, I think [my relative] is very safe; the staff are lovely and when they can they sit and talk with [my relative]". Visiting health professionals had no concerns about people's safety.

Staff were able to say how they kept people safe. For example, one staff member said, "We use equipment like slide sheets if necessary. We also use pressure mats for people who are at risk of falls". Staff had received training in safeguarding adults, knew how to identify and report abuse and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member told us, "I'd report it to head matron or head of care or go to you guys [CQC] or safeguarding". Another staff member said, "I have been going through my safeguarding training and am due my refresher. I know to be vigilant and ensure things are done properly. If they aren't then I'll report it to the nurse in charge".

There were appropriate policies in place to protect people from abuse. The registered manager and provider's representatives followed local safeguarding processes and responded appropriately to any allegation of abuse. The provider's representative described the action they had taken when a staff member had raised concerns about another staff member. The action taken had ensured the safety of people during the investigation and ensured relevant external organisations were informed.

Risks were managed safely and supported people to be as independent as possible. For example, with the supervision of the nurses a person was able to continue checking their own blood sugar levels and injecting their own insulin. Where risks were identified action was taken to reduce the risk. For example, people who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, according to the person's weight. Where people needed to be assisted to change position to reduce the risk of pressure injury, their care records confirmed this was done regularly. One relative said "My relative always looks comfortable; I know [staff] turn them every few hours". Moving and handling assessments clearly set out the way to move each person and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed equipment, such as hoists and standing aids being used in accordance with best practice guidance. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, use of bed rails, nutrition, moving and handling, and

developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm.

Environmental risks were assessed and managed appropriately. Records showed essential checks on the environment such as fire detection, gas, electricity and equipment such as hoists were regularly serviced and safe for use. A system was also in place to capture details of all accidents and incidents in the home, so any patterns could be identified and action taken to reduce the level of risk.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. Recruitment files contained evidence that all necessary pre-employment checks had been completed. Staff confirmed the recruitment process had been thorough and they had had to provide evidence of their identity and undertake a police background check before commencing employment at the home.

Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and fighting equipment was regularly checked. A staff member said, "Every Friday there is a fire test and the fire doors are checked". Staff were also aware of how to respond to other emergencies. Nursing staff described how they would respond to a medical emergency and were aware of the correct action they should take.

Good

Is the service effective?

Our findings

Where people could consent and agree to care this was sought prior to care being provided. One person said "if I want to go out in the garden I can". Another person said they could choose when to receive care. One relative said "[Care staff] always offer [my relative] a choice and they listen to them, if they say they don't want something then they are not made to do it". Another relative gave an example of how staff respected their relatives wishes; they said "They ask, if [my relative] says not they will try again later". Before providing care, we observed staff sought consent from people using simple questions and gave them time to respond. One staff member said "If a person says that they don't want care I will ask again and then leave them. I will then go back later or get another staff member to ask them". We observed staff doing this throughout the inspection.

Some people living at the home had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of alert mats to monitor their movements. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what is in the person's 'best interests'.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Best interest risk assessments were seen in care files in respect of some aspects of care people required such as bed rails and pressure relieving mattresses. We identified an instance when staff had provided personal care to a person although the person was not happy to receive care at that time. Although staff had acted in the person's best interest they had not formally assessed or recorded the person's capacity to understand the need for the care and consent to the care at that time. The registered manager stated that this was an area they were working on to ensure formalised assessments were in place for all people for whom best interest decisions were being made by staff.

The registered manager had requested confirmation of any legal structures such as lasting powers of attorney for health and welfare or finances which were in place for some people, meaning they would know who could legally make decisions on behalf of people.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). 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 care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were able to give clear accounts of the meaning of Deprivation of Liberty Safeguards and how these might affect people in their care. Where necessary applications had been made to the local authority

for an assessment under the DoLS legislation.

People and relatives were happy with the personal and health care provided. One relative said "[My relative] always looks clean and groomed; you know you can see that [staff] have taken care like brushing their hair". Another relative said they were "very satisfied with the care provided". Relatives told us they were kept informed by staff if their loved one had been unwell and seen the GP. They said the staff always contacted the doctor if they had any concerns about people's health. An external health professional commented "No concerns, I did a review there recently and everything seemed fine, records good and the person was having their nursing needs met appropriately". We also saw feedback forms completed by other visiting health professionals. These were positive about the service people were receiving.

People experienced positive outcomes with regard to their health. People looked cared for, in that they were wearing clean appropriate clothing with hair styled and attention to hand and mouth care. People looked comfortable in bed and when required were assisted to change their position on a regular basis. People's general health was monitored monthly or as needed. For example, the nurses checked people's blood pressure monthly or as required. Where people had specific health needs such as diabetes this was managed safely. Nursing and care staff described how they supported people which reflected the information in people's care plans. Wound care was managed effectively. We saw nurses used the correct procedures to assess and manage wounds. People were supported to access other healthcare services when needed. People were seen regularly by doctors, dentists, opticians and chiropodists as required.

People received the support they required to meet their nutritional needs. We heard staff reminding people what they were having for lunch and checking they still wanted their original choice. Support was provided in a way that helped people retain their independence. Discussions with staff showed they were aware of the specific needs of individual people. For example, a staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Staff were also able to describe how they reduced the risk to the person from choking such as ensuring they were in the correct upright position when receiving food or drinks.

People told us they liked the food and were able to make choices about what they ate. One person said, "The food is very good, but it's not the same as being at home. The food can be very fancy". Another person said, "Food is very good, they puree it for me but sometimes I have to ask them what I am having". There was always more than one choice and people could request different food if they didn't like what was on offer. Staff described the meals as being both "posh nosh" and "basic home cooking". A staff member said, "The food is lovely here but sometimes it's a little complex. The chef is an actual chef and not just a cook. When they first started we went round with a questionnaire. Following this all the puree meals got updated". A survey of people's views specific to food was completed in 2015. People were asked their opinions of the meals and their responses were used when designing new menus. Catering staff were aware of people's special dietary needs and described how they would meet these. Snacks were available to people at any time with staff having full access to the kitchen and food stocks to prepare these when a chef was not on duty.

Drinks were available throughout the day and staff prompted people to drink often. Staff monitored the fluid intake of people although the individual amount each person should be aiming to drink per day was not specified. Therefore staff may not be aware if people were drinking inadequate amounts. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place.

People were cared for by staff who had received appropriate training. People told us they felt staff had the

right training to support them. Staff had completed a wide range of training relevant to their roles and responsibilities. All staff regardless of their role, had undertaken essential training in areas such as dementia, safeguarding, MCA and health and safety. They praised the quality of the training and told us they were supported to complete any additional training they requested. New staff completed the Care Certificate while being supported by an experienced staff member acting as their mentor. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. We observed staff put training into practice when providing care for people. For example, staff were able to describe how they assisted people who were at risk of pressure injuries to safely reposition.

Staff were supported appropriately in their role and said they felt valued. Staff received formal supervisions on a regular basis. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at subsequent supervision meetings. Staff meetings provided opportunities for group supervision.

The environment was appropriate for the care of people accommodated. A nurse told us consideration was given to the environment when pre admission assessments were completed. They said "We have a lot of stairs which could be a risk to people; mostly we have people who are not independently mobile as it's a nursing home". People had access to external spaces. A decking area with ramped access from the home was provided, along with an enclosed garden accessible via an external lift. One visitor told us how their relative had enjoyed spending time on the decking area the previous summer adding "they had their lunch out there some days".

Good

Is the service caring?

Our findings

People and their relatives were consistently positive about the way staff treated them. People said they were treated with kindness and compassion and that all the staff were kind and caring. One person said, "The carers are kind". Another person said, "[Staff members] look after one so well in Kite Hill. I want to die here. The carers are so lovely; this is a good one [nursing home]. They look after us very well here. Very kind". A relative told us "I can't fault the staff; they are all lovely and support me as much as [my relative]. Although [my relative] can't talk now, the care staff always talk to her, they chat to her when they are doing something and [my relative] seems to enjoy this". Other relatives echoed this. One said "[Staff] always remember my name and say hello and stop to have a chat, I'm always offered a cup of tea and made welcome. I feel they care about me as well as [my relative]".

People received individual care and support from staff who knew and understood their needs and preferences. A staff member said "You can't treat everyone the same, it has to be personal to them". Staff were aware of the actions they could take to promote choice and ensure people were cared for in accordance with their individual wishes. For example, a staff member had raised a concern with the provider's representative about a person being assisted into bed very early and against the person's wishes. The provider's representative had taken appropriate action to ensure this did not reoccur. One staff member explained that one person preferred having a male carer when they had a bath. They explained that although there was only one male nurse and one male care staff they offered the person baths when they were on duty.

Staff showed a good understanding of the needs of people living at Kite Hill. They knew how to adapt the care to meet the changes in those living with dementia as it occurred. When it was difficult to understand what people were saying, staff used facial expressions, body language and appropriate touching to aid communication, to reassure people and make them feel listened to. Staff were observed explaining to people what they were going to do before offering support. Staff allowed people the time to respond to their questions.

Staff supported people to be as independent as possible. For example, a person was supported to continue to manage parts of their care and medicines. At meal times people were provided with the level of support they needed to maximise their independence. This included cutting up meals and verbal prompting with encouragement. Where necessary equipment such as plate guards were in use.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they needed. One relative told us the registered manager had visited the person in hospital and spent time talking with them and hospital staff. Comments in care plans showed relatives were involved in discussions about care and kept up to date with any changes required. This was confirmed by relatives we spoke with. One said "I can read the care plan whenever I want, I know what's in it and they asked me stuff, like what [my relative] liked to eat". Care plans contained individual information about people and reminded staff to offer people choices and to respect their preferences including the use of preferred names.

Staff ensured people's dignity was protected by speaking quietly and keeping doors closed when providing personal care. One person said, "Staff always knock and ask my permission". Relatives told us signs were placed on doors alerting other staff or visitors not to enter when personal care was being provided. People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided they ensured doors were closed and curtains pulled. Staff said, "When providing personal care we try and keep them [people] covered as much as possible with a towel. We knock before we enter and put a sign on the door so other staff know not to interrupt". We saw these signs in use throughout the inspection. Relatives stated that staff maintained their family member's privacy at all times and they had not witnessed any concerns with privacy or respect from staff interactions with their relative or other people. Equipment, such as continence aids and moving and handling slide sheets, which people required to meet their needs were stored discreetly within bedrooms to help maintain people's dignity and privacy. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. We saw thank you cards from various relatives for the way their family members had been cared for at the end of their life. Information about people's preferences for their end of life care were included within care files and, when necessary, doctors had completed do not resuscitate forms which would mean that staff would not have to commence resuscitation for people who were expected to die. Nurses were aware of how to obtain emergency medicines should these be required for end of life care. The provider's representative said they would not admit new people for end of life care if the home already had people receiving this level of support. They explained this was to ensure that staff had the necessary time to give people and ensure the person and their family would be correctly cared for and supported.

Good

Is the service responsive?

Our findings

Relatives said people received personalised care from staff who understood and met their relatives' needs well. One said "I have no complaints about the way they look after [my relative]. Another relative said "When [my relative] said they were in pain, the nurse not only gave them some paracetamol but also did some tests to see what may be causing the pain. They checked to see if [my relative] had a urine infection. That was good as they tried to find out why they were in pain which was unusual for [my relative]". Another visitor described how their relative had been "poorly since August [2015], they are reluctant to drink but [staff] keep trying and offer drinks every two hours when they [reposition my relative]. They write it all down. I can see that they are trying to get [my relative] to drink".

People received care and treatment that was personalised and they or their relatives were involved in identifying their needs and how these would be met. One person described how their needs had recently changed and staff had worked with them to meet their new additional support needs. They told us how they were supported to remain in control of areas of their care and supervised to manage some of their medical care needs. Where people's needs changed staff identified this and took the necessary action. For example, to request a GP visit for which antibiotics were prescribed when staff thought a person had a chest infection. In emergency situations staff also responded appropriately to seek paramedics and hospital admission.

Nursing and care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the help a person required with repositioning including that this was only a limited tilt due to the person's risk of choking and need to remain fairly upright at all times. It was evident that they and other staff knew everyone living at Kite Hill and how their needs should be met. Staff were kept up to date about people's needs through a formal handover meeting at the start of each shift. Relevant information about risks or concerns about specific people was handed over. All oncoming staff were present and the handover was of an appropriate duration to allow staff to ask questions or clarify information.

Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised and the guidance and information for staff within them was individualised and detailed. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. Care plans and related risk assessments were kept under regular review by the named nurse for the person.

One relative told us they felt there was inadequate mental stimulation although they added that as their relative's needs had increased they probably would not want or be able to take part in activities any more. Another visitor showed us some pictures their relative had been supported to colour. Several relatives told us staff had taken people out onto the decking area for meals the previous summer. The provider's representative explained that they had recently reviewed the activities provision within Kite Hill Nursing Home. As a consequence an additional activities staff member was to be employed to provide activities over seven days per week. Most people required individual activities within their bedrooms. The providers representative explained that they felt the provision of seven days per week activities staff would help meet

this need.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded and these were discussed weekly during a meeting with the registered manager and provider's representatives. Minutes of these meetings showed that where necessary action was taken to determine why an incident had occurred and what action could be taken to reduce the risk of this or a similar incident occurring in the future. There was also an analysis of all accidents and incidents to determine if there were any patterns or trends which required action. The analysis for the year November 2014 to November 2015 showed that there had been relatively few accidents or incidents but that each had been looked into as per the provider's policy and where necessary action taken.

The service actively sought the views of people and visitors. People were asked to complete a questionnaire when they had been at the home for a few months. Comments included "The home has an air of peace and friendliness" and praised the "concern staff show when interacting with people". Whilst most responses were very positive we saw that information from the questionnaires was used to make changes to the service. For example, one person had requested that the service stopped using hospital style blankets as it made it more clinical and suggested using duvet covers instead. We saw action had been taken to replace the hospital blankets with individual coloured blankets in order to make people's rooms more homely.

People knew how to complain or make comments about the service. One person said, "If I needed to complain I would just tell one of the carers". They felt that if they did complain, action would be taken. Another person said "I've been to the office once or twice and they have sorted it out". Relatives told us they had not had reason to complain but that if necessary they would do so. They told us that if they had raised a concern action had always been taken to listen to them and resolve the issue. There was an appropriate complaints policy in place, which people and relatives were aware of. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy. The findings of investigations were documented and the outcomes shared with the person or relative who had raised the concern. Where necessary we saw this included an apology and information of the action taken to reduce the risk of recurrence.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said, "There is nothing I would change about this place". Relatives were also positive about the home's management. One relative said "They are all very approachable, all the sisters and the matron". Relatives said they knew who the provider's representatives were and most had spoken with them. One said "The tall man, he owns this place and stops to talk to me if he sees me. Also there is a lady owner; I've spoken with her as well". Another relative said "On the whole I'm happy, they do a good job".

The provider's representative told us their vision was to provide a high quality service which met people's needs. They said, "As a provider we want to deliver the best service we can; that means making sure we have the right staff who we listen to". They added that when positive comments were received from people or relatives they made sure relevant staff were aware of these. The provider's representative also said, "We need to listen to the residents and continually look at the service we are providing to see if it can be improved." The provider's representative was at the home on the day of the unannounced inspection. They said they visited the home at least weekly as did other directors including one with a nursing qualification who oversaw the clinical side of the home. Their vision was understood and shared by the staff, who were committed to providing a good service and meeting people's individual needs.

People benefitted from staff who understood their roles, were motivated, and worked well as a team. A visiting health professional said, "They all seem to work together. The registered manager was able to get all the information I needed and was very approachable". Comments from staff included: "I love my job, I love it". There was a clear management structure in place, consisting of an experienced registered manager and deputy manager. A staff member said, "Management are very supportive, if I went to management with a concern it would get sorted".

There was an open and transparent culture at the home. Relatives said they could visit at any time and were made welcome. Staff members said that the service was well-led and they felt supported. The provider's representative had taken all the necessary action when staff had raised a concern with them about another staff member. This showed staff felt able to approach the provider's representative directly and that they were listened to. The provider ensured CQC was notified of all significant events and was aware of the need for a duty of candour policy, had sought guidance and put one in place. Where necessary this policy had been followed such as notifying relatives when accidents or incidents had occurred.

The provider's representative and registered manager sought feedback from staff, including through staff meetings and individual supervision. Staff were encouraged to make suggestions about how the service could be improved and these were acted upon. For example, one staff member had suggested introducing a sign to be placed on bedroom doors when personal care was in progress. This had been implemented and meant privacy for people could now be assured during personal care as other staff or visitors would know not to enter the room.

The provider understood the need for clinical governance and quality assurance systems which involved

staff and other stakeholders. Auditing of all aspects of the service, including care planning, medicines, infection control and staff training was conducted regularly and was effective. The provider had quality assurance and clinical governance systems which directed the registered manager to the areas they should audit throughout the year. There were procedures to monitor other quality indicators, such as accidents or incidents, and the provider's representatives were actively involved in aspects of the monitoring of the service.

The registered manager completed the Provider Information Return (PIR) to a high standard and demonstrated an understanding of legislation related to the running of the service. Through the PIR the registered manager showed they were aware of key strengths and areas for improvement, in respect of the home. For example, they described how they were liaising with a specialist dementia care nursing home with regard to mental health care planning, behaviour charts and activities. They were also developing the role of a dignity champion. The registered manager met with the registered managers of the provider's other homes and used their knowledge and experiences to improve the service at Kite Hill. For example they were formalising the end of life care using a six steps approach which had been piloted in another home within the group.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. We were told policies were reviewed by the registered manager yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run.