Cleeve Hill Healthcare Limited

Cleeve Hill Nursing Home

Inspection report

Cleeve Hill, Cheltenham,
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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

Overall summary

This inspection took place on 7 and 8 October 2015 and was unannounced. Cleeve Hill Nursing Home provides accommodation for up to 50 people. At the time of our inspection there were 39 people living there. Up to six people can be cared for in the Winchcombe Unit which provides intermediate beds for people needing end of life support or rehabilitation. The staff employed in this unit were recruited, supervised and trained by a local hospital.

There were four people in the home living with dementia and 10 people with short term memory loss. All bedrooms, apart from three, had en suite facilities. People had access to shared bathrooms and shower rooms as well as living and dining areas. People staying at the Winchcombe Unit had single rooms with en suite facilities.

Cleeve Hill Nursing Home is currently registered to provide the regulated activity, Transport services, triage and medical advice provided remotely. This regulated activity was no longer being provided from this location and was not inspected as part of this comprehensive inspection. The provider is in the process of removing this regulated activity from Cleeve Hill Nursing Home and registering this regulated activity at another location.

Summary of findings

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. A manager had been appointed and they were in the process of applying to become registered with CQC.

People living at Cleeve Hill Nursing Home received personalised and individualised care which reflected their wishes, likes, dislikes and preferences. They had accommodation which was maintained to a high standard and which was due for further refurbishment. People enjoyed a range of activities both inside and outside of the home seven days a week. Activities co-ordinators were employed to deliver these alongside external providers who delivered Zumba and Tai-Chi. Individual activities were provided for people who preferred to remain in their rooms. People had meals provided to a restaurant quality and with a wide range of choice. People who had specific dietary needs were catered for.

People staying for a short period of time at the Winchcombe Unit had care records which clearly identified their treatment and any changes in the health or well-being. Upgrades to the environment had been made by Cleeve Hill Health Care in response to infection control issues. They enjoyed catering supplied by the care home.

People's health and well-being was monitored and when changes occurred referrals were made to health care professionals. Relatives said they were kept informed of any changes and involved in decisions about their loved one's care. People had personal profiles in their rooms reflecting those important to them, their wishes for care and support as well as end of life care. When people needed help to make decisions, their legal representatives were involved and any decisions taken were made in their best interests. People said they felt safe living in the home and relatives were reassured that they were well looked after.

People were supported by sufficient numbers of staff to meet their needs. Staffing levels were flexible and monitored closely to make sure they responded to people's changing needs. Staff had access to a range of training to equip them with the skills and knowledge to support and care for people. They said they were well supported to develop in their role and spoke positively about working together as a team.

People were involved in quality assurance processes to give feedback about their experience of their care. This feedback along with feedback from their relatives, staff and community professionals was used to make improvements to the service. Relatives and staff spoke highly of the manager and recognised the need for consistent management to embed improvements.

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?

Good

The home was safe. People were kept safe from harm. Accidents and incidents were responded to promptly and the appropriate strategies put in place to prevent the risk of injury.

People were protected against known risks. Systems were in place to respond to emergencies.

People were supported by enough staff to meet their needs. When people's needs changed staffing levels reflected this. Robust recruitment procedures ensured the necessary checks had been completed before staff started work.

People's medicines were managed safely. Infection control measures were in place to prevent the spread of infections.

Is the service effective?

Good

The service was effective. People received care and support from staff who had the opportunity to acquire the skills and knowledge they needed to carry out their roles.

People's ability to make decisions was assessed and decisions were made on their behalf if needed.

People's health and well-being were monitored and they were supported to stay well. People were provided with meals of a high standard which reflected their dietary needs.

Is the service caring?

Good

The service was caring. People were supported with kindness, compassion and warmth. Staff understood their preferences, lifestyle choices and backgrounds. They treated people with respect and encouraged them to be independent.

People were given information about the service they were to receive and were involved in making decisions about their care. Visitors were made to feel welcome.

Is the service responsive?

Good

The service was responsive. People and those important to them were involved in the planning of their care. People's care was individualised and reflected their wishes, interests and preferences.

People were encouraged to join in a range of activities both inside and outside of the home. These were provided every day of the week. People who preferred to stay in their rooms were offered one to one activities of their choice.

People and their relatives knew how to make a complaint and were confident they would be listened to and action would be taken to address any concerns.

Is the service well-led?

Good

The service was well-led. People and those important to them were asked for their views about the service. Improvements to people's experience of care resulted from their feedback and analysis of accidents, incidents and complaints.

An open culture was promoted and staff reflected the values of the service to deliver the highest standards of care and to help people live the life they wanted.

Cleeve 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.

The inspection took place on 7 and 8 October 2015 and was unannounced. One inspector, an inspection manager and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was the care of older people and people living with dementia. Before the inspection, the provider completed a provider information return (PIR). The PIR 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 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. We also reviewed information we have about the service including past inspection reports and notifications. Services tell us about important events relating to the service they provide using a notification. Information had been shared with us by a local authority quality assurance team and Healthwatch.

As part of this inspection we talked with 17 people living in the home and seven visitors. We spoke with the manager, a representative of the provider, three nurses, six care staff, three domestic staff, a chef and maintenance person. We reviewed the care records for six people including their medicines records. We also looked at the recruitment records for six staff, training records for nine staff, quality assurance systems and health and safety records. We observed the care and support being provided to people. After the inspection we contacted eight health and social care professionals.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and relatives spoke of their reassurance that their loved ones were well looked after. People told us, "They are very kind and treat me well", "I am very content here I could not be any safer" and "I feel safe, someone comes very quickly if I need them". Relatives commented, "I have never heard anyone speak angrily" and "There are no signs of neglect, care is good". Staff had a good understanding of how to keep people safe, what to look out for and how to report suspected abuse. They recorded any unexplained bruising or marks on body charts and logged any incidents which were immediately raised with senior staff. Staff were confident any concerns would be followed up. They had completed training in the safeguarding of adults and had access to information about how to report suspected abuse. The manager had raised safeguarding concerns with the local authority and informed the Care Quality Commission of action taken to keep people safe.

When people had accidents or incidents comprehensive records were kept, monitored and audited evidencing the action taken in response to keep them safe and to prevent further harm. When needed people were referred to the appropriate health care professionals. If equipment was needed, such as bed sides or alarms these were supplied. People who were at increasing risk of falls had seen their GP to consider their physical health as well as being referred to the falls clinic. As a consequence the risks of falls to people had decreased. Staff helped people with safe moving and positioning techniques, telling them throughout the process what they were doing.

People were protected from any known hazards. Assessments identified potential risks and how these were minimised to keep people safe. For example, people whose skin condition was poor had a number of strategies to prevent their skin from breaking down. People described how staff helped them by applying creams or by turning them when in bed. People also had mattresses and cushions to help alleviate the pressure on their skin. Occasionally people had been admitted with pressure ulcers. Robust records were kept of the treatment and care provided to help their skin improve. Tissue viability nurses were involved with their care.

People had individual evacuation plans in place to describe how to help them leave the home in an emergency. Staff took part in fire drills to make sure they knew their roles and responsibilities. Contingency plans were in place in case of utility, lift or equipment failures as well as the risks of a heat wave or influenza outbreaks. Out of hours support was available for staff should they need it. The environment and equipment were monitored and the necessary checks and servicing had been carried out to make sure they were operated safely.

People were supported by sufficient staff to meet their individual needs. Some people thought there could be more staff at peak periods for example having to wait to go to bed or occasionally for the call bell to be answered. Other people told us, "When I use the call bell, I have a good response" and "There are usually enough staff, but it would be better if there were more". Relatives commented, "Staff check on her constantly, popping in to check her" and "The right levels of staffing, they have staff for every job". A member of staff always supervised people in communal areas, people were not left unsupervised. Staff reflected about the flexibility of staffing levels. They had raised concerns about meeting the increasing needs of people over the lunch time period and so additional staff had been allocated to help out. The manager said they did not use agency staff to cover spare shifts. The staff team helped out as well as staff from other homes owned by the provider. The manager said this ensured consistency because they had access to the same staff.

People staying at the Winchcombe Unit were supported by staff employed by a local hospital during the day and by a health care assistant overnight. The night nurse from the home supervised them during these hours and was responsible for medicines administration.

People benefitted from a robust recruitment and selection process to make sure staff had the right skills and competencies to meet their needs. Staff completed an application form which provided an employment history. Any gaps were investigated. They were appointed after all checks had been completed such as verifying why they left former employment in social care. Written references were followed up with a check to verify their authenticity. Disclosure and barring service (DBS) checks were in place. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered

Good

Is the service safe?

relevant to the post applied for. Staff had provided proof of identity and if needed eligibility to work in the UK. The credentials of nurses were checked with the Nursing and Midwifery Council.

People were protected against the risks of being supported by unsuitable staff. Action had been taken when necessary, under the provider's disciplinary procedures, to challenge poor practice. Staff said they would use the whistleblowing procedure and senior staff would take the appropriate action in response.

People's medicines were managed safely. They had given consent to nurses to administer their medicines. People had their medicines at times they preferred and the nurses made sure their medicines were administered with the appropriate length of time between each dose. For example, one person had their breakfast medicines late because they had slept in so their next dose was administered later than was prescribed. People's medicines were mostly stored in locked cabinets in their rooms. The temperatures of these cabinets were monitored. One person liked their room to be kept at over 25°C and so their cabinet was located in the corridor nearby. If people wished to manage their own medicines they were supported to do this.

Medicines audits had been completed to check that medicines had been correctly administered. Stock levels were maintained on the medicines administration record (MAR). Permission had been given by the GP for the use of non-prescribed medicines and for some medicines to be given to people with their food. Observations of the medicines round confirmed the safe administration of medicines. The nurse waited until people had taken their medicines before leaving them to sign the MAR. People were given explanations of what they were taking and asked if they needed any medicines to be taken when needed. Protocols were in place for the use of medicines to be taken as necessary stating the rationale for their use and the maximum dose to be taken.

Robust infection control measures were in place to prevent the spread of infections. Issues raised about the disposal and handling of waste from the Winchcombe Unit had been resolved. Nurses described the procedures put into place to make sure waste was disposed of appropriately. Infection control audits carried out by the unit were comprehensive and where actions had been identified, these had been completed. For example, the floor covering had been replaced. The Department of Health's guidance on the prevention and control of infections was followed and implemented. An infection control lead for the care home had been identified and an annual report had been produced. Staff had completed training in infection control. Domestic staff confirmed they followed a cleaning schedule which allowed for deep cleaning when necessary.

Good

Is the service effective?

Our findings

People commented, “We sometimes get inexperienced staff who do not know what they are doing” and “I have to instruct the staff half of the time”. Other people thought staff were well trained and knowledgeable and one person mentioned, “Staff are first rate, brilliant and friendly, could not be better”. Feedback to the provider included, “Staff are professional” and staff are “skilled”. Training was delivered through a training company owned by the provider as well as external training providers. Staff confirmed they had access to a range of training starting with the new Care Certificate as part of their induction. They had also completed training considered to be mandatory by the provider, such as moving and positioning, first aid and food hygiene. Training needs would be monitored through a training database which was being put together to make sure staff kept their training up to date. Staff spoke enthusiastically about end of life training they had completed as well as dementia awareness which equipped them with the understanding they needed to support and interact with people.

The needs of people living with dementia had been considered when organising training for staff. Two members of staff had been registered to complete training as dementia leads. They would be working with management to implement best practice guidance in the delivery of care to people living with dementia. Nurses confirmed they maintained their professional development to maintain their registration requirements and care staff had access to the diploma in health and social care.

People received care from staff who had been supported to develop in their role and who had the opportunity to discuss their personal development with senior staff. Staff had individual meetings with a named mentor at least every three months, which included an annual appraisal to reflect on their performance and also an observation of them carrying out their role. These meetings had been scheduled for August 2015 but senior staff had not carried them out as planned. They had been rearranged for October 2015. The representative of the provider shared a schedule of one to one meetings and annual appraisals which they intended to work from. Staff said they had attended staff meetings and had daily handovers to keep them up to date with people’s needs and any changes. The manager and deputy manager were open and accessible to staff, who were observed frequently dropping into the office to talk with them.

People or those legally representing them had given their consent for people’s care to be delivered. They had signed these forms. Staff had completed training on the Mental Capacity Act 2005 (MCA) and understood the need to assess people’s capacity to make decisions. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Where a person had a legal power of attorney for welfare or finances they had been asked to supply evidence of this. People were given the opportunity to make decisions and choices about their day to day lives such as what to eat, drink or how to spend their time.

Occasionally decisions had to be made in people’s best interests. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. These were well documented in people’s care records evidencing involvement of people’s relatives, GP and psychiatrist.

The manager was aware of changes in case law around the deprivation of liberty safeguards (DoLS). DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. Three people had authorisations in place for restrictions to their liberty. This was to keep them safe from harm. The representative of the provider shared an assessment being completed to review the deprivation of liberty safeguards currently in place and whether further applications needed to be made. Some restrictions had been agreed with people or their legal representatives, such as the use of bed-sides to protect people from falling out of bed. Where-ever possible the least restrictive option was used. For example, a bed which could be lowered to the floor was provided with a mattress if people were deemed to be at risk of using bed-sides.

Some people had a do not attempt cardiopulmonary resuscitation (DNACPR) record in place which had been discussed with them or their legal representative and was signed by their GP. The reasons behind this decision were clearly stated. People also had an advance care plan, detailing their wishes for end of life care. This also included evidence of decisions made in their best interests.

Good

Is the service effective?

Occasionally people needed help to manage their feelings and emotions. Staff were scheduled to complete training in this complex area. They were supported by mental health professionals who developed guidance for staff to help people to become calmer. Staff had a good understanding of what would upset people and what worked well to help them regain their sense of well-being. For example, music, a walk or a drink. Monitoring charts were kept to share with mental health professionals and to review the strategies being used.

People were generally happy with the food, commenting, "Good food but run of the mill", "Food is fine, plenty of choice", "Food is alright, could be presented better" and "meals are generally pretty good". People had access to hot drink making facilities around their home to help themselves to a drink if they wished. Cold drinks were also provided. People chose where to eat their meals and if they needed the support of staff this was provided. People were not rushed whether eating in their rooms or the dining areas. Staff chatted amiably with them, encouraging them to eat and drink. People had a choice of three main meals or an alternative if they wished. For example, one person expressed a dislike of the food they were eating and so another meal was provided for them. Soft or pureed diets were attractively presented. Special dietary requirements were considered such as fortified meals for people at risk of weight loss or a sugar free option for people living with diabetes. People staying on the Winchcombe Unit had their meals supplied by the care home. The head chef had won a local award which recognised the quality of their restaurant style food. The representative of the provider said no expense was spared on their budget.

People at risk of malnutrition or dehydration were closely monitored. Their weights were recorded weekly and a malnutrition screening tool was used to monitor their progress. The provider information return confirmed staff "liaised with GP's, dieticians and speech and language therapists in managing such risks." A pain assessment tool was used for people living with dementia who were unable to express verbally when they were in pain. People had access to a range of health and social care professionals to help them stay well. A health care professional commented that staff "consider people's needs and make referrals promptly". Records were maintained for all appointments and relatives said they were kept informed of people's health and well-being. A relative told us, "Staff were on the ball and had noticed a problem with my relative recently and they had requested a visit from the GP".

Good

Is the service caring?

Our findings

People told us, “Staff are very kind, thoughtful and considerate; they are full of fun”, “I am very happy with the care, staff are absolutely brilliant, they are good girls” and “I am very happy to be here, they are all so nice to me”. People were well looked after, their hair and nails had been kept trim and clean. One person proudly showed us their nails which had been manicured and varnished. People wore clothes of their choice, which were kept clean and reflected their lifestyle and age. People wore a variety of footwear some choosing to wear shoes, others slippers and some people having comfy warm booties. A health care professional commented about people’s appearance telling us they always looked “cared for” and “well washed and dressed”. Relatives reflected, “I am 100% happy about the care, staff are so lovely and natural, they care for my loved one exactly as they would wish” , “Staff never stop smiling” and “My loved one is well cared for”.

Some people needed help to express themselves and to communicate with others. One person who was not able to respond verbally had a communication book with illustrated words. A member of staff knelt down so that they were at the person’s eye-level, and asked, “What can I do for you?” then turned pages in the book until they found what the person wanted. Staff explained they also used pictures and objects to prompt people. People’s doors to their bedrooms were personalised with pictures or photographs if they needed reminding where they were. Corridors on each floor had different colour schemes to help people to find their way around.

People had personal profiles in their rooms which provided a summary of their life, preferences, people important to them and how they would like to be supported with their personal care. Staff had a good understanding of people and their personal histories. People and their relatives said they were involved in making decisions about their care and support. Staff treated people positively, with kindness and shared humour. People were given time and space to respond to questions and staff patiently listened to them and acted accordingly. Staff used the appropriate volume and tone of voice when talking with people. They used people’s names or preferred form of address. The provider information return (PIR) stated, “Staff recognise the individuality of service users and their individual cultural requirements.” Where people had preferences about the gender of staff helping them with their personal care this was respected. People also had the opportunity to receive communion or attend services reflecting their religious beliefs.

People’s needs were responded to quickly and in a timely fashion. People had call bells in their rooms and although they acknowledged at busy times they might have to wait, most said they were answered quickly. At a team meeting, staff were prompted to always answer a call bell even if they could not provide support immediately and to explain when they would return. Staff were attentive to people’s needs responding with warmth, compassion and reassurance when people were upset, confused or distressed. Relatives commented, “No need is too great, staff are very supportive in the care they give” and “They cope with her beautifully, staff follow her wishes”.

People had access to a range of information about the service they received. They had individual copies of the service user guide as well as notices displayed around the home telling them about activities, events, how to make a complaint and advocacy. The PIR stated, people have “access to the services of advocates and if required an independent mental capacity advocate.” The representative of the provider discussed ways in which they would make sure all people living in the home could access information by producing easy to read formats, photographs or using large print.

People were supported to do as much as they could for themselves. Their care records stated what they were able to do and prompted staff to encourage people for instance in their mobility or eating. A person confirmed, “Staff are kind, they encourage me to do as much as I can for myself”. A relative mentioned, “[name] goes out and about to visit friends. Transport is provided if he needs it. I believe he has lived longer because he is content here.” Visitors told us they were made to feel really welcome, “like part of the family” and “I can have a meal if I wish”. They mentioned their relatives kept in touch through personal telephones in their rooms or by skype through computer networks.

People said they felt comfortable when receiving personal care, and staff were respectful, considerate and maintained their privacy and dignity. People were observed being asked by staff, “would you like me to…?”, “would you mind

Good

Is the service caring?

if I…?", "will it be alright if I...?". Both people and visitors were positive about the care they received and confirmed that they were treated with dignity and respect. A relative said, "His dignity was respected".

Good

Is the service responsive?

Our findings

People were given care that was personalised to meet their individual needs and manage their risks. This was supported by robust documentation. The plans clearly set out people's individual needs and risks together with how these needs would be best met. For example one person had been assessed as at risk of falls due to their tendency to walk around the home unsupervised. The care records clearly set out a detailed plan supporting them to be safe in the least restrictive way possible. This included an alert mat to help staff know when the person was up and moving about and assistance with the exercises set out by the physiotherapist to maintain their mobility.

There was evidence of involvement from people and those that were important to them in the development of care plans. People or their legal representatives signed care records confirming they had the "opportunity to consider the information, ask questions and have these answered satisfactorily". Each care plan had been reviewed and updated on a monthly basis to accurately reflect the changing needs of people.

People staying at the Winchcombe Unit had either been discharged from other hospitals with their care records or referred by their GP. Their care records clearly stated the treatment and support they were to receive and provided a running record of their treatment throughout the day. Changes in their health or well-being were noted and the necessary adjustments made to their treatment when needed.

People had personal profiles in their rooms allowing them to share what was important to them with staff. This contained their past history, a pictorial representation of people important to them with photographs, and their preferences and wishes about their care and end of life care. Staff demonstrated an in depth knowledge of people's particular likes and dislikes. For example one member of staff said, "[name] can feel anxious when she is alone, she likes to know that someone is nearby". One person had a "twiddle muff" which kept their hands engaged when they wanted to fiddle with something. Another member of staff brought in their own family's train set for the enjoyment of one person who they knew used to be an engineer. An activities co-ordinator showed us place mats which they had designed for each person in the home. The place mats were made up of pictures and images that reflected people's personality and specific likes, for example one place mat had a lipstick, a dog, jewellery and nail varnish on it. These were used as conversation prompts.

Most people were able to meet up with each other in the communal areas of the home. However there were some who preferred or needed to stay in their room. Staff were aware of the potential for social isolation and made sure that these people were visited regularly. They were also offered activities of their choice in their room. The provider information return stated, "any risks of social isolation are identified during care planning and a risk assessment generated for those deemed to be at risk". The two full time activities co-ordinators maintained an activities timetable for each person. This enabled them to identify who was not regularly taking part in activities and therefore may need further individual attention. This could include interactions from a simple chat to playing board games or cards. A health care professional confirmed this, saying there were many activities for people to be involved in.

Access to community events was encouraged and facilitated where possible. For example, an outing to meet locals at a community church event and joining other people in another care home to celebrate a religious festival. Communion was available to people in the home twice a month.

People had the opportunity to take part in a variety of activities seven days a week; this included musical bingo, singing and Tai-chi. At the time of the inspection a Zumba keep fit class was taking place which people seemed to be enjoying a great deal. The co-ordinators ensured activities matched people's preferences as far as possible. One activities co-ordinator said "They spell it out if they don't like it. We try one thing and if that isn't what they want we just try something else".

People were currently taking part in a virtual cruise. This 'cruise' stopped at a different country every month and the staff tried to bring the culture of each particular country to the people through the clothes they wore, the music they listened to, and the food they ate. A photographic display of the virtual cruise reminded people of the route the virtual cruise had taken and was due to "visit".

People and relatives told us they knew how to make a complaint. Feedback was welcomed by the manager and there was evidence that feedback helped to drive

Good

Is the service responsive?

improvements in the home. For example one relative told us they felt their mother-in-law's room was a little bare of her personal effects and needed a shelf. The relative himself brought in a shelf and it was put up in the room by the next day. There was a concern raised about the toughness of the meat and this was immediately resolved by changing their meat supplier. One relative said, "They are very approachable. We have attended several resident and relatives meetings and they are always asking us for ideas or if we have any complaints".

Two complaints had been raised on behalf of people in 2015. Both had been managed appropriately and there was a clear record of actions taken and the outcome.

Good

Is the service well-led?

Our findings

People said, “It’s very good here” and “Overall it’s very good”. Relatives commented, “It’s one amazing place” and “It’s the best place I could have placed her”. Staff reflected these feelings saying, “It’s fantastic here. People are very supportive and the staff all get on” and “We give good care, this is our way”. People, relatives, staff and community professionals had been asked for their views about the service provided as part of the quality assurance process in 2014. A report had been produced and actions included reviewing staff levels at lunch times. A representative of the provider confirmed surveys were due to be sent out to people for the 2015 survey.

People’s experiences of care were being improved as a result of feedback from people and staff. People and those important to them were invited to attend meetings where cheese and wine was served along with opportunities for the sharing of information and exchange of views. A recent meeting to discuss forthcoming environmental improvements to the home was “very well chaired” according to a person living at the home. A staff meeting resulted in the review of staff breaks to improve the experience of people having their meals. Future plans included establishing a residents and staff council to run separately each month to provide another way of giving feedback.

The provider information return stated they were committed to “ensure that the highest standards of care are delivered and that service users receive the best possible outcomes and are able to live the life that they want to live”. This was verified by relatives who said care was of the highest standards; with one relative commenting, “I wish everyone could have this kind of care”. A health care professional supported this telling us, “I found the nursing home to be well run, very well maintained and a lovely environment to be in.” A quality assurance visit by the local authority in 2014 was very positive. They suggested a few minor actions for improvement which had been implemented. For example, providing dementia awareness training for staff.

There was not a registered manager in place at the time of our inspection. A manager had been appointed and had started the process to become registered with the Care Quality Commission (CQC). She understood her responsibilities as a registered manager and had submitted notifications to CQC. Services tell us about important events relating to the service they provide using a notification. People and visitors told us the manager was open, approachable and supportive. They held her in high regard. Staff were positive about her appointment and recognised they needed “solid, consistent management”. The manager was aware of the challenges facing her including ensuring care plans were kept up to date and inducting new staff. She said staff were working well and a “really good team” had developed over the past 12 months. People had become more involved and were asking for more activities outside of the home.

People’s experience of care was monitored closely through the analysis of accidents and incidents, complaints and staff feedback. The manager actively supported staff to raise concerns and report changes in people’s needs. Staff confirmed this. Staff also said they would confidently raise issues under the provider’s whistle-blowing policy and procedure. The provider information return stated, “the service has a complaints procedure which will be used to investigate, record any incident or allegation of bullying, harassment or unequal treatment amongst the staff team”. Recent staff meetings had focussed on how to build an effective and cohesive team. The achievements of staff were celebrated including awards, promotion and qualifications. Staff were awarded bonuses and letters of commendation. Key roles had been allocated to staff, such as end of life planning and dementia leads to keep up to date with national best practice. The provider was a member of a local care provider’s association and received alerts from national organisations to make sure they were aware of changes in practice and legislation.

The quality of care delivered to people was monitored and audited by a quality assurance system which included checks on care plans, medicines, the environment and health and safety checks. The manager and senior team confirmed resources were available to make improvements. The registered provider had attended senior team meetings to monitor standards of care and requesting feedback about the provision of additional equipment or aids to help staff work efficiently.