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Cooksditch House Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was carried out on 24 May 2016 and was unannounced.

The service provided accommodation, personal and nursing care for up to 50 older people. The accommodation spanned two floors and a lift was available for people to travel between floors. There were 49 people living in the service when we inspected. Thirty people were accommodated in part of the service which was designed for people who needed nursing care. Nursing staff and care staff assisted people to manage chronic and longer term health issues associated with aging or after an accident or illness. This included compassionate end of life care. The other part of the service provided residential accommodation and care to 19 people who had lower care needs.

There was a registered manager employed at the service. 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.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council (NMC). However, the registered manager had not ensured that a consistent system was in place for staff supervisions, appraisals and nursing staff revalidations.

We have made a recommendation about this.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred. End of life care was delivered by consent and mutually agreed with people and their families. Additional specialist end of life nursing guidance and training was provided by staff from a hospice.

The provider and registered manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had been tested and well maintained.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of

Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The registered manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. A robust agency back up system was in place. The provider had a system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively and the registered manager provided nurses with clinical training and development.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. The registered manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. The risk was assessed and the steps to be taken to minimise them were understood by staff.

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. This included checking nurse's professional registration.

We observed staff that were welcoming and friendly. People and their relatives described staff that were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained they were listened to and the registered manager made changes or suggested solutions that people were happy with.

The registered manager of the service, nurses and other senior managers were experienced and provided good leadership. They ensured that they followed their action plans to improve the quality of the service. This was reflected in the changes they had already made within the service.

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 was safe.

People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted on safeguarding concerns and notified the appropriate agencies.

There were sufficient staff to meet people's needs. The provider used safe recruitment procedures and risks were assessed.

Risks were assessed and recorded. Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protected people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was effective.

Staff received an induction and training and were supported to carry out their roles. Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role. Nurses were supported to continue their professional development.

People's rights were protected by staff who were guided by The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Nursing staff helped people maintain their wellbeing by routinely monitoring people's general health. Staff encouraged people to eat and drink enough.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as

individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them. Activities were organised to promote involvement and reduce social isolation.

Information about people was updated often and with their involvement so that staff only provided care that was up to date. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Complaints were resolved for people to their satisfaction.

Is the service well-led?

Good

The service was well led.

The registered manager was qualified with the appropriate skills and experience to lead staff in the service and drive through improvements to people's care.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered and actions were taken to keep people safe from harm.

The provider and registered manager promoted person centred values within the service. They planned to continually improve people's experiences. People were asked their views about the quality of all aspects of the service.

Cooksditch House Nursing & Residential 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 24 May 2016 and was unannounced. The inspection team consisted of two inspectors, a nurse specialist and an expert by experience. The expert-by-experience had a background in caring for elderly people.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. 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 observed the care provided for people. We spoke with 12 people and four relatives about their experience of the service. We spoke with nine staff including the registered manager, two nurses, one senior carer, the lead housekeeper, two care workers, the cook and activities co-ordinator to gain their views about the service. We also spoke with the provider for the service. We asked four health and social care professionals and a member of the local authority safeguarding team for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at fourteen people's care files, six staff record files, the staff training programme, the staff rota and medicine records. At the end of the inspection we asked for more information to be sent to us. The registered manager sent us further information about staff supervision and training and about how nursing staff updated their skills and knowledge after the inspection.

At the previous inspection on 30 August 2013, the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good

Is the service safe?

Our findings

People felt safe at Cooksditch House. One person said, "You always see a lot of staff walking around and they always have time to look after me." Another person said, "There's always someone here that will protect you, I really like that." And "This place is very safe, I had problems walking around on my own, the staff are safe as they are very helpful." Another person told us that at home they used to have a lot of falls, but they do not have any at Cooksditch.

Relatives told us that they felt that their family members were safe. They described a service that was also supportive to them. One said, "They (staff) look after her really well. She is so much happier since being in here. She came in from the hospital and was going downhill. I honestly believe if my mum didn't move in here she wouldn't be here today, they got her out of her shell."

An NHS Nurse told us they believe people were safe. Their experiences were that nurses and care staff had always taken on board any recommendations they had made in relation to people's care and safety. The team at Cooksditch House enabled specialist nurses to access all the relevant notes and care-plans to ensure people got the best nursing care.

People received their medicines safely from staff who had received specialist training in this area. The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. Nurse's medicines competences were checked by the registered manager against the medicines policy to ensure good practices were maintained. Staff trained to administer medicines in the non-nursing part of the service were supported to do this safely by qualified nursing staff. We observed the safe administration of medicines. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

Medicines were correctly booked in to the service by nurses and this was done in line with the service procedures and policy. Nurses and trained staff administered medicines as prescribed by other health and social care professionals. For example, medicines specific to end of life care were well managed. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Staffing levels were planned to meet people's needs. In addition to the registered manager, who was also the nursing clinical lead there were seven staff available to deliver care, plus two qualified nurses and a senior carer between 8 am and 8 pm. At night there were four care staff managed by an additional qualified nurse. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. People told us they did not have to wait long for staff to arrive when they asked for assistance. Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. We observed staff prioritising answering nurse call bell alarms and people confirmed to us they did not have to wait long for staff to assist them. People's dependency levels were reviewed at least monthly. There were enough staff available to walk with people using their walking frames if they were at risks of falls.

The provider's recruitment policy was followed by the registered manager. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Before employment, all applicants for posts at this service were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the registered manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Contingency plans were detailed and professionally written to ensure people's care would continue in emergency situations. Each person had an emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The registered manager operated an out of hours on call system so that they could support staff if there were any emergencies.

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The registered manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments considered the levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough.

People were protected from preventable harm and could call for help if needed. Safety observation checks were completed and recorded every 30 minutes within the service. The registered manager checked for patterns of risk. There had been 20 recordable incidents or accidents in January 2016 to date These incidents and accidents had been checked by the registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again.

Equipment was serviced and staff were trained how to use it. The premises environment was maintained to protect people's safety and to meet their needs. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed. We saw comprehensive records that confirmed both portable and fixed equipment was serviced and maintained.

Good

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. People said, "We get a choice of food and they always offer you something else if you do not like the menu", and "We need lots to drink and I have this in my room or just ask for a cup of tea and staff get it for me." One person said, "No problems with staff they all seem to know what they are doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals 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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

People's physical health and mental wellbeing was protected by staff who were qualified and trained to meet these needs. Registered nurses were available who had dual qualifications in mental health and adult nursing. One nurse gave us detailed information about the revalidation process with the nursing and midwifery council (NMC) showing a good understanding of the purpose and process. She had attended awareness session on the topic and had supported a colleague with the process. The registered manager provided us with further information about the support qualified nursing staff received from the provider to maintain their skills and NMC registration as part of the revalidation process.

People received nursing and personal care from staff who were supported and trained to meet their needs. Twenty eight of the staff had received a supervision since December 2015, and annual appraisals had been held for staff in 2015. However, there was a lack of documentation regarding how often supervision took place for each staff member. The registered manager told us that supervisions had not taken place as often as she would like as she had staff vacancies which meant she had covered some shifts.

We have recommended that the registered manager looks at appropriate systems to ensure supervisions are effectively managed.

Nurses informed us that they had received appropriate training to carry out their roles. This included statutory mandatory training, infection prevention and control, First aid and moving and handling people. The first aid training had provided them with information on how to manage/support people who may be

bleeding or choking.
Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, wound care and gained knowledge of other conditions people may have such as diabetes and dementia. New staff inductions followed nationally recognised standards in social care. For example, the new care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

People's health was protected by proper health assessments and the involvement of health and social care professionals. A GP visited the service every week, and people had access to occupational therapist and other specialist services. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.)

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. The cooks in the kitchen met with people individually to discuss their food preferences. People were complimentary about the food and told us there were always choices of meals. Nutrition assessment tools were completed every month for each person and actions were taken to support people to stay healthy if they were considered to be at risk. For example, in cases were the person's body mass index (BMI) had dropped, the catering team was informed and they provided fortified food for the person. We viewed 12 nutrition assessments and each person had a care plan in their care records. The care plans were very detailed to support people's wellbeing and enable staff to record progress. For example, 'Weights to be done monthly using hoist scales' and 'To be offered up to 2000ml fluids a day in a two handed beaker with no lid'. This gave staff the information they needed to deliver effective care.

People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. The staff were happy and up-beat, they enjoyed their work and this was reflected in the care we observed them providing. We noted the enthusiasm of the activity co-ordinator and the encouragement and welcoming of relative's involvement in the running of the service.

People were very complimentary about staff and a number particularly mentioned how friendly and approachable the registered manager was. Two people told us that staff were always, "Kind and friendly," and that, "The manager bent over backwards to get things sorted, that she was "loving" and she laughed and joked with her relatives." A relative told us that she never worried about her relative's treatment in her absence. She said, "All the staff are so friendly." Other comments included, 'The care and support given to my mother was superb' and 'The managers philosophy of good care and love cascades down to her staff.'

A Senior NHS Nurse Practitioner from the older people's mental health team said, "They (staff) are very caring towards their residents always looking for solutions to improve their quality of life if possible. They are approachable and friendly towards any professionals, relatives and visitors that enter the home always willing to give them time, nothing is too much trouble for them."

Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff and the registered manager.

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We saw staff listening to people, answering questions and taking an interest in what people were saying. We observed staff talking people through the care they were providing and confirming with people if it was okay. When speaking to people staff got down to eye level with the person and used proximity and non-verbal gestures (good eye contact, smiles and nods). People responded well to the quality of their engagement with staff. People could choose to stay in their rooms, chat to others in the main lounge and dining room or use the separate lounge to sit quietly and read or meet friends and relatives. This promoted a relaxed and homely atmosphere for people to enjoy.

Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these.

People's rights were protected. People told us that staff respected their privacy. Records showed that independent advocacy support was provided for people who lacked the capacity to make certain decisions. Staff we spoke with described the steps they took to preserve people's privacy and dignity in the service. People were able to state whether they preferred to be cared for by male or female staff and this was

recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. Staff confirmed they sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

People and their relatives had been asked about their views and experiences of using the service. The provider's quality policy included gaining written feedback from people about the service. There were very high satisfaction rates from people who had experienced the service, either as a resident or relative. For example, the results of the 2015 surveys/questionnaires were analysed by the provider and the average satisfaction rating was nine out of ten. This enabled people to stay involved with developments and events within the service and give them the opportunity to influence decisions the provider had made about changes in the service.

Information about people was kept securely in the office and in locked cabinets with access restricted to senior staff. When staff completed paperwork they kept this confidential.

Good

Is the service responsive?

Our findings

People's care was kept under review and changes were made to improve their experiences of the service. One person said, "There is always something going on exercises, singing, bingo, birthday cards, bowling there's lots and lots of things to do." People told us they could go to a registered manager in the event of any problems.

We saw records of referrals to GPs and other external professionals seeking advice from them when required. One family member told us that "GP's come out on the drop of a hat." Staff kept good records of when they liaised with healthcare professions to make sure people received prompt care and treatment to meet their physical and mental health needs.

An NHS Senior Nurse Practitioner told us. 'The manager and staff are extremely happy to work with our service. They are always open and willing to implement any suggestions or recommendations that we offer to them and will feedback whether the intervention has been of benefit or whether it can be adjusted if not working or successful.'

People received care from staff who knew their needs, their individual likes and dislikes and their life stories, interests and preferences. People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing or residential service was suited to the person's needs. Each person had their health and care needs assessed in 16 areas. Risk identified in each area had an associated care plan which listed interventions to be implemented to address the risks. For example, under communication a detailed care plan was in place for staff to follow when supporting a person who was registered blind.

There were some people who received additional support from the community mental health teams. Clear support and advice about this was available to staff on record. A person living with dementia had a reminiscence box and a texture blanket which were used to help improve her wellbeing. This demonstrated that the care people experienced was individualised to their needs.

People's health and wellbeing was protected by in depth care planning. The care plans were well written. They focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. We reviewed how wound care was managed in the care home. Registered nurses had received training in skin integrity in April 2016 according to staff interviewed. They also had support from District nurses via GPs when requested. Information about people's life histories was in place, telling others who people were and about their lives and loves. Knowing about people's histories, hobbies and former life before they needed care could assist staff to help people to live fulfilled lives, especially if they were living with memory loss, dementia or chronic illness.

The registered manager and staff responded quickly to maintain people's health and wellbeing. Dependency assessments had an emphasis on weight and body mass indicators. Nurses had implemented weight management plans based on advice from a dietician and emergency health care plans in response

to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining their health through good hydration and nutrition and minimised the risk of infection. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

Changes in people's needs had been responded to appropriately and actioned to keep people safer. For example, we saw in a care plan that to minimise the risk of falls a person needed their armchair raised. We looked at the person's armchair and saw that it had been raised with specialist feet. Care plans and risks assessments evidenced monthly reviews. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care. These gave guidance to staff and ensured continuity of care.

People had opportunities to take part in activities and mental stimulation. We spoke with the activities co-ordinator about their role which they clearly enjoyed. There was a range of activities available for people from arts and crafts, social evenings and themed parties. The coordinator worked in the service five days per week and was flexible in her approach trying to include as many people as she could to join in the activities she organised. We observed the coordinator was well known by people and had a good understanding of people and of what activities people liked to do. In the nursing wing staff visited people in their rooms to encourage them to take part in activities or help to bring people together as a group giving them as much stimulation as possible. The people we spoke with spoke highly of the activities coordinator and how well she planned the different activities that were provided. Some activities also took place outside the home and on an individual basis, if this was what was needed by individuals.

People experienced a service that enabled them to openly raise concerns or make suggestions about changes they would like. This increased their involvement in the running of the service. There was a policy about dealing with complaints that the staff and the registered manager followed. Information about how to make complaints was displayed in the service for people to see. There had been no formal complaints recorded so far in 2016.

Good

Is the service well-led?

Our findings

The registered manager had been in post for more than eight years and had worked hard to improve people's experiences of the service. They were supported to manage the service by the provider and a team of experienced and competent staff. People spoke highly of the registered manager and staff team. People and their relatives told us that the registered manager and staff greeted them warmly and with respect. People's comments included, "Can't fault it here, mangers are lovely and the boys and girls that work here are lovely too".

An NHS Specialist Nurse said, "The registered manager is very helpful, friendly, interested in caring for the clients, very open to the family's needs, the registered manager is dedicated to her role. Also everyone in the home is very helpful polite."

People's positive experiences of the service were underpinned by consistent improvement. The registered manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. There was a five star food hygiene rating displayed from the last food hygiene inspection. The registered manager told us that the provider listened to, considered and acted on requests made for additional resources. This underpinned the philosophy of care at Cooksditch House in providing warm, compassionate and comforting care.

The service was part of the 'Share my Care' pilot. A project which enables a wide range of health professionals looking after people in the last year of their life to share information 24/7, with a goal of improving the co-ordination of their care. The 'Share my Care' project allows GPs, paramedics, community matrons, district nurses, Macmillan nurses and specialist services to see at a glance, what discussions have taken place with the patient and what care plans are in place. This can include details about whether they wish to be resuscitated in an emergency, their preferred place of care, medications and other important information. This meant that people benefited from a learning based and joint approach outcomes to their care.

General risk assessments affecting everybody in the service were recorded and monitored by the registered manager. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service.

The registered manager reviewed the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. Each audit had an action plan. We could see that issues identified on audits were shared with staff and it had been recorded how and when they would make the improvements. For example, we saw that the registered manager had worked a full shift with staff and had fed back some areas of improvements needed at a minuted staff meeting held in March 2016. This ensured that issues identified on audits were actioned and checked to improve service safety and quality.

Staff told us they felt supported by their registered manager. There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings. These meeting were recorded and shared. Staff said, "The registered manager promotes good team work." And, "If I ever had a problem I know I could go the registered manager and she would sort it out." Information about how staff could blow the whistle was understood by staff. Staff told about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings and handover meetings. Staff felt that they could speak up at meetings and that the registered manager listened to them. For example, we could see from the minutes of a recent team meeting that staff had made suggestions about improving how they managed a person's care and the registered manager had taken this on-board. This meant that staff were fully involved in how the service was run.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The registered manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider was often on site. They had assisted the registered manager to develop the service systems and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed.