Clovelly House Residential Home Limited

Clovelly House Residential Home LTD

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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 14 December 2015 and was unannounced. This was a comprehensive inspection of the service at which we also checked that breaches of legal requirements identified at the last inspection on 12 February and 4 March 2015 had been addressed. We found significant improvements at the service since the previous inspection showing that these requirements were now met.

Clovelly House Residential Home LTD is registered to provide accommodation and personal care for up to 48 people. Many of the people at the home are living with dementia. The home has 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 using the service, and relatives were positive about the service. We found improvements in medicines

Summary of findings

management within the home to ensure that these were administered safely, and also improved safeguarding procedures. People's dignity was being protected, and they had more access to activities and stimulation, and more choices about food. There were improved systems for recording people's consent or best interest decisions made on their behalf if they were unable to do so themselves. Quality assurance procedures were also improved, with regular audits, and feedback sought from all stakeholders, and action plans in place to bring about improvements.

People's health and nutritional needs were met, and staff demonstrated their skills in supporting people with their individual social and emotional needs. People were treated with kindness and respect. This included supporting people who challenged the service patiently and proactively. Staff told us that the team worked well together, and there were enough of them present to meet people's needs.

The home was clean and well maintained, and staff received supervision and training in their role at the home. There had been further training provided in key areas since the previous inspection. An appropriate complaints procedure was in place, and people told us that they felt able to speak up about their concerns, so these could be addressed.

A new electronic care planning system was being used at the home, which had contributed to some shortfalls in monitoring records for people using the service. The registered manager was aware of this issue and working to ensure that these issues were addressed.

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 service was safe. Improvements had been made to ensure that risks to people who use the service were identified and managed, and systems in place to manage people's medicines protected them from harm.

Staff were aware of how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred. Recruitment procedures were in place to determine the fitness of staff to work in the home, and there were sufficient staff working to meet people's needs.

Is the service effective?

Good

The service was effective. Improvements had been made to ensure that the service protected people's rights to make choices about their care. Decisions were made in their best interests if they were unable to do so. Staff supported people with their nutritional needs with dignity, and there was improved choice and presentation of food.

Staff received training and supervision to provide them with the skills and knowledge to care for people effectively.

People's health care needs were monitored and they were referred to health care professionals as required.

Is the service caring?

Good

The service was caring. We observed improved personalised interactions between staff and people using the service that protected their dignity.

People were consulted about the care provided to them, and were supported to maintain independence skills, and with their spiritual needs.

Is the service responsive?

Requires improvement

The service was not always responsive. There was an improvement in the activities and stimulation available for people living at the home. However care records on a new electronic system, did not always record the monitoring of people that their care plans required.

People using the service and their relatives were aware of how to use the home's complaints system.

Is the service well-led?

Good

The service was well-led. There was an improvement in the systems in place to monitor the quality of the service people received.

Summary of findings

People were encouraged to provide feedback, and this was taken into account in bringing about improvements to the service.	

Clovelly House Residential Home LTD

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 last inspection of the home took place on 12 February 2015 and 4 March 2015 at which we found five breaches of regulations concerning safeguarding people, medicines, dignity, care records and activities, and quality assurance. This inspection took place on 14 December 2015 and was unannounced. It was carried out by two inspectors and an inspection manager.

Prior to the inspection we reviewed the information we had about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements, and notifications about significant events relevant to the people who used the service.

There were 45 people living at the home during our inspection. We spoke with eight people who lived at the home, two relatives, a health care professional and a Minister visiting the home. We also spoke with six care staff, the head of care, the activities coordinator, two domestic workers, an administrator and the registered manager. We spent time observing care and support in communal areas including breakfast and lunchtime.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We inspected the home premises including bedrooms and bathrooms within the home. We also looked at nine care records of people who lived at the home, six staff records, and records relating to the management of the service.

Following the inspection we spoke with a health and social care professional by telephone.

Good

Is the service safe?

Our findings

At our previous inspection we found a lack of action taken to report or seek medical advice for significant unexplained bruising found on one person living at the home. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 14 December 2015 we found that the provider had followed their action plan to address the breach described above. This included recruiting a second deputy head of care, arranging safeguarding training for all staff, checking staff understanding of when and how alerts should be made, use of body maps to record bruising, a new electronic care recording system, and auditing accident and incident reports.

People told us that they felt safe in the home, and relatives and other visitors to the home did not have any concerns over people's safety from abuse. People told us that they could talk to staff if they were worried about anything.

Staff members confirmed that they had received safeguarding training and we saw certificates to confirm this. As one staff member told us, "Everyone has had safeguarding training now." They were able to describe different types of abuse, and possible indicators that something might be wrong. They were aware of the procedure for reporting concerns and the home's whistleblowing procedure. They described to us the actions they would take if they had a concern including recording, asking advice and reporting to the person in charge, and whistle blowing if their concerns were not addressed. Records showed that bruises were recorded in people's daily records as they were found, and these were also recorded on body map charts.

At our last inspection we found that people did not always receive safe support with their medicines, including lack of supervision of a person taking their medicines and a lack of clear guidelines for PRN (as required) medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to this regulation. No medicines were left with people without staff supervision to ensure that they were taken safely, and there were no longer any PRN medicines for behavioural management prescribed. Guidelines were recorded for the triggers for other PRN medicines administration. Staff administering medicines wore a tabard to ensure that they were not disturbed whilst carrying out this task. They had information available to them about what medicines were for and side effects to look out for.

There were no gaps or inconsistencies between medicines stocks and records, and medicines were signed in and out of the home as appropriate. Controlled drugs were stored and recorded appropriately, and medicines stored in the clinical room had the storage temperature recorded to ensure that this remained within the required limits. The temperature of each medicines trolley that was stored securely in the lounges was not being monitored. We discussed this with the registered manager and she advised that this would be put in place without delay. Medicines were being audited monthly by senior staff at the home, to ensure that there were no gaps in records, or other errors that might place people at risk.

There were risk assessments in people's care records to ensure that risks to their safety were minimised. These were reviewed on a monthly basis covering relevant areas such as moving and handling, falls prevention, preventing pressure ulcers, and addressing behaviour that challenged the service.

We saw that specialised chairs and cushions were available for people needing these and height adjusters had been fitted for others. We also observed staff supporting people to transfer and mobilise safely using equipment as detailed in their care plans.

Health and safety audits were carried out monthly, and there had been a recent visit from a fire officer in November 2015 which indicated that fire safety procedures were satisfactory. Each person had a personal emergency evacuation plan in place. Staff had training and demonstrated an understanding of action to take in an emergency such as a person being injured from a fall.

People living at the home and their relatives were satisfied with the staff support provided. Staff told us that there were enough staff available to ensure people were well cared for. Our observations indicated that there were

Good

Is the service safe?

sufficient staff members to provide person centred care to people across the home on the day of the inspection visit. We looked at the staffing rota for the previous month and the week of the inspection. These indicated that there were usually at least nine staff on during the morning (including the head of care), six staff on in the afternoon and four staff on duty at night. Agency staff were used in the home on rare occasions when other cover was not available, and extra staff were booked to escort people to hospital appointments.

The registered manager advised that the home was fully staffed, with recruitment already underway to cover a staff member who would be leaving at the end of January 2016. She had created a second position of deputy head of care, and also appointed an activities coordinator since the previous inspection. Staff told us that sickness and absences were usually covered effectively. The night staff continued to provide morning care for seven people at the end of their shift, however we were told that these were people who preferred to get up early. One staff member who had worked at the home for under a year, told us that there had been a lack of staff when they started, but this was much better now, so they now rarely had to use agency staff.

Safe recruitment procedures were in place to ensure that staff were suitable to work with people. Inspection of staff files, including those for newly recruited staff, included evidence of people being checked for fitness to work. We saw records of application forms, interview records, disclosure and barring checks, written references, identity checks, and copies of employment histories and qualifications. There were records of induction training provided to new staff, including observations of care provided. Only staff with a national vocational care qualification and experience of working with people with dementia were recruited to provide care within the home.

The home was clean and in a good state of repair and decoration throughout, with no unpleasant smells detected. Appropriate health and safety certificates were available for the home, and maintenance records indicated that repairs were carried out swiftly when needed. Kitchen inspection checklists were available to ensure that food hygiene procedures were followed. Cleaning staff told us, “We have done COSHH [control of substances hazardous to health] training, fire training and safeguarding.” We observed them using colour coded mops and buckets for different areas of the house.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about the support provided by staff with their day to day care, provision of food and access to health care professionals.

At our last comprehensive inspection of Clovelly House Residential Home we found that the service did not always protect people's rights to make choices about their care and have decisions made in their best interests if they were unable to do so. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 homes 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.

At our inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements of the above regulation. This included submitting DoLS applications for all relevant people, with urgent authorisations prioritised, holding best interest meetings, and staff training on the MCA and best interest decision making.

Care records included information about whether people had capacity to make decisions about their care and treatment, and included best interest decisions made for those who were unable to do so. Staff could explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. The registered manager conducted regular audits of DoLS applications to ensure that these were up to date. At the time of the inspection 46 applications had been submitted, with 31 granted. However we did note that in the small number of cases where conditions were attached to the authorisations, these were not always clearly recorded in people's care plans with evidence of how they were being met. For example one person was to be offered regular activities, but as they often refused these, offers to engage in activities were not always recorded. We discussed this with the registered manager who undertook to ensure this was made clear within the home's new care planning system.

We observed staff enabling people to walk around the communal areas of the home without restrictions, but with support when needed. Bedrooms had a basic summary care plan displayed so all staff knew the person's preferred getting up time, likes/dislikes, and important care needs. Approximately half of the people living at the home were up and dressed when we arrived at 7.45 am. People we spoke with did not express any concerns about the time they were supported to get up in the morning or go to bed at night. They told us, "It's alright here," and "It varies although I can stay in bed longer if I want to."

Some people had signed their care plan confirming their agreement with it but it was not clear how they or their advocates had been involved in the drawing up of the care plan. People's consent was recorded for the use of people's photographs in care planning. We discussed with the registered manager how more decision specific mental capacity assessments, could be recorded, with best interest decisions where needed, for example as to whether people wanted to have a flu jab, agreement to medicines, bathing and clothing purchases.

At our previous inspection of Clovelly House Residential Home we found that staff support to meet people's nutritional needs did not always protect their dignity, a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements of the above regulation. People told us that they were satisfied with the food served in the home. One person told us, "She's a lovely cook," and a relative told us that the food had "got better." We observed that food provision had improved both in choices

available and in its presentation. Tables were laid attractively with a colour coded theme to indicate the particular lounge, for example the red rose lounge had red napkins and flowers. Some people living at the home assisted in setting the table, for example putting out water jugs.

Since the previous inspection, the registered manager had taken action to provide more food choices for people, providing large print menus, and ensuring that people were not sitting at tables for long periods of time unless they chose to do so. Drinks and food (such as toast or tea) were no longer preprepared for people, ensuring that they could make choices about their diet. Staff communication with people during meal times had also improved.

People's nutritional needs were assessed and when they had particular preferences or needs regarding their diet these were recorded in their care plan. Drinks and snacks were available at regular times throughout the day. People identified as not eating well, were supported to eat patiently, with the staff member engaging with them throughout. Staff were aware of people who had particular dietary needs, and an alternative menu book was in place for recording alternatives provided to people from the main menu. There were also dietitian instructions available in the kitchen for particular people.

Breakfast was served at 8.50am on the day of our visit. Most people ate in the dining areas of the various lounges although a few preferred to take breakfast in their armchairs and staff made small tables available for them to use. Staff told us that two people preferred to have breakfast in their room. Staff asked people what they wanted for breakfast. For example one person who was said to usually prefer a different cereal wanted cornflakes on the day of our visit. We saw that a selection of cereals were available or hot porridge. People were asked if they wanted milk with their porridge and sugar with their cereal. People were offered a choice of brown or white toast and served with the conserve of their choice. We saw that people were offered coffee or tea. One person who was on a special diet was served an additional boiled egg. There was a quiet but pleasant atmosphere over breakfast and lunch. Staff chatted to people as they were served their meals and supported people to eat where this was required. We saw that staff supported people to eat in an unhurried and courteous manner. Our observation of lunch showed that staff continued to offer choice and to support people appropriately. They gently encouraged people back to the table if they wandered off unless it was clear that the person had finished their meal and preferred to sit elsewhere. People were offered second helpings and a choice of desert.

People were supported by staff who had the necessary training to meet their needs. Staff said they received regular supervision and appraisal, and there had been a lot of training in the past year. They told us, “It’s a brilliant place to work. It’s a big care home but it doesn’t feel like it. It’s homely and there is good team work. We have regular staff meetings. For example at the last one there was a discussion about care plans and the new system.” Senior staff told us, “The staff are up for change and see the point of it,” and “‘I always stop staff if I see them doing things the wrong way. And show how things should be done.” One senior staff member said, “I have been doing a lot of training and teaching with staff. About personal care and how to provide this, about taking to people living here, about activities they can try, manual handling and how to interact with residents. And training on using the hoists.”

Staff records showed that staff had received supervision sessions approximately two-monthly and annual appraisals in line with the provider’s policy. Records showed that supervision sessions were themed, to cover a relevant area of training such as safe moving and handling, and the dining experience. Records did not evidence a two way discussion between staff and their supervisors, and we discussed this with the registered manager, who undertook to ensure that this was addressed.

Staff who had recently started to work at the home had completed induction training and were working towards the Care Certificate as appropriate. Training records showed that most staff had completed all areas of mandatory training in line with the provider’s policy, and those who had not had been identified and were due to complete this training. Staff had recently completed training in safeguarding, infection control, moving and handling, dementia, challenging behaviour and pressure ulcer care. An action plan was in place for training, with further staff booked to undertake training in medicines, food hygiene, nutrition, mental capacity, and fire safety. Care staff had attained a national vocational qualification in care, with many staff trained to a higher qualification such as a nursing qualification.

Good

Is the service effective?

A health care professional told us, “Staff seem to handle people and challenging behaviour very well, often diffusing potentially tricky situations by the way they respond to people who are agitated.”

People were supported to access the health care they needed and said they were able to see their GP and other health professionals when they wanted. Relatives told us they were kept up to date with their relative’s medical situation. Care records showed that people had regular contact with health care professionals including district nurses, community psychiatric nurses, dentists, opticians and chiropodists. Health care professionals told us that they were happy with the support provided by the home in meeting people’s health and social care needs.

People’s weights were monitored regularly with appropriate support plans put in place to address people who were losing weight. We observed that relevant people were provided with supplements and fortification (on the advice of a dietitian or GP), GP monitoring, and referral to a speech and language therapist if needed.

The home had three floors and five separate staircases. Since the previous inspection efforts had been made to differentiate different areas of the building. For example the red rose lounge had colour coordinated table setting, flowers and other decorations in red. Other lounges were less distinctive although there was increased signage provided throughout the building.

Good

Is the service caring?

Our findings

At our previous inspection we found that people's dignity and choices were not always respected. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements the above regulation. This included appointing a dignity champion to monitor whether people's dignity was protected within the home.

Relatives told us, "Carers are so caring you wont find better," and "They put themselves out, so approachable," and "They are a friendly voice at the end of the phone." Staff spoken with were positive about the culture within the home. They told us, "I like working here. Its good to provide care for these people," and "Mrs Thorn wants us to provide high quality care for people. I prefer working in a place that cares about the quality of care." Staff showed an understanding of people's needs with regards to their disabilities, race, sexual orientation and gender.

We observed good interaction between staff and people living at the home. They spoke with people at eye level, and let them know what was happening when they were supporting people, for example with food or mobility. We saw staff knocking on people's doors and entering after a pause with a cheerful 'good morning.' People were able to walk about as they pleased. We observed a staff member taking the time to find out where a person wanted to go and supporting them to do so.

People were largely comfortable with staff and happy to chat. Staff made an effort to engage people in conversation for example one staff member asked, "what's in the paper today?" They were also very polite with others who did not want to chat. We saw them asking people before they did something, for example 'do you want a table?' and 'can I help?' before supporting people with food or to move around. One member of staff explained that they tried to find distractions for one person who could become fixed upon picking things up from the floor, keeping them busy with helping to lay the tables for example.

The dignity champion talked to us about the importance of using people's preferred names, and advised that she conducted regular observations in the home. She arrived at the home with a custom made birthday cake for one person whose birthday was celebrated that day. People looked clean and tidy and well presented. The majority of bedrooms were personalised and homely. Care plans included detailed life stories about people using the service and evidence that people's spirtitual needs were met with support to attend places of worship or have religious services within the home. On the day of our visit, a church minister was visiting the home, who told us they came regularly to visit two people as well as providing regular communion services and a recent carol singing service. They told us that the owner was proactive in initiating and maintaining the link with the church. There had also recently been a Chanukah lighting ceremony for Jewish people living at the home.

People were encouraged to feedback about their experience of care in the home at resident and relatives meetings held on a regular basis. Visitors to the home told us that staff were friendly and helpful and skilful at working with people who could be challenging.

Requires improvement

Is the service responsive?

Our findings

At our last inspection we found that care plans were not always accurate in outlining people's care needs, and were not always being followed appropriately, and people did not always receive sufficient stimulation within the home. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements the above regulation. However due to the implementation of a new electronic care planning system, there were some gaps in monitoring and recording for people living at the home.

People told us that there was enough to do at the home, one person told us, "I think so. I like to go into the garden. The staff will take me out there." A relative told us, "They've got more activities than they had." We observed a significant increase in recorded activities for people living at the home including recent reminiscence, music, and art sessions, ball games, and quizzes. Religious services were held regularly, and entertainers were booked to attend the home on a regular basis. There had been a recent Christmas pantomime performed at the home, regular musicians performed, and an activities group specialising in activities for people in care homes visited regularly. We saw records of regular trips out for people in the local area when the weather was good. People were supported to use an accessible keyboard to access the internet, and this was being developed to encourage them to keep in touch with friends and family and pursue their interests and hobbies. The day before our inspection, a Christmas party took place at the home, and people told us that this was very enjoyable.

We observed staff engaging people in a range of activities on a one to one basis, throughout the day of our visit. This included conversations about the news, providing art materials for one person, and encouraging them to be involved in household tasks, such as watering the plants.

Staff also told us about their key working responsibilities for identified people, including ensuring that they had all clothing, toiletries and other supplies they needed from the local shops, engaging them in activities of their choice, and supporting them to maintain contact with relatives and friends.

Since August 2015, care records had been transferred on to an integrated computer system for storing people's care planning records and for monitoring purposes. This was accessed via a desk top computer, a lap top and three tablets (one per lounge). The layout of care records included an assessment overview covering a detailed list of areas, graded as high, medium or low risk, and the last care review (dated and signed). Topics covered included the support to protect the person's rights, medical and life history, nutrition and hydration, pressure area monitoring, mobility, dementia, mental health, mental capacity, personal care requirements, spiritual needs and night time routines. Where appropriate advanced life plans were in place including whether the person wished this to be regularly reviewed or not. Some of these plans needed more personal information about people's preferences to ensure that they were person centred, for example more details on how best to support somebody with their mobility.

Relevant risk assessments were recorded, including assessments for behaviour support where needed. A health and social care professional told us, "X manages quite well. The staff have worked very well with X's family in respect of how best to support him with his behaviours .. and physical needs. As a consequence X's weight is becoming under control and he is moving about more." They also noted that staff worked well with a person who could become very agitated. "They are also able to manage her behaviour very well and are able to help her calm down."

Staff told us that each person's care plan was reviewed monthly triggered by the computer system and that risk assessments were integrated within each person's plan. Daily entries were colour coded to indicate people's mood. Risk assessments identified action to be taken to address people's risks but we did not always see evidence that these were being carried out. For example two people were to be checked two hourly at night, and another person was to be checked hourly, but there were no records of this being undertaken. Staff confirmed that records on such monitoring was not recorded. Another person was recorded as needing weekly monitoring of their blood glucose levels, however this had stopped in November,

Requires improvement

Is the service responsive?

without any clear recording of the reason why. This person had a risk assessment describing the risk of a drop in their glucose levels which might result in them becoming unconscious. However there was no information for staff as to what actions needed to be taken should this happen. In two people's care plans, it was recorded that they should be encouraged to mobilise and undertake gentle exercise. However support to mobilise or exercise was not monitored or recorded in any way. Overall it was difficult to confirm from daily entries recorded for people that their care plans and risk assessments were met.

Daily notes had very recently been transferred to the computer system, and we found significant gaps in these records in recent weeks, with very few records of any night care provided. We found paper copies of turning charts, body charts and food and fluid charts being completed for people. We were told that although these were available on the new system, they could not be accessed from the tablets that staff used in each lounge. Although body maps were being used to record bruising or other changes in people's skin condition, their use was not consistent. Frequently new bruises were recorded on the same charts as previous bruises, making them difficult to follow. Some bruises were not mentioned in people's daily notes, although recorded on the body maps, and some were recorded in daily records without being recorded on body maps. Often there was no attempt to investigate how bruises might have been sustained. In view of the newness of the electronic record keeping system, we discussed some of these issues with the registered manager as areas for further developing staff use of the system, to ensure that it provided safe monitoring of people's care. She undertook to work with the staff team to address these issues.

Records of incidents and accidents indicated that appropriate action had been taken to address concerns including seeking GP or an occupational therapist's advice, recording any bruises, and rearranging furniture, providing sensor mats, and bed sides. Audits were undertaken of these records, but we did not see evidence that any patterns or trends had been identified.

People living at the home and relatives we spoke with said that they knew how to make a complaint. They were confident that if they made a complaint this would be listen to. Copies of the complaints procedure were available in the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the registered manager and inform her about this promptly. Records showed that when issues had been raised these had been investigated and feedback was given to the people concerned within 28 days. Complaints were used to bring about improvements to the care people received. People were also encouraged to discuss their views about the home at residents and relatives meetings. Records of compliments received by the service were also seen.

Good

Is the service well-led?

Our findings

At our previous inspection we found that there were gaps in the systems to monitor the quality of the service people received. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 14 December 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements of the above regulation including engaging a consultant to support the home with quality management, and regular audits of key areas of the home's performance. We found significant improvements in place since the previous inspection. The home had also gained reaccreditation under the Gold Standards Framework for end of life care.

Recent quality assurance audits had been undertaken for the home. Action plans were produced for improvements to be made in each area. For example the activities action plan included setting up a number of activities on the the new computer system for residents to use including skype accounts, games, art and drawing sections, youtube clips of interest, and photograph portfolios.

Other audits undertaken regularly included audits of infection control, care plans, deprivation of liberty safeguards, kitchen safety, laundry and maintenance. Each had a list of actions to be taken as a result, and records indicated that these were carried out. The integrated quality in care homes team from the local authority had also been providing support to the home, and the home had a work plan in place of areas to address.

People and their relatives spoke positively about the home's management. One person told us, "The home is very well organised." Staff at all levels were open, and happy to answer questions and spoke well of the management of the home. They told us, "Management are very supportive. Meetings are a two way conversation," and "The manager would take it very seriously if people were not providing care properly. She would be giving warnings about this."

Staff felt well supported and supervised. One staff member said, "I have good supervision from [the registered manager]. I think she is very good. It's very good to be able to talk with someone who has so much experience." Staff told us that their suggestions were listened to by management.

Staff were clear about their roles and responsibilities and attended regular team meetings. These were well attended, and covered a range of areas including grooming, rota changes, training, and awarding the employee of the month.

Minutes of residents and relatives meetings indicated that these were used to consult with people about the service, and provide them with relevant information. For example the most recent meeting covered menus, likes and dislikes, staffing updates, planned outings and activities.

A residents and relatives satisfaction survey from June 2015, with a response rate of 28 out of 44 people was generally very positive, with one suggestion for more musical and singing activities at weekends. A further residents survey from September 2015 with a response rate of 65 percent was also very positive. The most recent staff satisfaction survey with a response rate of 29 out of 43 people was positive, except in staff feeling involved when changes were made. There was also good feedback from the visiting professionals satisfaction survey with 10 of 13 people responding.

An annual quality assurance assessment report for the home from September 2015 included the responses from all recent surveys, and the CQC inspection report, and listed things that were done well and actions to be undertaken.

Staff advised that management were swift to take action when repairs were needed in the home. We saw records of regular fire drills and fire bell checks, water temperature checks, and servicing of alarms and firefighting equipment as appropriate. A fire risk assessment and evacuation plan were in place, and appropriate safety certificates were available for the building. There was a rolling maintenance and redecoration programme in place for the home.