Christadelphian Care Homes

Olivet

Inspection report

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Date of inspection visit:
06 July 2017
10 July 2017
13 July 2017

Date of publication:
25 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 06, 10 and 13 July 2017 and was unannounced on the first day but the registered manager knew we would be returning on the 10 and 13. At the last inspection on 08 and 09 April 2015, we found that the provider was meeting the requirements of the Regulations we inspected and had been rated as Good in all domains.

Olivet Nursing Home provides accommodation and support for up to 68 people with nursing and personal care needs. The home comprised three units, Garden House for residential care, Magnolia for nursing care and Cedars for those living with dementia. At the time of our inspection there were 65 people living in the home.

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

There were systems in place to monitor and improve the quality of the service. However, these had not always been consistently applied to ensure where shortfalls had been identified, were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

People received care and support from care staff that had effective skills to meet people's needs, although some of the training for the nursing staff required updating. Staff received supervision and appraisals, providing them with the appropriate support to carry out their roles.

We saw staff treated people as individuals, offering them choices whenever they engaged with people. Staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible. Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. However, mental capacity assessments were not always up to date and consistently completed to clearly show what decisions people were being supported or asked to make in relation to their care. Applications had been submitted to deprive people of their liberty, in their best interest; therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who lived at the home were kept safe. Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. Potential risks to people had been identified and appropriate measures had been put in place to reduce the risk of harm. People were supported by sufficient numbers of suitable staff that had been recruited safely. People received their medicines as prescribed.

People spoke positively about the choice of food available. Staff supported people who were living with dementia to eat and drink to maintain their health and wellbeing in a caring and sensitive way. People were

supported to access health care professionals to ensure that their health care needs would be continuously met.

People and relatives told us that staff were kind, caring and friendly and treated people with dignity and respect. The atmosphere around the home was warm and welcoming. People were relaxed and staff supported people in a dignified way. People and relatives told us they were well supported by staff and the management team and encouraged to maintain relationships that were important to people. People's health care needs were assessed and regularly reviewed. Relatives told us the management team were good at keeping them informed about their family member's care. People were supported by a dedicated activities team that provided numerous opportunities to optimise people's social and stimulation requirements. People and their relatives told us they were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly.

The management team had a number of systems to gain feedback from people living at the home, relatives and visitors. This included resident/relative meetings, satisfaction questionnaires, regular reviews and a suggestion box. People, their relatives and staff told us the home was well organised and 'well-led.'

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 remained safe.

People were safeguarded from the risk of harm because staff was able to recognise abuse and knew the appropriate action to take.

Risks to people were assessed and managed appropriately. There were sufficient numbers of appropriately recruited staff to provide care and support to people.

People received support to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received care and support from staff that were trained and knew people's needs, although the nursing staff required some of their training to be updated.

Mental capacity assessments did not consistently identify what decisions people were being asked or supported to make in relation to their care.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

People were supported to receive food and drink that met their needs and staff supported them to receive medical attention when needed.

Is the service caring?

Good

The service remained caring.

People had good relationships with staff, and their individuality, independence, privacy and dignity were respected and promoted.

People made decisions about their care with support and guidance from staff and were supported to maintain contact

with relatives and significant people in their lives.

Is the service responsive?

Good

The service remained responsive.

People were involved in planning and agreeing their care and received care that met their individual needs.

People were confident that their concerns would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the service but they did not always ensure identified shortfalls were investigated thoroughly and appropriation action plans put in place to reduce risk of reoccurrences.

People were happy with the service they received and were positive about the registered manager and staff.

Olivet

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 unannounced inspection took place on 06 July 2017 with further announced visits on the 10 and 13 July 2017. The inspection team consisted of one inspector, an expert by experience and a specialist advisor on the first day and one inspector on the 10 and 13 July. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health difficulties.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

We spoke with 13 people, four relatives, the registered manager, the deputy manager, the group care manager and seven staff members that included nursing, care and domestic staff. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a 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 looked around the building to check environmental safety. We also looked at records in relation to five

people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included three staff recruitment files to check staff were recruited safely. The provider's training records to check staff were suitably trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a quality service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt people were safe living at the home. One person told us, "Oh yes, very much so. I'm glad to be here." Another person said, "They [staff] can all be trusted." A relative explained, "Well I would say [person's name] was safe." Another relative told us, "[Person's name] has been here a few years and yes I'd say she was safe." Not everyone could tell us about their experiences of living at the home but we saw from their demeanour around staff people looked happy and relaxed.

Everyone spoken with said they would speak with the registered manager or a staff member if they had any concerns. Staff told us they had completed safeguarding training and demonstrated in their responses, they were confident about recognising signs of and reporting abuse. One staff member told us, "If I noticed any behaviour changes that was unusual for people I'd tell the nurses or [registered manager's name] – that's something we are quick to pick up on." Another staff member explained, "There is a set protocol for us to go through but if nothing was done I'd go further up but they're [management team] are really good at dealing with any problems." The provider's safeguarding procedures provided staff with guidance on their role to ensure people were protected. We looked at records and these confirmed that staff had received up to date safeguarding training. The provider kept people safe because there were appropriate systems and processes in place for recording and reporting safeguarding concerns.

People and relatives we spoke to confirmed they were involved in completing risk assessments. One relative told us, "[Person's name] had a very nasty fall a few years ago and it affected their walking, they can no longer weight bear so they have a recliner chair now which Olivet arranged for her." A staff member explained, "The main risk we come across is people falling. A lot of people like to walk around, it helps maintain some independence and we don't stop people but it means we do have to be nearby, checking on people. We have crash mats in some rooms and there are also alarms that are triggered if people get out of bed this makes us aware who's walking around." We saw risks were recorded in people's care and health records and appropriate professionals were involved to help keep people safe. People were protected by staff members who understood the risks to them and how to reduce the likelihood of harm through ill health, accident or injury. Staff we spoke with explained what they would do in the event of a fire. Staff were also able to describe the risks to individual people and the steps they took to reduce the risk of harm. For example; staff understood risks including those related to pressure areas and risk of choking.

There were mixed responses from people and relatives we spoke with about staffing numbers. One person told us "As far as I'm concerned they [staff] are around when I need them." Another person said, "I do not think they have enough staff." A relative explained, "Staff are always around and come quickly when they are needed." Another relative told us, "Broadly speaking there is sufficient staff but when there is the changeover in shift you only tend to see visitors on the floor and it can become difficult if you see people becoming a little upset and it's the visitors that deal with it – I think the handover needs to be split." The provider information return (PIR) stated that staffing levels had increased to reflect the increasing support needs of people living at the home. The registered manager explained how the staffing levels were determined and we saw there were sufficient numbers of staff in place to keep people safe during the inspection.

Staff we spoke with confirmed there were sufficient staff to keep people safe and to meet basic care needs but felt they could be more proactive with the provision of person-centred care if they had more staff. One staff member told us, "We're always understaffed, there's supposed to be six on [name of unit] but more often there's only five so we get used to it. We can't answer bells as quickly as we could or spend time with people talking to them." Another staff member said, "When staff are sick at short notice we have to cover each other and it's not always possible. My fear is that the goodwill is running out, staff are tired, they feel helpless and are worried that if action is not taken soon it will impact negatively on the residents' care." The registered manager confirmed they do not employ agency staff, but there was bank staff available that was known to people who lived at the home and volunteers were also available to provide support in emergencies. We discussed the concerns raised to us with the registered manager and group area manager. Both agreed this was an area that required urgent reviewing and reassured us staffing levels were sufficient based on the number of people receiving care. They confirmed they would review this and raise the comments with the provider.

The provider had an effective recruitment process in place to ensure staff were recruited with the right skills and knowledge to support people which was reflected accurately in the PIR. Staff told us they had pre-employment checks before they started to work at the home, including a Disclosure and Barring Service (DBS) check and references. The DBS check can help employers to make safer recruitment decisions and reduce the risk of employing unsuitable staff. We looked at three staff files and found the appropriate checks had been completed.

People told us that they received their medicines as prescribed. One person told us, "I get my medicines when I need them." A relative told us, "As far as I am aware there are no problems with [person's name] medicines." During our inspection we saw several examples when nurses explained to people it was time to take their medicines and encouraged them to take it. We saw guidelines were in place to show staff how to administer certain medicines such as creams or medicines required on an 'as required' basis. We found where necessary, in people's best interest, discussions had taken place with the family members, nursing staff, GP and pharmacist for the medicines to be given disguised in food. Staff recorded the administration of medicines on Medicines Administration Records (MARs). We looked at five MAR charts and the controlled drugs book in detail for the last three months. The book had been completed correctly however there were some medicine recording errors on the MARs. We found on checking individual care records; there had been no impact on people's health and wellbeing. Medicines coming into the home had been clearly recorded. Medicines were stored safely and there was an effective stock rotation system in place.

Requires Improvement

Is the service effective?

Our findings

The provider information return (PIR) stated that medicines were managed by 'medication trained nursing and senior care staff.' However, on checking staff training and competencies for safe management of medicines, we found nursing staff had not received refresher training in medicine management or had their competencies checked for four years. Although the provider's medication policy stated that medicines should be given by suitably trained and competent staff, the policy did not specify how competency would be attained or how frequent training should take place. Appropriate training, support and competency assessment for managing medicines is essential to ensure the safety, quality and consistency of care. There should be robust processes for the training and competency assessment for staff administering medicines. This is to ensure staff receive appropriate training and support, have the necessary knowledge and skills, are assessed as competent and have an annual review of their knowledge, skills and competencies. The registered manager started to arrange for refresher training at the time of our inspection.
Staff we spoke with told us they had received training to support them in their role. One staff member said, "I'm happy with the level of training I've received." Another staff member told us, "There is always some sort of training going on." The PIR stated the new staff completed an induction that including working alongside more experienced staff before being assessed for their competency and 'signed off'. Staff also received training to support completion of the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. This was confirmed when we spoke with staff new to the home. One staff member explained their induction to us, "It was good, I had to shadow other staff although I did feel it was a little rushed at times but if I had any problems, I could always ask." Staff we spoke with confirmed they had supervision although it may not have been as frequent because a senior staff member had left the provider and a new deputy manager had only recently joined and was in the process of reviewing supervisions and appraisals. Staff we spoke with told us they generally felt supported by the management team and that they would speak with the registered manager if they were concerned about anything.

People and relatives we spoke with all told us they felt staff had the skills and knowledge to support people living at the home. One person told us, "I can't fault them [staff]" Another person said, "The staff are excellent, they do such a difficult job." A relative explained, "[Person's name's] needs are most definitely met by the staff, they know mum very well and just what to do to care for her."

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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked the provider was working within the principles of the MCA. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "This person cannot make decisions sometimes, when this happens we re-assess their capacity and give them information to enable them to make the right decision. I do this always thinking of their best interest in mind." We saw where people lacked mental capacity to make certain decisions for themselves mental capacity assessments had been completed. However, it was not always clear what

decision relating to the person's care and support was being made in the person's best interest. We saw some assessments contained information relating to other people and were similar in context; therefore not always individualised to the person's circumstances.

People can only be deprived of their liberty so that they can 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). Staff we spoke with were aware of their responsibilities to sometimes restrict people from certain activities in order to keep the person safe. One staff member explained, "We have a lot of people living here with dementia and they don't always know what is best for them so we [the provider] sometimes have to make those decisions, in their best interests, to keep them safe." Although we saw applications had been made to authorise restrictions on people's liberty in their best interests in order to keep them safe; the mental capacity assessments completed to support the applications were not always time specific. For example we saw some applications referred to mental capacity assessments completed up to two years ago. However, the best interest assessors upon visiting the home agreed people lacked the mental capacity to consent to certain decisions and the Supervisory Body agreed the applications. This ensured the provider complied with the law and protected the rights of people living at the home. We discussed with the registered manager and group manager the shortfalls in the completion of mental capacity assessments. They agreed processes would be put in place immediately to review, where appropriate, people's mental capacity to consent and ensure accurate and up to date information was recorded in people's care plans.

People we spoke with told us they were satisfied with the food they received. One person said, I think that it is very good [food] and I'm a bit fussy about food so that's high praise from me." Another person told us, "I am happy with the choice, they have more variety here." A third person explained "It's excellent [food], they've just taken on a new chef." We saw people that were seated in communal areas, were supported by staff to choose for themselves, whether to eat at a dining table or in their lounge chairs. Staff provided one to one support for people who required support. People with specific dietary requirements were given appropriate meals and supplements to meet their health and nutritional needs. The PIR referred to a 'Food Focus Group' and during our visit, the group had met to discuss menu changes and what improvements could be made. Changes to the menu included new gluten free, vegetarian and low sugar foods being made available. One person told us, "It's good that we are involved it has greatly improved, the new chef has made it [food] much more interesting with spices and so on." We saw people who chose to remain in their rooms had drinks available to them.

People's nutritional needs were assessed regularly and there was information in people's care plans that detailed their nutritional preferences and needs. The care plans we looked at showed some people were at risk of losing weight and we found plans had been put in place to guide staff in how to support people to gain weight and prevent further weight loss. We found advice was sought from dieticians and staff would add additional calories to people's food. For example, the use of cream instead of milk. Additional support was also sought from speech and language therapists (SALT) where people had difficulty swallowing their food.

People we spoke with told us they were regularly seen by health care professionals, for example, the GP, tissue viability nurses, optician or dentist. Relatives we spoke with had no concerns about their family member's health needs. A relative said, "They [staff] are very quick to get the doctor in when needed." We saw that care records were in place to support staff by providing them with clear guidance on what action they would need to take in order to meet the people's individual care needs. This supported people to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

Everyone we spoke with said staff were kind and caring. One person said, "When my husband died, I always got a cuddle from staff when they saw that I was feeling low. They [staff] are always bright and cheerful when they come in, they [staff] are very caring." A relative told us, "We are in no doubt about the care mum receives from staff is excellent, they are always caring and it is genuine affection they show to mum, we couldn't be happier with the home." The provider information return (PIR) stated that the provider's ethos was to enable 'loving, individual care and recognise the individuality and value each person' living at the home. We saw people were relaxed in the company of all the staff and staff were visible and engaged in friendly conversation. We saw that staff treated people with kindness and empathy; they spoke to people in a sensitive, respectful and caring manner. Staff understood people's communication needs and gave people time to express their views, listening to what people said. Staff were able to demonstrate in their responses to us that they knew people's individual needs, their likes and dislikes and this ensured people received individualised support and care.

People we spoke with told us they felt involved in decisions about their care and support needs. One person said, "They [staff] do give me a choice and say do you want this or that." Another person said, "I'm completely independent, if I don't want something, I tell them [staff]." Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. For example, one person could become upset when personal care was being given. Staff explained they would leave the person for a period of time and return later. If the person was still upset, a different staff member would attend to the person. Care plans we looked at included information about people's previous lives, their likes and dislikes and their individual preferences. This ensured staff were kept informed of any changes and people were supported to make their own decisions about their care and staff respected people's individual choices.

People we spoke with told us staff respected their privacy and dignity. One person told us, "I can lock my door and the staff always knock before coming in." A relative told us, "Most definitely the staff respect mum's privacy, they always ask us to leave the room if they need to do anything." Staff addressed people by their preferred names and knocked on people's bedroom doors before entering. Some people chose to have their bedroom door open or closed and their privacy was respected. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Staff were friendly and they laughed with people and supported people to move around the home safely. This was carried out with care ensuring people moved at the pace suitable to them.

Everyone we spoke with told us there were no restrictions when visiting. A relative told us "Although we tend to visit at the same time, I'm sure we could just turn up and it wouldn't be a problem." There were separate rooms and areas for people to meet with their relatives in private. We found people living at the home were

supported to maintain contact with family and friends close to them.

Good

Is the service responsive?

Our findings

People we spoke with and their relatives told us they were satisfied with how people's needs were being met. We found people were supported to receive care and support based on their individual needs. The provider information return (PIR) stated that care plans and life histories were updated for people living at the home. A relative told us, "We're all involved in amending/updating care plans." One person explained when asked if they were involved in their care, "I am the boss." Staff we spoke with were knowledgeable about people's needs and risks associated with their care and were able to give good examples of personalised care and how they managed difficult situations. For example, when people became upset and angry. Care plans we looked at were person centred and included details of people's preferences and choices and showed that people's needs were reviewed on a regular basis. Staff told us that they received updates in changes in people's needs in handovers between staff at shift changes. Any changes to a person's health was identified and recorded in the care plans and showed the involvement of health care professionals when needed.

We saw that people were supported to participate in social activities of interest to them. The PIR referred to the provider's 'well-being team' delivering group and 1:1 activities, events and outings. On the first day of our visit a large group of people from Cedars had been taken to Weston Super Mare for the day. We were told by people and relatives we spoke with that the provider went to 'great lengths' to ensure people had enough to keep them stimulated and prevent social isolation. One person told us, "There is always something going on." We saw staff encouraged people to participate in gentle exercises, other people were engaged in reading magazines, newspapers and books. During our visits, we saw people were also being supported by volunteers, people smiled and laughed with volunteers during their conversations. A relative said, "We are a very close community at Olivet and have a common interest." Most of the people living at the home followed the same religious faith. People we spoke with told us their religion was important to them and they attended services conducted at the home. For those people who were unable to attend the services due to ill health, they could view the service on their television that was streamed into their room. This enabled people to continue to pray in private and practice their faith in the comfort of their own bedroom.

Complaints information was displayed at the home. People and relatives we spoke with told us they knew how and who to complain to. One person told us, "I've no complaints, I'm very happy here." A relative said, "I'd let [registered manager's name] know there was a problem." We reviewed the complaints file which contained an up to date policy and the PIR stated that two complaints had been made since our last inspection. The registered manager told us complaints and concerns were be taken seriously and used as an opportunity to learn and improve the service. We saw the complaints had been investigated and resolved to the satisfaction of the parties concerned. People and relatives we spoke with confirmed the provider did invite them to feedback on the quality of the service. There was a visitor feedback form available at the main reception and we saw feedback surveys had been received from people and relatives that gave the provider a high satisfaction rate of between 92% and 100%.

Requires Improvement

Is the service well-led?

Our findings

The provider had internal quality assurance processes in place that were completed by the deputy and registered manager to monitor the quality of the service. The provider information return (PIR) stated medicine errors were low and almost all of these were signature omissions on the medicine administration records (MAR). However, the PIR also showed a high a number of medicine errors that had been identified following a thorough audit. We looked at the medication audits for the last 12 months and found people generally received their medicines as prescribed. Nevertheless, there were occasions when this did not happen. For example, although we saw no evidence of any impact on people, some people had received the incorrect amount of medicine or a medicine that was not prescribed for them. The errors had been identified quickly and we found that guidance and advice had been sought from healthcare professionals. However, there was no consistent approach to thoroughly investigate and analyse why the errors had occurred and what measures could be put in place to reduce the risk of reoccurrence. We spoke at length with the registered and deputy managers and the group manager. It was agreed investigations had not been sufficiently completed and measures were immediately put in place at the time of our inspection to address this issue. For example one reason for medicine errors was the 'constant interruptions' to nursing staff during medicine rounds through answering telephone calls and speaking with visiting relatives. The registered manager explained this had been partly addressed with administrative staff arriving earlier in order to take phone calls and reduce the number of calls taken by nursing staff, but agreed more needed to be done.

There was a registered manager in place and the conditions of registration were met. It is a legal requirement that organisations registered with the Care Quality Commission (CQC) notify us about certain events. We had been notified about significant events by the provider and we saw where accidents and injuries had occurred appropriate treatment and observations had been put in place to ensure the person's safety and no long term injuries had been sustained. However, we found on four separate occasions, people who had been injured or a near miss of being injured, there was no thorough investigation of how the injuries or near misses had occurred. We could not see what action had been taken by the provider to address any shortfall. For example, in staff training or what measures had been put in place to reduce the risk of any reoccurrence. We were re-assured by the registered and deputy managers that the staff involved would have been spoken to at the time of the incidents. However, it was agreed that a more formal approach to address any shortfall in staff knowledge or training was required to ensure people's continued safety was maintained.

People and relatives were complimentary about the quality of the service. We found the atmosphere of the home to be calm and relaxed. Everyone knew who the registered manager and told us that they could speak with him whenever they wished and that he was visible around the home and approachable. One person told us, "I see him [the registered manager] on a daily basis. You don't have to make an appointment to see him and if I want to raise any issues I'm sure he'll be readily available to discuss the matter." Another person said, "He's [registered manager] very interested in what is going on." A relative told us, "I have no doubt in my mind that mum is in the best place she could ever be, Olivet is a happy place with good carers and a supportive management team." Another relative explained, "Olivet is an extremely well run home, it

provides a fantastic environment and mum is looked after." Staff largely felt supported and if they had a problem they would approach the registered manager. One staff member told us, "[Registered manager's name] is a good manager, easy to talk to and he listens and is definitely approachable." All the staff told we spoke with explained how much they 'loved' their job and 'enjoyed' working at Olivet.

People and relative we spoke with told us there were 'resident meetings' held regularly and their views were sought on 'all kinds of matters'. For example, a new lounge, décor and while we were on site a focus meetings was held with people living at the home to discuss the menu and what improvements could be made. We saw people and relatives were also encouraged to give feedback through surveys. One relative told us, "We do get questionnaires to complete." Records we looked at showed people and residents were happy with the service and support people received.

Staff members we spoke with told us the management team were approachable and if they had concerns regarding the service, they could speak with them. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations for example, CQC. Staff told us they were aware of the provider's policy and would have no concerns about raising issues with the provider or registered and care home managers and if it became necessary, external agencies. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from out last inspection is displayed within the home. We found the provider had displayed their rating as required. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice. We also found the provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.