Colten Care (2009) Limited

Whitecliffe House

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

This inspection took place on 21 March 2018 and was unannounced. The inspection continued on 22 March 2018 and was announced.

Whitecliffe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 31 people across three floors. The service is located in Blandford and is a large purpose built building with rooms arranged over three floors and a central ground floor lounge and dining area. There is both lift and stairlift access to the first and second floors. Bedrooms had toilet and basin facilities and there were both accessible showers and baths on each floor. People are able to access an outside courtyard space at the home. There were 21 people living at the home at the time of our inspection.

There was a registered manager 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.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care. Medicines were stored securely and recorded accurately.

People were supported from the spread of infection by staff who understood their role in infection control and used appropriate Personal Protective Equipment (PPE).

People were supported to make choices about all areas of their support and staff understood the principles of mental capacity. Where decisions were needed in people's best interests, these were in place. Where people required application to be made to the local authority for DoLS, these had been completed.

People were supported to have enough to eat and drink and there were systems in place to ensure that any concerns around weight loss were monitored. People's preferences for meals were well known and choices

were offered if people did not want the meal provided. Feedback about the quality of food was positive.

People were supported to receive personalised, compassionate end of life care and their wishes and preferences were recorded.

People and those important to them were involved in planning the support they would receive and also regularly asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People were supported by staff who respected their individuality and protected their privacy. Staff told us that they would ensure that people's religious or other beliefs were supported and protected. Staff had undertaken training in equality and diversity and understood how to use this learning in practice.

Interactions with people were kind and caring and relatives told us that their loved ones received safe, compassionate care.

People were supported to access healthcare professionals when required and the service worked with a number of external agencies to ensure that people received joined up, consistent care.

People were supported to have one to one time with staff in social activities which were meaningful to them. Activities were varied and planned monthly after discussion and feedback from people. Visitors were welcomed at the home and kept up to date about how their loved ones were.

Staff were confident in their roles, enjoyed their jobs and felt supported by the registered manager and provider. People and relatives spoke positively about the registered manager and felt they were approachable and saw them on a regular basis.

Quality assurance measures were used to highlight whether any changes to policy, processes or improvements in practice were required. We were given examples where feedback had been used to drive improvements at the home.

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

Risks people faced were understood, recorded accurately and managed by staff.

People received their medicines as prescribed. Storage and disposal were managed safely.

People were supported by staff who had been recruited with safe

pre-employment checks.

Sufficient numbers of staff were deployed to meet people's needs.

People were protected from the risks of abuse by staff who understood the potential signs and were confident to report.

People were protected from the spread of infection by staff who understood the principles of infection control.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Good

The service was effective.

People were asked to consent to their support and assessments of capacity and decisions were made in people's best interests where needed.

Staff received training and supervision to give them the skills and knowledge they needed to carry out their roles.

People had prompt access to healthcare professionals when required.

People's needs and choices were assessed and effective systems were in place to deliver good care and treatment.

People were supported in an environment which was adapted to meet their needs with personalised rooms and an accessible outside courtyard.

People were supported to eat and drink enough and had choices about what they ate and drank. Any concerns about weight or fluid intake were effectively managed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate and kind in their approach.

Staff knew how people liked to be supported and offered them appropriate choices.

Visitors felt welcomed at the service and visited whenever they chose.

People and their relatives were listened to and felt involved in making decisions about their care.

People were supported by staff that respected and promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Activities staff spent time speaking with, planning and supporting people in a range of social opportunities and activities.

People and those important to them were involved in decisions about their care and treatment and reviews were regular and reflected people's changing needs.

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People received person centred, compassionate end of life care.

Is the service well-led?

Good

The service was well led.

People, relatives and staff spoke positively about the registered

manager and provider of the service.

Staff felt supported, enjoyed their jobs and were confident and clear about their roles and responsibilities within the service.

Quality assurance measures provided regular oversight and enabled the service to identify good practice and areas for further development.

Development of new quality assurance systems were focussed on improving the accuracy of data collected about the service.

Feedback was used to highlight areas of good practice and where development was needed. Information was used to plan actions and make improvements.

Whitecliffe House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 21 March 2018 and was unannounced. The inspection continued on 22 March and was announced.

The inspection was carried out by one inspector and an expert by experience on the first day and by two inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience in dementia care and care home services.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority and clinical commissioning group to obtain their views about the service.

We had requested and received a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information prior to the inspection.

During the inspection we spoke with 11 people who used the service and five relatives. We also spoke with nine members of staff, the operations manager, quality manager, clinical manager and the registered manager. We spoke with two professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection, these included six care records. We also looked at information relating to the management of the service including quality assurance audits, health and safety

records, policies, risk assessments, meeting minutes and staff training records. We looked at four staff files, the recruitment process, complaints, training and supervision records.

Good

Is the service safe?

Our findings

People were protected from the risks of abuse because staff understood the potential signs and were confident to report any concerns. One staff member explained that they would be concerned if people were "jumpy, crying, any visual signs" They told us how they would report any concerns. Another staff member explained that because they knew people well they would be aware of more subtle changes in behaviour which could indicate potential abuse and would report any issues. The service had a safeguarding policy which gave guidance for staff about how to report and provided contact details for other organisations including the local authority safeguarding teams and CQC.

Staff understood the risks that people faced and were able to tell us how they managed these. Staff knew people well and understood how to support them in a way which was safe. For example, one person was at risk of falls, staff understood that to manage this they needed to remind and encourage the person to use their frame when they walked and we saw them supporting the person in this way during the inspection. Another person had developed an area of sore skin linked to a deterioration in their health. Staff had identified this quickly and were providing regular support to assist the person to move. Equipment was also in place to manage the person's skin and health professionals were involved. Staff were providing support as recommended by health professionals and the person's pressure area was improving as a result. Where people had identified risks around malnutrition, swallowing or vulnerable skin, care plans included person centred risk assessments which identified what actions were needed to manage these risks.

We observed that visitors brought dogs in to see people at Whitecliffe House and that people responded positively to seeing and interacting with them. Sometimes the pets could be excitable and were seen to jump on to people's laps. People enjoyed this but there was the potential for people to be injured if they had fragile skin. The registered manager and operations managers told us that they would complete a risk assessment to ensure that any potential risks were identified and actions planned.

There were sufficient numbers of staff deployed to meet people's needs. People had access to call bells and we observed that staff responded promptly to these during our inspection. Instead of call bells sounding in the main home, the system was linked to individual pagers carried by staff. This meant that staff were aware of people when they called wherever they were in the home and the registered manager explained that the response times were monitored to ensure that people received support in a timely way. People, relatives and involved professionals all felt that there were sufficient staff available to provide support and staff feedback was also positive.

People were supported by staff who had been recruited safely, with appropriate pre-employment checks. Staff files included identification checks, application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. There were some planned changes to the management team due imminently. The registered manager and operations manager explained the plans in place to ensure that the changes happened in a planned way and explained how staff had been made aware of the changes.

Staff told us that they had access to enough suitable equipment to support people safely. We observed that staff had timely access to the correct equipment to support people and were confident in using different pieces of equipment safely. The service had identified that they did not have anyone skilled to be able to audit the maintenance of the equipment. The provider had sourced someone from another service to complete this and where some equipment had needed to be replaced, these had already been ordered.

People received their medicines as prescribed and these were recorded safely. Where people had medicines prescribed to be taken 'as required', staff asked whether people wanted this before administering and recorded this accurately in the person's Medicine Administration Record (MAR). Additional guidance was in place for 'as required' medicines which included how these were to be administered and pain assessment tools were used where people were not able to verbally express pain. We looked at the MAR for five people and found that these had been recorded accurately. Where people had prescribed creams, these had body maps to guide staff about where these needed to be applied and were recorded accurately. Staff administering medicines had regular competency checks to ensure they were carrying out this role safely.

The service had safe arrangements for the ordering, storage and disposal of medicines. Where medicines required additional security checks, these were in place and records of stock balances were correct. Some medicines required colder storage and this was provided with regular temperature checks in place.

Fire evacuation procedures were in place and each person had a Personal Emergency Evacuation Plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks of the fire alarms, fire doors and fire safety equipment. Fire drills were carried out and recorded to ensure that people could be evacuated safely in the event of an emergency. Guidance for visitors in the event of a fire were displayed in the home and equipment to enable people to be evacuated from the upper floors of the home was in place.

People were supported in an environment which was kept clean and safe with regular monitoring checks and cleaning. Housekeeping staff were visible and all areas of the home were clean with no malodours. Staff had access to appropriate Personal Protective Equipment (PPE) and told us how they used this to prevent the spread of infection. There were regular audits of infection control and any outbreaks of infection were audited. There had not been any outbreaks of infection in the 12 months prior to our inspection.

Staff understood their responsibilities to raise concerns or report incidents and these were used to learn and drive improvements at the home. For example, a previous concern about potential theft had been investigated and learning shared with staff. The registered manager told us what actions had been taken and to prevent any similar concerns from arising. They also explained that any concerns or incidents were discussed as part of group and individual supervisions with staff to discuss learning and review responsibilities for recording and reporting.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

Where people were unable to make decisions in relation to specific areas of their care and treatment, assessments of capacity and decisions in people's best interests had been made. Where people had legal arrangements in place to manage decisions about their support, these were recorded and copies included in their care plans. MCA assessments were decision specific and included explanations of how decisions had been made. Best interests decisions included those important to people and again, explained how decisions had been made. Explanations did not always include other options considered or details about why the outcome chosen was the least restrictive option for the person. The registered manager told us that this rationale would be included in any decisions made in people's best interests.

No-one at the home had an DoLS authorisation in place but there were several applications pending assessment by the local authority. The service had a monitoring tool in place which identified when applications had been made and how they were progressing.

People had been involved in initial assessments to identify whether Whitecliffe House were able to meet their support needs. The service completed an initial needs assessment with people which considered physical, emotional and spiritual needs. This assessment was used to identify what support a person may need and formed the basis for the person's care plan. We saw that initial assessments were fully completed and included details about people's relationships, choices and preferences. This demonstrated that the assessment was effective in considering all areas of the person's life .

Staff had the correct knowledge and skills to support people and received relevant training and development opportunities for their roles. Staff told us that they had access to a variety of training, some of which were considered essential by the provider. These included dementia awareness, pressure area care, fire safety and infection control. Training in other topics was offered which staff told us was relevant for the people they were supporting.

Registered nurses had access to online learning resources in a range of areas including nutrition screening,

pressure ulcer prevention and catheter care. Other face to face training was also planned for registered nurses including catheterisation and training in a system used to administer medicines to people in receipt of end of life care. Registered nurses were given support to complete their revalidation with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK.

Staff received regular supervision and an annual appraisal. There was an annual plan for supervision dates and a supervision structure was on display which showed who provided supervision for each staff member. Colten Care suggested various topics for supervision and some group supervisions were also arranged. Staff feedback was positive about supervision and we were told that it provided staff with the opportunity to discuss practice and reflect on particular topics relevant to their roles. Appraisals considered staff strengths and areas for development and we were told about examples of staff progression.

New staff to the home were supported through an induction and probation period with Colten Care and completed the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff completed shadowing as part of their induction and worked through an induction file over their probation period. This was monitored and used to identify any further training or development needs.

People were supported to have a balanced diet and where people needed foods prepared in a certain way to eat safely, this was accommodated. The chef was able to explain about people's particular dietary requirements and was aware of any allergies or intolerances. They had copies of safe swallow plans if these were in place for people and knew how people needed food to be prepared to ensure it was safe for them. For example, some people required a mashed or pureed diet. The chef also understood people's likes and dislikes and saw any new people within 24 hours of moving in to the home. They also visited people monthly as part of the 'resident of the day' programme and gathered feedback and any changing preferences about what people liked to eat and drink.

The chef explained that they had regular updates about any people who were losing weight and there was a nutrition pathway in place which they followed. This meant that there was a consistent approach to ensuring people received the correct level of fortified meals and drinks if there were concerns and risks that they were not eating or drinking enough. The clinical manager explained that the nutrition pathway helped to ensure a consistent approach and close monitoring if people were at risk of losing weight.

Feedback about meals at the home was positive. Comments from people included "the food is lovely, imaginative and beautifully presented", "If I don't like something they don't give me any or take it away and give me something fresh", "I always get nice food here". We observed people during a mealtime and saw that condiments were available and people had choices of drinks including some alcoholic options which a few people chose. Staff supported people with their meals where needed and interactions were reassuring and encouraging. Staff chatted to people during their meals and the chef also came out to speak with people and ask how their meals were.

People had a choice of a main meal daily and if people preferred to have their main meal at a different time or have something which was not on the menu, this was accommodated. Whitecliffe House had separate staff who served meals and drinks to people and this meant that care staff were able to spend one to one time with people if they needed assistance to eat.

The kitchen had been awarded a five star food standards rating and all staff had received food hygiene

training.

People were supported to receive person centred, consistent support when they went to hospital or transferred between services. Whitecliffe House were using the 'red bag pathway', designed by the National Institute for Health and Care Excellence(NICE) to support transitions for people. The red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital episode and is returned home with them. Staff understood how to use this and the registered manager told us that it had worked well when people had been admitted to hospital. People also had transfer information in their care plans which included details about what support they needed and any allergies. These were sent in the red bag and ensured that other involved professionals were aware of how to provide care and treatment for the person.

People were supported to receive prompt access to healthcare services when required. Involved professionals told us that staff sought advice and referred appropriately and were able to provide up to date information about people when asked. Whitecliffe were working with a local health professional on prevention of hospital admissions and were trialling systems to identify potential infections and ensure people received treatment without delay. We saw this working in practice and the registered manager explained that this approach was proactive and reduced the potential stress and anxiety for people if they needed to go to hospital.

People were able to access all areas of the home and go out if they wished. One person liked to smoke and was able to access an outside space to do this independently. The home had some quieter areas which could be used by people and their families if they wanted to spend time together outside people's rooms. There was a small courtyard garden with seating for people to use and signage in the home to help people to orientate. The reception area had a digital display which changed regularly and displayed planned events, the menu choices for the day and any daily activities. The main lounge was regularly used for communion with people who wished to attend and people were offered tables to share meals with family if they wished.

Good

Is the service caring?

Our findings

People and relatives told us that staff were kind and compassionate in their approach. Comments included "I am happy here. Everybody is friendly, and you don't often fall out. The care is A1", "staff go out of their way to be kind" and "everyone talks to you, even the cleaners stop and have 10-15 minute conversations". Relative's feedback was also positive with one explaining "I think it is fabulous here mainly because of the continuity of care". Another relative told us (Name) is well looked after. Nurse (name) is always trying to sort things out, they go above and beyond". We observed relaxed conversations with people and tactile contact to reassure and engage people.

Whitecliffe House used a 'resident of the day' system to ensure that people had a day each month where they were given additional one to one time and valued by the staff team. The resident of the day received a posy of flowers or box of chocolates in their room and we saw that where a person had requested an alcoholic drink instead, this had been provided. Staff also asked the person if there was something they wished for that day, something to make them feel special and then tried to achieve this. We saw that one person had wished to be supported to attend a family event and staff were in the process of arranging this with them. People received cakes on their birthday and were also offered a meal of their choice and were able to invite a relative or someone important to them to come in and share their special birthday meal with them. We were told that one person had chosen a steak dinner and had been able to share this with their family.

Verbal communication with people was respectful and friendly. Staff knelt next to people if they were seated and chatted to people if they were walking with them. We observed one staff member commenting on how much better a person looked than the previous week when they had been unwell. The person responded by stating "thank you, I feel much better". Another person explained "staff are friendly, I get on well with all of them. They would help you if you were upset". This demonstrated that staff cared about people and their wellbeing and we observed other staff having similar conversations with the person during our inspection.

People were actively involved in making choices about all aspects of their care and treatment. One staff member told us that they would be supporting a person with a bath in the evening because this was their preference. Another staff member explained that they always sought consent before supporting people and explained that they offered choices about how people wanted to spend their day. For example, "I ask if they want to get up…..(name) sometimes doesn't want to get up until later". A staff member explained how they would support someone if they were upset and explained "I offer one to one time to see what's upsetting them. Let them air it, kind words and a cup of tea…..you can put things right".

People with communication difficulties were enabled to make choices about their support. For example, one person had limited verbal communication so staff asked them closed questions and the person could indicate their decision by nodding or shaking their head. Another person was unable to communicate verbally and staff had picture cards which were used so that the person could indicate their choices.

Staff respected people's privacy and consistently knocked and sought entry before going into people's

rooms. We observed staff introducing themselves when they entered people's rooms and a staff member explained that they "always close doors, always make sure they are covered". They went on to say that if two staff were needed, the second staff member always waited outside the door until the person was covered before being told they could enter.

Whitecliffe House ensured that people's preferences and protected characteristics were respected. Initial needs assessments considered whether people had partners or spouses and how they wished their relationship to be supported. The registered manager explained that they would support people by ensuring that they had private space to spend time with their loved one if they chose and stated "we would ensure that relationships and privacy is respected". Another member staff told us that they respected people's wishes and explained "it's a matter of talking to the people to see what they want and be respectful". Staff all received training in equality and diversity and staff understood how to use this learning in practice. The provider advised that staff completed a reflective workbook as part of this learning.

Visitors were welcomed at the home and told us that they could visit whenever they chose. A relative told us "I can visit at any time, no problem at all". Another explained "I can visit at any time, no restrictions". There were dedicated reception staff who welcomed visitors and ensured that they signed in and out of the building. When the reception was not staffed, the front door was locked for security and accessed using a code. This meant that visitors were able to come and go when then wished but that people were supported in a safe environment.

People's information was stored securely to ensure that records were confidential. We observed that care plans were kept locked and that all staff knew and adhered to this. Records were taken out when staff were updating them but then locked away again. Staff files were also kept securely.

Good

Is the service responsive?

Our findings

People had access to a range of social opportunities and one to one time with staff. Colten Care employed separate activities staff who designed a monthly programme of activities which was adapted regularly to take account of people's preferences and requests. One of the activities staff explained that people were able to feedback each month using the back of the activity planner. It had sections for people to tell staff what they enjoyed, what they would like the service to provide and what they had not enjoyed. This information was then used to inform the plans for the following month. People were assisted to complete a 'life diary' which was reviewed every 6 months or as needs changed. This provided information about people's changing interests and helped activities staff to plan social opportunities for people. Activities were also discussed at regular residents meetings and feedback gathered and used.

People and relatives fedback that activities were varied and enjoyable. One person explained "I find the quizzes interesting. I am amazed at the things people do (and gave examples of others skills eg knitting, crafting etc). The day is filled and I am not bored." Another told us there was "lots of entertainment". One person had been supported to go out the day before with another person from the home because they got on well and told us that they had enjoyed their time out. Another person explained I go out when the sun shines. I do lots of word searches, painting, knitting. I am knitting eight inch squares to make the biggest tea cosy. I don't know where they will find the biggest tea pot!". A relative told us "I think my (name) does too many activities – I'm jealous!! They take photos of trips out as reminder for (name). This is good because (name) has memory loss".

There was regular one to one time planned to ensure that people who chose not to take part in any group activities were not socially isolated. Activities staff arranged one to one time with different people each day and kept records to ensure that everyone was supported in this way if needed. Regular visitors to the home included a local pre-school who spent time with people and art classes. Events were planned and held throughout the year and we saw that people were currently engaged in preparing and making things for Easter. Other dates in March 2018 included celebrating British pie week and world poetry day. People's spiritual and religious needs were met through monthly faith sessions and regular communion provided by a local vicar.

Staff communicated effectively with each other throughout the inspection which meant that people received joined up, consistent support. Staff had a handover at each shift and any updates were added onto the written handover sheet to ensure that these were shared with staff.

People were involved in reviews and decisions about their support. We saw that meetings were arranged with people and those important to them to discuss care and support and make any changes required. Care plans reflected monthly reviews updates were made where there were changes in people's presenting needs. For example, a review for one person included feedback from their family which had been actioned through referrals to speech and language therapy and a rehabilitation team. Relatives told us that they felt involved in the care and support their loved ones received. Comments included "I feel 101% updated and involved in (names) care" and "they inform me of (name) health and care decisions…I'm informed quickly of

any incidents".

People and relatives told us that they would be confident to complain if they needed to do so. One person explained that they had complained about an issue to the registered manager and action had been taken promptly to try to address their concern. We saw that where complaints had been received, these were monitored and dates recorded for when they had been acknowledged and responded to. Information leaflets about how to complain were accessible for people and visitors in the reception area of the home and included contact details for external agencies including the local authority and clinical commissioning group. There was a complaints policy in place which included timescales for managing any complaints. We saw that these had been adhered to.

The service met the accessible information standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were documented and understood by staff. One staff member explained "We do initial assessments to record sensory loss. If (the person) has hearing aids we need to keep it clean and batteries are new. We photograph spectacles and hearing aids so we know whose is whose". We saw these details in people's care records. A relative also told us that a staff member communicated with their loved one in a different language. They explained that their loved one really enjoyed this communication.

People were supported to receive personalised end of life care which considered people's requests and preferences. Care plans reflected that people had been asked about what they wanted to happen if they needed emergency assistance and whether people had any medical decisions in place. They included whether there were things that people were worried about and whether people had any 'spiritual, religious, specific wishes or arrangements you would like to be followed'. We saw that where a person had made decisions about their death, these were recorded and their preference to remain at the home and not go to hospital were also documented. Colten care had an end of life strategy which set out to 'support residents, their families and staff taking account of their physical, psychological, spiritual, cultural and social needs at the end of their life and into bereavement'.

Good

Is the service well-led?

Our findings

Feedback about the management of the home from staff was positive and comments included "Registered manager is nice, (name) interacts with residents, is easily approachable…residents have commented a number of times that (name) comes and chats to them", "registered manager always says thankyou at the end of a shift…makes team tighter if we praise each other". Another staff member explained that the registered manager had started a "Friday afternoon catch up with residents…the sherry trolley comes out!." This gave people a regular opportunity to chat informally with the registered manager. Comments about the registered manager from people included "(name) talks to people about their lives not just their complaints. I enjoy my chats with (name), they are lovely", "(name) is very good for coming around to find out if I am worried about anything. You can make suggestions to (name)". The registered manager had an office on the first floor of the home. They explained that they often spent time out and around the home to see and speak with staff, people and relatives and feedback confirmed this was the case.

The staff team worked effectively together and spoke positively about their roles. Staff understood their roles and responsibilities and consistently told us that staff worked well together. Comments included " we know all the staff, it's a nice environment to come to work in", "I come here because I enjoy it…staff team are quite close", "staff team get on very well…use a diary to hand over from day to night shifts and verbal communication is effective". We saw that handover records included relevant information about support people required and were updated with any changes for each shift. Staff also told us that they enjoyed their roles and that they felt working at the home was like a family. Two staff mentioned that they viewed people like their own relatives and cared for them as they would do so a family member.

Staff felt supported and valued by the management team and Colten Care. Some staff we spoke with had previously worked for the provider and returned as they felt that they were a good employer. Some staff were working through national qualifications and others told us that there were lots of development opportunities if staff wanted to progress. The Colten Care clinical manager, operations manager and quality manager for the area visited Whitecliffe House monthly to complete quality assurance checks and also speak with people and staff. Staff told us that they were approachable and provided an additional level of support and we saw staff speaking with these managers during our inspection.

The registered manager told us that they received regular support from the provider and had regular visits from the operations managers who provided oversight and quality assurance for different areas of the service. There were regular management meetings which the registered manager used to discuss any concerns or practice issues and to share practice which had worked well in other locations. The service worked in partnership with other agencies including the local authority and clinical commissioning group. The registered manager explained how they used external agencies for advice and support where required to ensure that people received joined up, consistent care and support. For example, we saw that there was an action plan in place following a visit from the clinical commissioning group and found that this information had been used to take actions to improve service delivery.

Quality assurance systems were regular and effective. Information was used to identify any trends or gaps

and to populate action plans to drive improvements. The clinical manager showed us a new online monitoring system which was currently being trialled. It enabled the operations staff to have a current picture of Whitecliffe House and to access details about a range of quality assurance information. Analysis of audits was completed at operation manager level and then sent to the registered manager with a summary of the information and to answer any queries. For example, where a cause for a skin tear had not been recorded, this was highlighted to the registered manager to complete. This meant that systems were working effectively and the service was developing a responsive system which would be 'live' and updated instantly when information was recorded.

Feedback was gathered through regular surveys, meetings and informal conversations. Surveys were sent out to people, relatives, visitor and professionals involved with Whitecliffe House and had last been sent in June 2017. Responses had been analysed and the results were displayed on a large colourful poster in the reception area of the home. Out of the 20 people living at the service, 13 answered the survey. The display included the percentage of positive responses to questions asked and also highlighted areas raised for improvement and what actions had been taken. This was identified as 'you said, we did' on the display. For example, feedback had indicated that activities needed to be improved and that menu selections needed to be widened. Actions included development of the 'companionship team' to improve the quality and quantity of activities. Menu choices had been reviewed and now included a wider selection.

Meetings were held regularly for staff, people and those important to them. Minutes indicated that information was shared relating to changes or developments at the service. For example, a meeting with peoples and those important to them had included discussing the changes to the menu's and discussions about upcoming events. Staff meeting minutes included updates about staffing, the use of the pagers and any innovative or new ideas. Minutes from a staff meeting in September 2017 included keeping a photo album for each person to be regularly updated so that families could see what activities they had been involved in. This had been added for staff to action.