

Clova House Ltd

Clova House Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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 visit took place on 24 January 2017 and was unannounced. This was the first inspection visit for the service since the provider registered with us in June 2016.

Clova House Residential Care Home provides care and accommodation for up to 20 older people. At the time of our inspection, there were 16 people using the service. The service is a converted domestic dwelling located in a residential area of Shelton Lock, Derby. Accommodation is provided across two floors and is served by both a passenger lift and a stair lift.

The service had 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 told us they felt safe with the staff and the care provided. Staff understood safeguarding (protecting people from abuse) and knew how to keep people safe.

The risks to people's safety and well-being had been assessed and minimised. Staff knew what action they needed to take to keep people safe and followed risk assessments to promote people's safety.

There were enough staff to provide safe and effective care for people. Staff were recruited in accordance with the provider's recruitment procedures. This helped to ensure staff were suitable to work with people using the service.

People received their medicines they needed when they needed them. Further improvements were needed to medicine records to ensure these were completed accurately and correctly and to the storage of medicines to ensure the condition of medicines was maintained.

Further improvements were needed to the management and storage of laundry to ensure laundry was managed in line with infection control guidance.

Staff told us they felt supported in their roles and the registered manager provided staff with clear guidance and leadership. Staff had completed a range of training and qualifications they needed and we saw they used this knowledge to provide people with safe and effective care.

Staff ensured people's rights and best interests by working within the principles of the Mental Capacity Act (MCA) 2005 to obtain consent or appropriate authorisation for their care. Staff understood the importance of obtaining consent from people before providing care and support. Mental capacity assessments required further development to ensure they were decision and time specific. This is important to ensure that people are able to make their own decisions and where they lack mental capacity, any made on their behalf are

made in their best interests.

People were positive about the food provided and enjoyed their meals. People were supported to eat and drink in sufficient amounts. People were supported to maintain and improve their health and nutrition and had access to a range of health care professionals who worked with staff to support people's well-being.

Staff were caring and attentive in their approach to meeting people's needs. People told us they felt staff treated them with dignity and respect and supported them to maintain their privacy when they needed assistance.

Staff knew people well and used the information they had about people's interests and preferences to provide care that was person centred. People and, where appropriate, their relatives were involved in the development of their care plan. Where people's needs changed, people were involved and consulted to ensure care plans reflected people's current needs and preferences as to how they wanted their care to be provided. Staff supported people to pursue activities that were in keeping with their interests. The registered manager was in the process of developing support for activities to ensure people had more opportunities for one-to-one support.

People were informed and knew how to raise any complaints or concerns about the service. People and their relatives had confidence that their concerns would be listened to and acted on.

The registered manager oversaw all aspects of the service. People, relatives and staff told us they had confidence in the registered manager and the provider and felt the service was well-managed. People, relatives and staff were able to approach the provider and registered manager and share their views on a regular basis.

The provider consulted with people, relatives and staff when proposing changes and improvements to the service. These included changes to the environment, working practices and systems. The provider had a system in place to assess and monitor the quality and safety of the service. However, we found that quality assurance systems were fragmented and required further improvement to enable the provider to assure themselves that people were receiving good care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Risks to people's safety and welfare were assessed and managed effectively. There were sufficient numbers of staff available to meet people's individual needs and keep people safe.

People were supported to take their prescribed medicines but records pertaining to the storage and administration of medicines were not always completed correctly or accurately. Further improvements were needed to ensure people were protected from the risk of the spread of infection in the service.

Is the service effective?

Good ●

The service was effective.

Staff had the training they needed to provide effective care and support. Consent to care and treatment was sought in line with legislation and guidance.

Mental capacity assessments required further development to ensure people were supported to make their own decisions and that any decisions made for people were in their best interests. People were supported to have sufficient to eat and drink and maintain their health and well-being.

Is the service caring?

Good ●

The service was caring.

Staff had developed positive, caring relationships with people. People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Good ●

The service was responsive.

People had their needs assessed and care plans were updated regularly. People received personalised care that met their individual needs and preferences. There was a clear complaints

procedure if people needed to use it.

Is the service well-led?

Good ●

The service was well-led.

The registered manager had demonstrated good leadership. People and staff were able to share their views and influence how the service was run. The provider assured themselves that people had a good quality of life. However, quality assurance systems required further development to ensure audits and checks were effective in ensuring people were receiving good care.

Clova House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection visit took place on 24 January 2017 and was unannounced.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had experience of supporting a person living with dementia.

On this occasion we did not ask the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us.

During our inspection we spoke with three people who used the service and one relative. We also spoke with three care staff, one catering staff, the registered manager and the provider. We contacted the local authority responsible for funding some of the people who used the service and asked for their views about the service.

We observed care and support in communal areas. Some people had communication difficulties, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records for three people. This included risk assessments, care plans and medicine records.

We also looked at four staff recruitment records, records relating to staff training and the management of the service including quality assurance records.

Is the service safe?

Our findings

People told us that they felt safe with the care provided and the staff that looked after them. One person said, "Yes, I feel safe. Staff are alright, you can relate to staff." Another person told us, "I am absolutely safe here. The general attitude of the staff makes me feel safe." A relative told us, "My mum is safe because there's staff around all the day and night if she needs anything. There is always someone to help her. For example, [name of family member] has a walker but there is always staff walking behind her to keep her safe."

Staff demonstrated that they understood their responsibilities to safeguard (protect people from abuse) people. One staff member told us, "I have updated my knowledge about safeguarding and we have new paperwork in place that helps us to record if we have any concerns about someone. The [registered] manager is very open and supportive and I know if I had any concerns they would be listened to and acted upon." The provider had a whistleblowing policy which all staff were aware of and which supported them to raise concerns outside of the service if they felt their concerns were not acted upon. However, the provider did not have a policy or procedure for safeguarding people within the service. This is important to ensure staff have the guidance they need to protect people and work with other authorities with safeguarding responsibilities to keep people safe.

We discussed this with the provider and registered manager who told us they would ensure a safeguarding policy and procedure was available to staff. The registered manager provided us with a copy of the safeguarding procedure following our inspection visit. We saw this included the information staff required if they had concerns about the welfare of any of the people using the service.

We saw that risks to people's safety were assessed and risks were effectively managed and reviewed to keep people safe. For example, one person used a walking aid to enable them to move around the service. The person's risk assessment identified the person was at risk of falling as they tended to rush when walking. The assessment provided guidance that staff should support the person to stand and stay with them whilst they walked and provide reassurance to the person. We observed staff provided support to the person in line with the guidance in the risk assessment. We saw they supported the person to use their walking aid safely and provided reassurance to walk at a steady pace. The person looked happy and at ease with the support provided by staff. This showed that staff understood the measures that needed to be taken to keep people safe.

Risk assessments included the risk of falls, developing pressure wounds, the risk of social isolation and risks associated with people's health conditions. Care plans included measures staff needed to take to reduce risks and detailed any equipment the person required to keep them safe, for example hoists or walking aids. Where people had complex health conditions, risk assessments acknowledged that the person may be at greater risk some days more than others. Assessments required staff to monitor and report any changes in the people's health conditions and the risk assessment was reviewed accordingly. This meant staff were provided with the information they needed to support people safely.

The provider maintained systems to monitor accidents and incidents within the service. Staff completed report forms for all accidents and incidents and submitted these to the registered manager for review and action. We saw that the registered manager reviewed all records and took action as necessary to minimise the risk of further accidents or incidents. For example, where a person had experienced a fall, the registered manager had made a referral to the falls prevention clinic to undertake an assessment and support the person to reduce the risk of further falls. This showed that the provider monitored and responded to any trends or patterns in accidents or incidents to minimise risks to people.

People told us they felt there were enough staff to keep them safe. One person told us, "There seems to be enough staff here, I don't have to wait too long for a response when I press my buzzer." Another person told us that they felt there was enough staff and when they pressed their buzzer for help, staff came quickly in the day and during the night. Staff felt there were enough staff to meet people's needs. One staff member told us, "We are fully staffed now and this means we can spend more time one-to-one with people which is good." Another staff member told us that changes to staff rotas meant that more staff were around during busy times, such as handovers between shifts. This meant a staff member could stay in the communal areas to ensure people were safe during handovers.

Records, including the staff rota, showed that the staffing levels we saw were the usual ones. We observed that although staff were busy, they had time to spend talking with people and attending to their individual needs. This showed that there were sufficient number of staff deployed within the service to keep people safe.

Records showed that staff were safely recruited. Staff recruitment files we sampled showed that the provider made the necessary checks before staff started working at the service. This included a history of previous employment, proof of identity and a check with the Disclosure and Barring Service (DBS). The DBS provides information to enable employers to make decisions as to the suitability of applicants to work within health and social care. This showed the provider had taken the necessary steps to help ensure staff employed were suitable to work in the service.

People's medicines were mostly safely managed but records to show whether people's medicines had been given to them were not always properly recorded. Records kept of medicines received into the service were completed accurately. Medicine Administration Records (MAR) included photographs of each person to ensure staff could correctly identify the person to receive the medicine. MARs also included information about people's allergies and any special instructions for medicines, such as 'do not chew' or 'take with water'. However records to show people had received their medicines were not always properly recorded. For example, we saw that some MAR charts had not been signed by staff to indicate the person had received their medicine. When we checked medicine stocks, the medicines were not in the blister packs which indicated the person may have received their medicines but staff had not signed to confirm this. The controlled drugs book requires two staff to sign each time a controlled drug is administered. In several entries, we saw only one staff member had signed. This showed that staff were not following the provider's policy for the safe administration of medicines. We discussed this with the registered manager who told us they would ensure that all staff signed medicine records correctly in future.

Medicines were stored securely in a designated area. We found that medicines kept in the fridge and medicines stored in the designated area were not regularly checked to ensure they were stored within the recommended temperatures. This is important to ensure the condition of medicines is maintained. We also found that some bottled medicines were not dated when opened. This is important because some of these medicines only have a limited shelf life. The registered manager told us they would ensure temperatures were checked and monitored for the storage area and the fridge on a daily basis and dates of opening were

put on bottled and topical medicines. This would help to assure people that their medicines were kept securely and stored safely.

We observed a staff member administering medicines to a person at lunchtime. They followed safe procedures and completed the medicine administration records once the person had taken the medicine. We observed them talking with the person and being patient to make sure the person had taken the medicine. Staff who were responsible for administering medicines told us they had received medicine training, which included an assessment of their competency. This included an assessment by the registered manager who had been trained by the pharmacist to assess staff competence. Related records for staff training confirmed this.

Staff had been trained in infection control and were shortly due to undertake training to update their knowledge. We saw staff used disposable gloves before going into people's bedrooms to support them with their personal care. The laundry room was not well organised to reduce the risk of soiled laundry coming into contact with clean laundry. The provider had recently improved the design of the laundry room by increasing the size of the room to improve the management of laundry. However, we found that the building work had not been completed. For instance, walls had not been finished, sockets had not been sealed and the floor had not been recovered. Clean laundry was stored above soiled laundry and several of the machines had doors that were taped up which indicated the doors were faulty. This could increase the risk of the spread of infection in the service. The provider told us the room would be completed following our visit to ensure it complied with the code of practice for infection control in care homes.

Is the service effective?

Our findings

People who we spoke with said they were confident the staff were trained and competent to carry out their roles. One person said, "Yes, on the whole I think staff are well trained." Another person told us, "Staff have improved a lot. They [the provider] are building staff up now and they know what they are doing."

The staff we met were knowledgeable about their roles and responsibilities. They said they were happy with the training which enabled them to provide effective, person-centred care. One staff member told us, "The training is good. We work through workbooks in different areas. I don't feel under pressure or rushed to learn as I can sometimes feel in classroom learning." Another staff member told us, "The training is work book based followed by a test. You have to demonstrate you have taken all the information in to be able to pass the test. I have completed dementia training. This included the principles of dementia, different types of dementia and how it affects people. This gave me more insight into the illness and helped me to support people more effectively."

The provider maintained a training matrix which showed training staff had undertaken and when this was due to be refreshed. The provider had recently introduced a new training system which included a range of training the provider felt was essential for staff and specialist training such as supporting people living with dementia. The registered manager was an approved trainer for manual handling. This meant training could be provided to meet people's specific needs. If staff needed training to meet the needs of particular people this was provided. For example, some staff had been trained by a local district nursing team in the administration of insulin to support a person to manage their health condition. The registered manager did not allow untrained staff to undertake this task. The provider was in the process of updating training for all staff to ensure they had the knowledge and skills they needed in their roles.

Records showed that new staff were supported to work through the Care Certificate. This is a nationally recognised qualification that identifies a set of care standards and introductory skills that health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care. The registered manager told us they used an external trainer to support staff to work through the care certificate due to the time involved. However, as part of their induction, new staff were provided with the opportunity to work alongside existing staff. This enabled them to be introduced to people and understand how they liked their care to be provided before they started to support them.

We observed a new member of staff shadowing (working alongside) an experienced staff member. The experienced staff member provided clear guidance and explanation as to why a person liked things to be done in a certain way. We asked the new staff member how long they were shadowing for. They told us, "It depends how it goes and how much experience I have. They [manager] look at things like that to decide how long you need to shadow." This showed the registered manager was committed to ensuring staff had the skills and knowledge they needed to provide effective care.

The registered manager told us they had introduced a new system of supervision and appraisal for staff.

Staff told us they received regular supervision and, where appropriate, annual appraisal from the registered manager which they appreciated. One staff member told us, "I have had an appraisal and regular supervision. I don't have to wait for this though as the office is always open. The registered manager is very supportive." Staff were able to give examples of how they had been supported by the registered manager to achieve a good work/life balance. They told us this had made them more effective and committed in their roles and improved the staff morale overall.

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. We found that they were and related assessments and decisions had been properly taken.

Some people's freedom was being restricted in a way to keep them safe. For example, when people were not able to leave the home without support or locked doors. We found the provider had followed the law by submitting applications to a relevant 'Supervisory Body' for authority to restrict people's liberty in this where required. Where formal authorisations had been issued, all relevant documentation was in place. We saw the conditions of authorisations were met. The registered manager told us they had made applications for other people, where relevant, and were awaiting best interests assessments for the local DoLS team. The registered manager told us they were developing a system to monitor the expiry dates of DoLS authorisations to ensure, where necessary, applications were made in good time. This helped to ensure that decisions made when people lacked mental capacity were in their best interests and lawful.

The registered manager and staff demonstrated an understanding of DoLS and the importance of people consenting to their care. We saw that staff supported people to make choices and asked for their consent before they provided care whenever people were able to give this. For example, we observed staff asking people if they were happy to receive support with their personal care or to take their medicines before staff provided the support.

Many people were not always able to consent to or make important decisions about their care because of their health conditions. People's care plans included an assessment of their mental capacity and the support they needed to make decisions and choices. For example, choice of clothing, what time they liked to get up and how they liked their care to be provided. Although assessments detailed the level of support people needed to make decisions on a day-to-day basis, they did not relate to any specific decisions made at any specified time. For example, decisions about healthcare treatment. This is important to ensure that people are able to make their own decisions and where they lack mental capacity, any made on their behalf are made in their best interests. The registered manager told us they would review and develop mental capacity assessments to support people in making decisions.

People told us they enjoyed the meals at the service. One person told us, "The food is excellent, really excellent." Another person told us, "The food is fantastic. It's better than the best hotel in town." A relative

told us that their family member enjoyed their meals, especially the home-made soups.

We spoke with the cook who prepared people's meals. They told us people were offered a choice of meals through four-weekly menus. These were reviewed and updated regularly to take into account people's preferences and the seasonal foods available. For example, if the cook tried a new recipe, people were consulted and their feedback gained before deciding if the dish should be introduced to the menu. We saw that the cook was provided with the information they needed to meet people's specific nutritional needs, such as soft diets. The cook told us that as meals were freshly prepared on site, they could cater for a range of special diets and meet cultural preferences.

People were supported to access snacks and drinks throughout the day. We saw staff had provided a hydration station in the communal areas which meant people could access cold drinks and fruit at any time. In addition, staff regularly offered a choice of hot and cold drinks and additional snacks of biscuits and freshly baked cakes throughout the day. Where people were unable to access food and drinks independently, we observed staff ensuring they were regularly provided with these and supported to eat and drink.

We observed the lunchtime meal to understand people's mealtime experiences. Most people chose to sit in the dining area, although some chose to sit in the lounge or to have their meal after the main sitting. We saw that staff respected people's choices and preferences and supported them to eat when and where they wished. Tables were covered with table cloths and people were provided with napkins and a range of condiments to compliment their meal. Where people required support to eat their meals, staff provided this discreetly and sensitively. For example, where people required their food to be cut into bite sized pieces to reduce the risk of choking, staff provided this support carefully and discreetly. We saw that one person required staff support to help them to eat their meal. The staff member sat with the person and supported them to eat at their own pace, maintaining appropriate conversation throughout the meal. People were supported to have drinks with their meals and staff were available to chat with people and provide encouragement. Where people were at risk of weight loss, staff ensured they had sufficient to eat. We saw that where one person declined their meal, staff offered them an alternative. We saw the person responded positively to this and began to eat the alternative. This showed that people were supported to ensure they had sufficient to eat and drink.

Records showed that an assessment of people's nutritional needs and plan of care was completed which took account of their dietary needs. People's weights were regularly measured and where concerns about people's food or fluid intake had been identified, they were referred to their GP and through the SALT (Speech And Language Team). For example, one person required a specialist diet to enable them to manage their health condition. We saw the person was provided with choices in line with their dietary needs during the lunchtime meal. This helped to ensure staff had the information they needed to support people to eat healthily.

People told us their health and medical needs were met. One person told us, "The doctor comes quickly if I need them. You can have your choice of doctor. I also have help to make sure my feet are looked after." A relative told us, "[Name of family member] health problems are always followed up quickly. If there is something, they [staff] always say we 'phoned the doctor. [Name of relative] has also got a chiropodist that visits and an optician is coming in next month."

People had their healthcare needs assessed and care plans put in place to meet their needs. People were supported to access specialist health professionals where necessary. For example, where a person with mental health needs had experienced a change in moods, we saw that staff had referred this to the relevant

health professionals to ensure the person received the support they needed. Where another person experienced changes in their mobility, we saw their care plan provided guidance for staff to follow to refer their concerns to an occupational therapist and physiotherapist. This helped to ensure the person had the aids and adaptations they needed to manage their health condition. This showed people were supported to maintain their health and well-being.

The premises required further work to support the needs of people living with dementia. The premises were clean and comfortable but there were areas where improvements could be made. For example, bathrooms and toilets were in need of upgrading to improve access and facilities. Lighting in some corridors and bedrooms required upgrading as some areas were poorly lit. There was little in the way of signage around the service and floor and wall coverings did not support people to find their way around. The provider told us they were in the process of upgrading the premises this year, with some work already planned and underway.

Is the service caring?

Our findings

We saw that staff and people got on well together. The atmosphere at the service was warm and friendly and people appeared relaxed and at home. One person told us, "I am happy with my care, it provides me with all my needs. Yes, I do think the staff have a caring manner. They show me respect." Another person told us, "It's like being at home. They [staff] allow me to do what I like really. I can have visitors whenever I want. It really is my home." A relative told us they were happy with their family member's care, they said, "We know the care is good, and we just know [name of family member] is safe."

We observed staff treated people with respect when supporting them with their meal and personal care needs, referring to them by their preferred name. We saw that staff spoke with people before providing support to them, consulting them as to what they wanted to do and if they were ready for support. We also saw staff spoke with people after support was given to check they were happy. We observed shared humour and conversations between people and staff. There was evidence in the care plans that staff were in contact with people's relatives to update them on any care and welfare issues.

We asked people how they were involved in decisions made about their care and how they wished to be supported. People told us they were asked what support they needed as part of the care planning process. One person told us, "I choose what I want to do. When I'm tired I go to bed and in the morning I get up when I wake." Another person told us staff provided care in line with their wishes and respected their choices. This included how the person wished to spend their time and when they wanted visitors. A relative told us they were involved in their family member's care planning and were kept informed and involved through discussions with staff when their family member's needs had changed. This showed people made decisions about their care that was important to them.

Staff demonstrated they were aware of the importance of maintain people's privacy and dignity. We saw there was information around the service explaining what dignity means and how to protect people's dignity. This was available to people, staff and visitors. People felt staff treated them with respect and their dignity was maintained. People's bedrooms were respected as their own space and we saw that staff knocked and did not enter until asked to do so. Where people shared bedrooms, privacy curtains were provided to ensure people's privacy and dignity was maintained within their rooms.

Staff were aware of supporting people to maintain their independence. For example, we observed staff support a person with their mobility. Whilst they provided verbal and physical prompts and encouragement, they supported the person to do as much as possible for themselves. We saw that, where people required support with their mobility, staff removed people's frames once they were seated and stored them in a central area in the communal lounge. This meant people could not easily access their walking frames when they wanted to. We raised this with the registered manager who immediately ensured all people had access to their walking frames. They told us they would inform staff they should leave frames with people so they had ready access to the frame when they needed it.

Is the service responsive?

Our findings

People told us they were encouraged to make decisions about how they spent their time and who they spent it with. One person told us, "I can make my own choices within reason, for instance if I want to have a lie in, they [staff] let me have a lie in." Another person told us, "I can do what I want to do. I can join in activities or choose to play my own music. I can say if I want to go to bed early. Sometimes I do and sometimes I stay up. It's like being at home."

People had an assessment of their needs when they moved to the service. This included an assessment of their physical needs in addition to their likes, dislikes, abilities and preferences. Wherever possible, relatives and people who knew the person well were involved in the assessment. The information from the assessment had been used to develop the care plan. An example was for a person who used to enjoy driving. Their care plan included significant events, such as first car and memorable incidents so that staff could talk to them about it. People's care plans contained up to date information about their needs and had been updated to reflect changes in needs. For instance, one person's care plan stated they may experience periods of anxiety. The care plan had been updated to reflect the change in need and the additional support the person required from both staff and health professionals to enable them to manage their anxiety. The records of care showed staff were responding to the change in needs and providing the person with extra support and reassurance whilst monitoring the person's well-being on a daily basis. Staff told us they had read people's care plans and that senior staff and the registered manager were always helpful if anything needed explaining or advice was needed. This meant that people received care that was personalised and met their needs.

Care plans included people's preferences, for example, what time they like to get up and how they liked their care to be provided. Records showed that their wishes had been taken into account in the care provided. Staff knew what people liked, for example staff offered a person a choice of their favourite food because they knew they liked it. People and their relatives told us they were involved in their care. One person told us, "I have a care plan. I choose how I want things. I can have visitors and I go out and meet with friends anytime. Staff know me really well." A relative told us they had been involved in the development of their family member's care plan and were kept informed and consulted about changes in the care provided. They told us, "You are always involved, not shut out." This showed people were supported to control their care and ensure it reflected their wishes.

We asked people about the activities provided by the service. One person told us, "On the whole, I don't get bored. There is always something to do. They [staff] don't just put the television on all the time. There is nice music and a chap comes in once a fortnight and I join in." Another person told us, "I join in [activities] fairly often, I do like the Bingo. I spend a lot of time talking with other people." We saw some people were engaged in activities which tended to be provided on an individual basis. For example, one person was reading a newspaper with a staff member whilst other people had an appointment with the visiting hairdresser. There was good banter and conversation between people and people enjoyed the company of the resident cat. The registered manager told us they had revised the position of activity co-ordinator as they had struggled to recruit the right person for the role. They had recently appointed a staff member as a 'be-friender'. This

involved the staff member having dedicated activity hours to spend with people one-to-one or in small groups. Ideas for activities included reminiscence sessions, sewing 'mending' sessions and household activities to support people who liked to help out around the service. This would help to ensure people had access to activities that were important to them and were protected from social isolation.

The provider's complaint policy and procedure detailed how to make a complaint and the person to report to. The policy included contact details for external agencies in the event that people were not happy with the outcome of their complaint. The service had not received any complaints at the time of our inspection.

People and their relatives told us they felt comfortable to raise concerns or complaints. One person told us, "I can't think of any complaints. If I did, I would go and see the lady in charge [registered manager]. She always listens to what people have to say." Another person told us, "I've no cause to make a complaint at all. If I did, I would go and see [name of registered manager]." A relative told us, "We have no complaints but if we needed to, we would go and see the (registered) manager." This showed that people felt comfortable to raise their concerns and felt assured that they would be listened to and acted upon.

Is the service well-led?

Our findings

People told us they were happy at Clova House and considered it to be their home. People and relatives reacted positively when we asked them what they thought of the service. One person said, "I can't think of anything that needs to improve. The food for one thing is good and I don't have to wait too long for help. They [staff] will listen to what you have got to say." Another person told us, "[Name of provider] has brought a lot of thoughtful things in, there is real quality behind things, and I have found him to be approachable. He [provider] spends a lot of time talking with residents. You are not treated as a 'throw away' here but as part of the family." A relative told us, "The home is well-managed. The atmosphere is great, friendly and warm. Visitors are treated the same, nothing is too much trouble. If you want anything, you just have to ask. The care is especially good. The [registered manager] is lovely. All the staff are lovely. They couldn't do anything more for [name of family member]."

The registered manager was involved in all aspects of the service. She told us she spent time with people and staff every day getting their feedback on the service. We observed that the registered manager got on well with people who happily approached her whenever they wanted to. Staff told us the registered manager was "Really good, she listens to you and is very supportive," and "Consults with us and asks for our opinion on changes." Staff said they had confidence in her as a registered manager and thought she provided them with good leadership. We looked at records of staff meetings that had recently been held. We saw these were used to provide staff with information in addition to discussing improvements to working practices. This provided staff with the opportunity to share their views about people's care and contribute towards improvements within the service.

The provider and the registered manager were able to demonstrate their commitment to improving care for people using the service. People and staff spoke positively about the provider who had recently purchased the service. One person told us, "They [registered manager and provider] are interested in developing the service. I think he [provider] has brought a lot of improvement here. It is very well managed." One staff member told us, "They [provider] haven't just jumped in and made changes. They have taken the time to consult and decide on changes slowly." The registered manager and the provider were able to share their action plan for improvements they had identified were needed to the service. These included upgrading the environment so that it supported people more effectively and introducing regular tenant and relative committee meetings with information channelled through this forum. They told us people had volunteered to join and they were in the process of consulting with relatives and agreeing the terms of reference. The registered manager told us they were in the process of sending out satisfaction surveys to people and their families to gain their feedback on their care and the quality of the service. This would help to ensure people were able to share their views about the service and influence how it was run.

The provider visited the service regularly and spent time with people and staff to monitor its progress. The registered manager told us that the provider gave her constant support and encouragement and could be contacted at any time for advice if required or would refer to other agencies for specialist advice, such as employment issues. This meant the registered manager had access to support and guidance from the provider when she needed it.

The provider had a system in place to assess, monitor and improve the quality and safety of the service but we found this was fragmented. The registered manager told us they undertook spot checks and audits in key areas such as medicines, housekeeping and care plans. However, records did not show that audits had consistently been undertaken and the registered manager did not record the outcome of spot checks. The provider undertook observations and checks during their visits and recorded outcomes. We saw these were discussed in meetings between the provider and the registered manager and used to identify where improvements could be made or to confirm if changes were working well. For example, the provider had consulted with staff about new recording systems and identified that the changes were working well and had had a positive impact on people's care through more effective monitoring and information sharing between staff. The registered manager and the provider told us they were in the process of developing the quality assurance systems and would ensure that a schedule of audits and checks was in place and records maintained of outcomes. This would help to ensure that both the provider and the registered manager had an overview of how well the service was running and assure themselves that people were provided with good care.

The registered manager and the provider were aware of their legal responsibilities, including their responsibility to notify us about significant events within the service. We saw that appropriate notifications had been made to the Care Quality Commission and other external agencies to ensure people in the service were kept safe. When we spoke with local authority commissioners, responsible for funding some of the people using the service, they told us they had no significant concerns and were happy with the provider's action plan to bring about improvements to the environment.