Ashdown Care Limited

Culm Valley Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 22 and 25 May 2017.

Culm Valley Care Centre is registered to provide accommodation for 56 people who require nursing and personal care. There were 47 people living at the service on the first day of our inspection. They consisted of 22 people who had been assessed as requiring nursing care were having their nursing needs met by the nurses at the service. There were also 25 residential people whose nursing needs were met by the community nursing team. There were two further admissions on the first day of the inspection and a person arrived for a respite visit on the second day of our visit.

There was a registered manager. 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.

We had previously carried out a comprehensive inspection of this service in June 2016. Three breaches of legal requirement had been found at that inspection. The breaches were because risks assessments were not always completed correctly to assess people's individual risks. Environmental risks were not always being safely managed, which could put people at risk in the event of a fire. Care plans had not always been put into place to reflect people's emotional and mental health needs. The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. However these were not fully effective as they had not identified the breaches of regulations found at this inspection. At this inspection we found action had been taken regarding these concerns and the requirements had been met.

There were adequate staffing levels to meet people's needs. People and staff felt there were adequate numbers of staff on duty to complete people's personal care but said they were often busy which meant they did not always have time to interact with people. People had mixed views about the response time to call bells with some people saying they did not feel their call bells were responded to promptly. The registered manager regularly assessed the dependency levels of people and adjusted staff levels accordingly to ensure there were sufficient staff on duty. They undertook random bell audits to monitor staff response times which were all promptly responded to. During our visits bells were responded to promptly. We had concerns that people using the outside terrace could not alert staff if they required assistance. The registered manager put in place regular checks and was looking at ways this could be addressed.

Risks assessments were completed correctly to assess people's individual risks. Care plans were developed when people came to the service following a pre admission assessment involving people and their families. Care plans were personalised and recognised people's health and social needs. They were regularly reviewed and updated to reflect people's changing needs. However improvements were needed to ensure there were care plans in place for people's oral care. Action was taken to put these in place.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Staff were following the MCA in regard to people with capacity consenting to their own care at the service. Where a power of attorney (POA) was appointed for a person, there was a system to identify whether the POA was authorised for making care and treatment decisions, financial decisions or both.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff received regular training, supervision and appraisals. Staff relationships with people were mostly caring and supportive. However some people said they felt not all staff were polite and friendly.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed. Improvements had been made in relation to people having their prescribed creams applied as required.

People's views and suggestions were taken into account to improve the service. Advice and guidance was sought from relevant professionals to meet people's healthcare needs and to ensure the care and treatment was right for them.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. Where there were concerns or complaints, these were investigated and action taken. The premises and equipment were managed to keep people safe. People's safety was protected by effective fire and environmental monitoring.

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.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were adequate staff on duty to meet people's needs.

Appropriate risks to people were identified and reduced as much as possible. People's safety was protected by effective fire and environmental monitoring.

Medicines were safely managed

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were monitored and any trends identified.

Is the service effective?

Good

The service was effective.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (MCA) (2005) was followed.

Staff received regular training, supervision and appraisals.

Improvements had been made in relation to staff having skills to effectively communicate with people. Although some people still said they had difficulties.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

People were supported by staff who respected their dignity and were on the whole respectful in their manner.

People and their families were involved in making decisions about their care.

Visitors and friends were welcomed.

Is the service responsive?

Requires Improvement

The service was responsive.

People's needs were assessed. Care plans were developed to meet people's needs and reviewed and updated to reflect people's changing needs. However improvements were needed to ensure there were care plans in place for people's oral care. Action was taken to put these in place.

Activities were available for people to partake in if they chose and were able. Improvements were being made to ensure people in their rooms were not at risk of social isolation and undertook activities which were meaningful to them.

There was an effective complaints procedure in place. People knew how to make a complaint and were confident they could raise concerns. On the whole people were confident concerns would be dealt with.

Is the service well-led?

Good

The service was well-led.

The majority of people and staff spoke positively about the registered manager and said they were approachable. The management team were visible at the service and inspired staff to provide a quality service.

People, relatives, professionals and staff views and suggestions were taken into account to improve the service.

The provider had an effective audit program to monitor the quality of care provided and ensure the safe running of the service.

Culm Valley Care Centre

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 checked 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 comprehensive inspection took place on 22 and 25 May 2017. The first day was unannounced and was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. We made arrangements for one adult social care inspector to return on a second day to complete the inspection.

The provider had been requested by the Care Quality Commission (CQC) 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. We reviewed this and other information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met the majority of the people who lived at the service and received feedback from 17 people who were able to tell us about their experiences. We also spoke with five visitors to ask their views about the service.

We spoke to 17 staff, including the registered manager, a clinical lead, nurses, team leaders, care workers, the cook, housekeeping staff, activity worker and administration staff. We spoke at the inspection to two visiting professionals and a visiting hairdresser.

We reviewed information about people's care and how the service was managed. These included four people's care records in full and partially looked at three to look for specific information. We reviewed five people's medicine records, along with other records relating to the management of the service. These included staff training, support and three staffs recruitment records, quality assurance audits and minutes of residents and team meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from two health and social care professionals.

Good

Is the service safe?

Our findings

At our last inspection, there was a breach of the regulation. This was because people were not always receiving safe care and treatment and risks were not being managed safely. Following the inspection we were sent an action plan setting out the actions the provider was going to take. At this inspection we found the actions had been taken regarding this breach and the requirement had been met.

People felt safe, and were confident they could speak with staff if they were concerned about anything. People said they felt safe at the service. Comments included, "Everyone here is very nice. I have no worries on that score…", "Staff are considerate…they came quickly when I fell" and "Safe? Yes I am." One health care professional said, "I go to two or three other service and this is one of the best I go to." Staff had received safeguarding training and were aware of how to report any concerns relating to safeguarding issues. They were confident the registered manager would deal with any concerns and they were aware of external agencies they could contact if their concerns were not acted upon; such as the local authority; police and the Care Quality Commission (CQC). Two visiting professionals said they had not witnessed poor or concerning practice at the service.

Risks to people's personal health and safety had been assessed. Risk assessments and care plans were in place and described what staff should do to reduce the risks. These included areas such as falls, pressure damage, and nutrition. Where people were at risk of pressure damage, pressure relieving equipment was available such as mattresses and seat cushions. Pressure relieving mattresses were set appropriately and regularly checked to ensure they were in good working order. Where one person had developed pressure damage (prior to their admission to the service), risk assessments and care plans were developed to ensure regular dressings were in place and regular reviews to monitor the progress and effectiveness of the treatment. There were pressure relieving charts completed, which showed people were repositioned regularly to avoid skin damage. We noted one person was to be repositioned three to four hourly. Their record showed on occasion they had not been re-positioned for five hours. The registered manager said this was a recording omission and the person did not have any skin damage. A monthly audit was undertaken of pressure ulcers which showed one person had a pressure ulcer in April 2017. The registered manager confirmed two people were being treated for pressure ulcers at the time of the inspection. One person said staff checked their skin to ensure they were not getting sore, saying "They check on that."

People's weight was monitored and any concerns were discussed with the GP or community dietician. One person was at risk of choking and was unable to take food orally. They received their food and fluids via a special tube. This was recorded in their care plan and staff were aware of the risk to the person. Where another person enjoyed smoking, a risk assessment was in place to ensure they were supported by staff to reduce the risk of incidents associated with cigarette smoking.

People were supported to transfer safely using equipment such as hoists. Staff used the equipment confidently and competently, and ensured people understood what was happening throughout the move. People were reassured by this and transferred safely.

There were enough staff to provide the personal and nursing care people needed. However, people had mixed views about the response time to call bells and said staff were often busy which meant they did not always have time to interact with them. One person said staff usually responded within five or 10 minutes when they called. They said on occasion this might be longer, when staff were busy or if there were staff absences. One person said, "I sometimes wait longer than others but there's more than me here, they can't split themselves in half." Another said "fairly quickly as a rule, things back up if they have a lot of bells ringing." We also had mixed views from health care professionals. One said, "I see quite a lot of staff around. The bells go off a lot but it's a big place. There have been occasional comments from relatives about staffing but just a couple." Another said they felt the staff level at times "appeared to be low and that during most visits the call bells continue to ring."

The registered manager used a tool to help them decide on the staffing levels. This took into account people's needs in relation to personal care; moving and handling and whether people required assistance with meals. They undertook random bell audits to monitor staff response times to call bells which they found were all promptly responded to. During our visits bells were responded to promptly. The registered manager confirmed the preferred staffing levels were two registered nurses, or a nurse with a team leader throughout the day. In the morning the preferred level was nine care staff from 8am until 2pm and six care staff between 2pm and 8pm. Ancillary staff were also employed, such as reception and administration staff, a maintenance person, activity person, cooks and housekeeping who undertook cleaning, laundry and the preparation of meals. At night the staff level was a registered nurse and four care staff.

There were no staff vacancies at the service and planned and unplanned absences were usually covered by existing staff. Staff reported improvements to staffing levels since the last inspection. They said when the full staff team was on duty, the shift ran smoothly. However, when absences occurred and could not be covered due to short notice, staff described being "very busy". On these occasions they said they had little time to spend with people, other than when delivering care. Comments from staff, "It is good here. We do have more staff, although it can fluctuate. I don't think it is unsafe. We pull together and muddle along…"; "Staffing is usually ok but there is not a lot of time to spend with people in their rooms. But we do try to sit and chat; do their nails, it depends on the time we have…" and "If everyone is here its fine, it works well. But we do have unexpected sickness…then it is busy. I go home shattered…"

On the first day of the inspection one member of staff was off sick, however a replacement had been found by 10am. Consideration had been given to ensuring the appropriate skill mix of staff. Staff were allocated duties at the beginning of each shift, with less experienced staff working with experienced staff. Staff were busy throughout the day.

Recruitment and selection processes were in place to protect people from unsuitable staff. Appropriate checks were undertaken before staff began work at the service. A ten year employment history had been obtained and any gaps in employment history had been followed up. We discussed with the operations manager the need for a full employment history and they were going to look at this as part of their review process. All pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

Records showed action was taken to explore why the accident happened. Referrals were made where necessary to the GP in order to establish if there might be underlying causes. Care plans were reviewed following accidents to ensure any additional actions to protect people were in place. One person who fell

recently said staff came immediately to help them. They said, "It was my own fault, I just over reached. Staff were lovely, very reassuring. The nurse checked me out and dressed my head…"

People received their medicines safely and as required. People's medicines were administered by nurses and team leaders who had received medicine training. The team leaders had received training in medicine administration and were able to administer medicines according to their job description to people receiving residential support. However we discussed with the registered manager that they were also administering medicines to people who had a nursing need. The registered manager said they would review their job description and role to ensure they were administering medicines in line with their job description. We observed a medicine round. The nurse assisted people and ensured they were not rushed and administered medicines in a safe way. They had a good understanding of the medicines they were giving out to people.

Where people had medicines prescribed as 'when needed', (known as PRN), protocol care plans were in place about when and how they should be used. There was a system in place to monitor the receipt and disposal of people's medicines. There was a procedure to monitor daily the temperature of the medicine fridge where medicines were stored and ensure it was at the recommended temperature. Medicines were locked away in accordance with the relevant legislation. Medicine administration records (MAR) were accurately completed. The pharmacy which supports the service had recently undertaken a review and raised no significant concerns.

Improvements had been made in relation to the administration of topical creams, as previously this had not been effective. Prescribed creams were recorded on people's MAR. The information had been transferred on to cream administration sheets which had body maps to identify where creams needed to be applied. These were held in a file for care staff to record when they had administered prescribed creams. There were a few signature gaps which we discussed with the clinical lead regarding the nurse's oversight to ensure all creams were administered as prescribed. They said they would remind the nurses of the need to check the cream charts at the end of each shift.

The environment was safe and secure for people who used the service and staff. There was a maintenance person employed at the service. They undertook checks which included regular checks of the water temperature and window restrictors. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire equipment such as extinguishers had been serviced and maintained. The fire escapes were clear of any obstructions and the fire escape staircase looked in a good state of repair. Staff had undertaken fire/emergency evacuation training to ensure they knew what to do in an emergency. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. The registered manager monitored the environmental and maintenance records each month to ensure they had been completed.

The home was clean throughout with very small pockets of odour in places which were explainable in relation to individuals health needs. One person said, "They clean every day. They seem quite organised." The laundry room was well organised, clean and well equipped. There were systems in place to protect staff when dealing with any soiled linen. There were ample supplies of protective equipment such as disposable aprons and gloves and staff used this equipment appropriately, for example, when delivering personal care.

Good

Is the service effective?

Our findings

People received care and support from staff who had received training and support on how to undertake their role safely and effectively. The mandatory training which staff were required to complete included, Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS), fire safety awareness, infection control, moving and handling, food hygiene, equality and diversity, dementia, diet and nutrition and safeguarding vulnerable adults.

Staff were observed moving people with the assessed equipment they required; this included hoists. They were skilled and confident when using the equipment and people seemed quite relaxed being moved around. People and visitors were positive about staff skills. Comments included, "They walk behind me", "They seem alright, It's a learning curve when they're new", "They seem to know what they are doing", "two different teams of carers, each team has a nurse attached to them. Registered nurses are very good" and "'Yes I think so, when they're new it takes them a bit of time."

Staff were positive about the training they had received and said they had good training opportunities. Comments included, "We get lots of training. (The registered manager) is hot on that…", "I had good training to move into a caring role…" and "We have in-house and external training and refreshers are offered too…" They confirmed they had received training to support people with specific needs, including dementia and diabetes awareness and falls awareness.

The service used training workbooks for some training and external trainers including the local care home educators to provide face to face training. The registered manager said recent falls awareness training had been popular and productive. As a result of the training staff were able to explore concerns about individual people in their care by reviewing their care plan and risk assessment and ensuring risks were mitigated.

Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK.

Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. The induction and orientation was usually over three days and included some basic fire safety training; orientation to the building; introduction to staff and people and reading policies and procedures. One new care workers who had no care qualifications was undertaking the 'Care Certificate' programme which was introduced in April 2015 as national training in best practice. They said they were finding it interesting and relevant to their work.

Staff said they attended regular supervision meetings with their line manager and annual appraisals. These meetings enabled staff to discuss their development and training needs, as well receiving feedback about their performance.

At the last inspection people and visitors raised concerns about difficulties they had experienced speaking

with some staff whose first language was not English. At this inspection four people said they had experienced language difficulties with some overseas staff. One person said, "The nurse came to me, I didn't know what she was saying. She went and got the box 'paracetamol'. She was asking if I wanted any. The person dishing out tablets should be able to speak good English, it's dangerous." There had been no new nurses employed at the service since our last inspection. During the last inspection and at this inspection we have met all of the nurses employed at the home and have not had any difficulties understanding any of them or staff we have spoken with. We discussed this concern with the registered manager who confirmed that nearly all the newly recruited staff had English as their first language. Where staff had poor English in the past this had now improved and they were speaking more fluently. The registered manager felt people might find it difficult because staff whose first language was not English did not tend to have a "natter" which might be the problem.

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 of authorisations to deprive a person of their liberty were being met. People who lacked the mental capacity to make particular decisions were protected. People's liberty was restricted as little as possible for their safety and well-being. For example an assessment was undertaken whenever the use of bedrails or a pressure mat was considered for the person's safety. Some people were not free to leave the service and were under constant supervision. As a result, DoLS applications had been made to the local authority DoLS team and the service was awaiting a decision. Not all staff were aware of which people had a DoLS application in place. We discussed this with the registered manager and a list was put in place to advise staff.

The registered manager and staff had an understanding of the MCA and DoLS and how to ensure people's legal rights were protected. Staff confirmed they had received training to help them understand their responsibilities. Where people lacked the mental capacity to make decisions the staff followed the principles of the MCA. Records demonstrated that relatives, staff and other health and social care professionals were consulted and involved in 'best interest' decisions made about people. One person had a specialist advocate to help ensure decisions were made in their best interest. Best-interest decisions relating to this person were clearly recorded. For example, relating to their placement and care and treatment. Where a power of attorney (POA) was appointed for a person, there was a system to identify whether the POA was authorised for making care and treatment decisions, finance decisions or both.

Staff explained how they would always seek a person's consent before providing care and support and they aimed to involved people in decisions about their daily activities. Staff gained people's consent and cooperation before care or support was given. For example, when staff assisted with personal care or administered medicines. People were offered choices about their day to day decision making, such as what time to get up, what to wear, and how they wished to spend their day. People confirmed on the whole they were involved in decision making. Comments included, "It's up to me" and "Whenever you feel like it" (getting up and going to bed). However one person said "I go to bed at eight o clock, they pull the bed out.

That's the time it's got to be, I was up at five o' clock this morning." We contacted the registered manager regarding this comment, they confirmed, "Yes they all get a choice and this is reflected in care plans as either like to get up early/late and when they like to retire."

People confirmed how they had been listened to when they had requested changes. One person commented, "In the past I was early and didn't like that, (staff member) said "would you like to go later?", 'I said about 8 or half past'' they confirmed that was the time they went. Another said, "Lately I haven't been getting up I haven't been feeling very good."

People had access to health care professionals to meet their needs. For example, GPs, podiatrist; community dietician, speech and language therapist, and hospice care nurses. People's care records showed their health needs had been assessed and were being monitored. For example, one person had been assessed by a community dietician and their recommendations had been incorporated into the person's care plan. One person said, "The chiropodist has been today. You can ask to see the doctor… They asked if anything overcame me would I want to go to hospital or stay here. I said stay here, where everyone knows me here." Another said, "If you're not well it's the local doctor who comes to see you… Chiropodist, opticians and dentist come round."

Staff monitored people's health needs and reported concerns, for example, during the inspection one person's health deteriorated. The nurse in charge immediately contacted the GP to discuss the person's health and obtained advice about additional treatments to reduce their distress. Another person wanted portable oxygen in order to be able to go on outings with their family. The staff had arranged some portable oxygen but this only lasted three hours, which wasn't long enough. Records showed the staff had been in contact with the person's GP a couple of times to arrange for larger portable system. However the person said they were frustrated by the time it was taking to get this arranged.

A visiting professional described the service as "one of the best I visit". They added, "They are very good overall. I am alerted to any changes or new people who would like to see me. People seem happy here overall…" A visiting social care professional described how several people admitted to the service had "flourished". They added that staff were "really good", and they were able to discuss anything they needed to know about a person. They described communication with the service as "good."

People were generally positively about the food they received at the home. People were offered a varied and nutritious diet. Comments included, "The food is lovely…", "I can't grumble about the food, we have a choice and there is plenty to eat", "The food is very good for me. It is difficult to cater for everyone but we get a good choice" and "The roast dinner yesterday was lovely…" During our visits we observed that in all cases people had a glass of juice close by and a jug of juice in the room.

A cooked breakfast was offered three mornings a week and we saw several people enjoying a cooked breakfast. One person said, "You can't beat a good breakfast!" Several people had breakfast in the main dining room, which was sociable, with people greeting each and chatting. Staff were attentive and ensured people's needs and requests were met.

We observed a lunchtime meal. Tables were laid with a set of cutlery, condiments (salt and pepper), serviettes and a table centre of flowers. There was background music playing. There were two members of staff to serve the meals, clear plates and support as required; they referred to people by their chosen name. Staff offered people choices regarding vegetables and further drinks and asked if they had had enough. One person had individualised cutlery and a plate guard to meet their needs. The activity person noted that the plate guard had been incorrectly placed. They advised the other member of staff of where to put the plate

guard and why.

Daily menus were displayed in the lounge, which offered alternatives to the main dish of the day. People, were aware of what was being served for lunch. Various dietary needs were catered for, including diabetic and pureed meals. The cook used food shape moulds to display pureed food to make it look more appealing. We observed that one person declined lunch, although they were offered alternatives. They said they had enjoyed a good breakfast and the pudding that day, and would have supper later. They said they generally enjoyed the food but "didn't fancy the lunch" that day. Their care records showed that they had not lost weight or were at risk of malnutrition. People assessed as at risk of weight loss and not having enough nutrition, had their weight regularly monitored. They had additional snacks twice a day, these included mousse and cake. Referrals had been made to people's GPs and where necessary supplements had also been prescribed.

Some people required their nutrition to be delivered via a special tube as they were unable to maintain adequate nutrition with oral intake. The community dietician had been involved in these people's care and they had established a regime to ensure people had sufficient nutrition and fluids. Records confirmed that people received the recommended and required nutrition to maintain their health. The dietician had recommended people also received sufficient fluids via the tube; their recommendation had been incorporated into the care plan and staff responsible for managing the regime were aware of the recommendations. Staff had received training to support these people to ensure their practice was safe. However, the records did not provide a daily total of intakes so it was difficult, at a glance, to confirm that the required nutrition and fluid had been given. In some records there were some minor shortfalls. We discussed this with the registered manager and clinical lead nurse. They explained that the deficit was due to staff not recording water they needed to us to flush the tubing. They put in place a new recording chart to incorporate daily totals which would be calculated by a nurse each night. They said nurses would be reminded to record all fluids inserted via the tube.

Good

Is the service caring?

Our findings

People and relatives were on the whole happy with the quality of care at the home. Comments included. "Very nice", "absolutely lovely staff", "very respectful…", "Staff are extremely nice", "I'm satisfied with everything, they can't do much more than they do", "Very friendly always, all know my name", "They are very good; some of them don't talk to you", "Very satisfied, I can't judge against another place" and "They call you by your Christian name. Most of them I know, I get on well with them. I get on alright with everyone really." Although some people gave us mixed feedback when asked if staff were polite, caring and friendly. Comments included, "Some get a bit bad tempered, I think it's the job. You can see they get impatient" and "They're polite, friendly, some of them depends who you have." We shared this feedback with the registered manager who was surprised by the comments and said she would speak with staff.

We observed staff engaging positively with people in a sensitive and caring way. Staff were not seen rushing people and their approach with people was gentle and considerate. For example, one person was very attached to a doll and obviously derived comfort and pleasure from the doll. When staff interacted with the person they acknowledged the doll and its importance to the person. Clothes were also obtained for the doll by the service.

One member of staff was skilful when speaking with people, encouraging conversation and reminiscence over breakfast and throughout the day. One person shared their experience of their first job in service, another person spoke about their life as a young person. There was lots of banter, jokes and smiles from people in the main lounge. The staff member was engaging and interested in what people had to say, and they responded positively to that approach.

Staff were aware of people's communication needs. For example, one person had a profound sensory loss. The person used a communication board as well as signs and gestures to make their wishes and needs known to staff. Staff were aware of these communication methods and we saw several positive interactions between the person and staff, with the person smiling and giving the 'thumbs up' to indicate their satisfaction. Another person who had a hearing impairment required staff to write down questions on a pad.

Staff were mindful of people's privacy and dignity. People confirmed they were treated with respect and their personal care was delivered in private. People's comments included, "The staff are very good on that account. They make sure the door is closed and I am comfortable", "They keep me covered up as much as they can" and "Always pull the curtains." Before entering people's room's staff knocked on their doors and they addressed people in a respectful way. Some people's personal care was well attended to. Several people had their hair done regularly, which they said was very important to them. Their nails were painted and they had smart matching clothes and accessories, showing staff understood the importance of people's appearance to their self-esteem and well-being. Some other people appeared less cared for, for example unshaven; we established that this was their choice.

People were offered choices; staff asked people their preference. For example, whether they wanted to go to the lounge, would like to watch television, had they finished their lunch or did they require more. People

discussed with us that they had not had regular opportunities to have a bath or shower. One person told us, "Yes I have my own bathroom; I go in there to wash and change. I'm not very quick. I don't bath I only wash down completely every morning. I suppose I could ask them to give me a shower." When asked if they had been offered a shower said "No not offered". When asked if they would like to shower, they said 'I would love one'. Another person said how staff washed them all over but that they only occasionally had a bath. A third person's family had also raised their concerns with the registered manager through the complaints process about not being offered regular showers since arriving at the home. The person said, "They started asking me (staff). I've had strip washes and one shower." Records showed staff recorded when people were offered baths or showers and showed people had been offered regularly but people had declined and opted to have a strip wash. Staff said that people were regularly offered baths and showers and could change the times. The registered manager told us about one person who liked to have a bath at a set time early in the morning each week. If they did not have their bath at this time it would cause them anxiety for the whole day. Therefore staff were deployed to ensure the person had a bath at their chosen time. One person when asked if he undertook their own personal care replied, "I try to, they help you bath about every three weeks as I get out of breath (confirming this arrangement suited them)."

People's wishes regarding their end of their life care had been discussed with them and recorded where people felt able to talk about this sensitive subject. Treatment Escalation Plans (TEP) were in place, which recorded important decisions about how individuals wanted to be treated if their health deteriorated. This meant people's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice.

One person was receiving end of life care at the time of the inspection. We observed that their condition was monitored regularly by staff. Medicines were given as prescribed to reduce any unwanted symptoms, such as pain. Staff visited the person regularly to provide care and treatment, such as repositioning and fluids, as well as ensure the person had some company.

At the time of the inspection people who required an advocate had support to access a service. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights.

People's relatives and friends were able to visit without being unnecessarily restricted. Throughout our visit, visitors were greeted by the reception administrator. People were able to personalise their rooms by bringing personal possessions from home, rooms were numbered with a slot providing the residents names.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, there was a breach of the regulation. This was because people were not always receiving care and treatment which was appropriate and met their needs. Following the inspection we were sent an action plan setting out the actions the provider was going to take. At this inspection we found the actions had been taken regarding this breach and the requirement had been met.

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre-admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This helped to ensure the service could meet people's needs and expectations. The registered manager said it was very important to meet people to discuss what they wanted and to ensure Culm Valley Care Centre was the right place and could meet their needs.

People's needs had been assessed and plans of care had been developed to assist and guide staff. The care plans related to people's activities of daily living. These included communication, continence, mobility, nutrition and personal care needs. Care plans also reflected people's emotional and mental health needs. The plans identified people's needs and how the staff needed to support people to achieve them. The care plans were reviewed each month and more regularly if people's needs changed.

Care plans contained details of people's health care needs; personal care requirements and were reviewed on a regular basis or when needs had changed. For example, following a visit from the community dietician the care plan had been reviewed with current recommendations. There was good information about one person's communication needs and how they expressed themselves. However one person made us aware that their dentures had not been soaked and been left on the side, overnight. They had not made the staff aware and waited to have their personal care the following morning before they had them cleaned and put back in their mouth. We discussed this with the registered manager who said she would look into this. We also made them aware that the person's care plan did not contain guidance for staff regarding the person's oral health. On the second day of our visit the registered manager said they were reviewing everybody's care plans to ensure oral health had been included.

People were asked whether they would recommend the home to others. The majority said they would. Comments included, "Oh I would yes", "I think so from my experience, it is quite good" and "Things are good, things are bad." One person new to the home told us they were finding it difficult to adapt to their new surrounding and were missing their previous home. They said, "'The staff are friendly they are so busy they haven't got time…I do miss them (people from previous home)…I'm so lonely…" When we discussed this with the registered manager they were aware the person was finding it difficult and told us what the staff were doing to help them settle. On the second day staff had spent more time with the person and were trying to introduce them to others at the home.

Some people were unable to confirm if they had been involved in planning their care. However, one person

confirmed that staff had discussed their needs and preferences and they had signed a consent to care and treatment form. They said, "The staff know me by now, how I like things done." The registered manager said that people were involved in developing their care plans, adding "certainly at admission they are discussed."

On the afternoon of our first day, one person was assisted to sit outside. However, they did not have a bell in order to make staff aware and staff did not check on them regularly to ensure they remained happy to be outside. We spoke with the person, who had been outside for an hour and half; they said they needed to use the toilet. We alerted staff who immediately assisted the person. We were told due to the change in staff, staff were unaware the person was outside. We discussed the concern regarding the person being able to call for assistance when out on the terrace with the registered manager at the end of the first day. On the second day of our visit they said they had been in contact with the call bell installers regarding having a call bell outside. In the mean time they had put in place 15 minute checks for people sat outside. People had access to a call bell when in their rooms; these were seen to be by their side, often clipped to a blanket.

An activities co-ordinator worked from 8am until 4pm, Monday to Friday providing group activities, mainly in the ground floor lounge. At weekends a member of the care staff were designated to work in the main lounge and support people with their social needs. The activity coordinator was keen to get people involved in various activities and we heard them asking people if they would like to take part in one of the regular baking sessions. A small oven had been purchased to enable people to bake cakes in the kitchenette, rather than having to use the main kitchen.

The activities coordinator was enthusiastic and spoke about some of the activities people had engaged with and ideas for future, such as a quilting group which had been suggested at a 'residents meeting'. Regular activities were organised and advertised via the home's newsletter. The newsletter had been improved since our last inspection and had more detail and activities people could complete, for example, word searches. Several people said they enjoyed the group activities and participated regularly. Activities included; planting seedlings and nurturing them; external entertainers and pets as therapy visited. One person particularly enjoyed this activity.

Social profiles had been completed for everyone and identified people's interests and possible hobbies. This enabled the activities co-ordinator to plan appropriate group activities which reflected people's preferences. An activities survey had been undertaken in November 2016, with 26 completed and returned. As a result of the survey a shopping trolley had been put in place for people to be able to purchase sweets and toiletries. People who chose to stay in their rooms were asked what activities they would like; 20 people said they would not like activities provided in their bedroom. Four people said they would like to knit; do word searches or read. In response to this word searches had been added to the newsletter and a 'knit and natter' group had been formed.

At a 'residents' meeting in March 2017 a person asked about possible outings. The registered manager explained this would be difficult to organise as a mini-bus would need to be hired and a nurse would also need go with people. They were looking at ways people could access the local community if they chose and were able.

People and visitors overall were happy with the provision of activities at the service. However some people said they were lonely and would like to just have a chat. Comments included, "You get a letter, what's going on. We're well informed. I don't join in any activities, if they've got a sale of work we (my family and I) go down to see what we can buy", "I like to be in my room all the time…I'm happy with the tele", "They have different things going on downstairs…I don't go downstairs very often'', "It's not really my cup of tea… Exercise, I joined in that, (activity coordinator) runs the activity you get a monthly thing that tells you what's

going on. There's a hairdresser every week", "The only complaint is I'm so lonely. There is only the staff that come in to give me my medication and meals and they're too busy to talk", "Chat, not very often. It would be nice for somebody to come in and have a chat" and "If it was a person who could join in, then it's different. You could if you wanted to go down and have a laugh. It's there if you want it." A health professional said, "Because it is so large, if people are immobile then there may be fewer opportunities but the communal area is good for social activities. I know many service users enjoy the activities."

Several people chose or needed due to a health need to remain in their room and not take part in group activities. One person said, "Activities are not for me. I like my own company, I have my TV and plenty of visitors." However another person who spent the majority of time in their room was unable to tell us whether they were happy with the level of social interaction or activities. One person's social care plan stated, "loves interaction". Their activities record showed they had been offered to take part in sessions in the lounge but they had declined. Records showed the person spent the majority of time in their room. Staff visited regularly to provide care and support and for brief chats but otherwise the person was alone watching TV.

We discussed concerns raised with us with the registered manager. They confirmed they had been actively looking to get volunteers to visit the service with very little success. They said that a member of care staff was designated each afternoon to undertake up to an hour of social interaction with people in their rooms. Care staff said time constraints meant they did not always have time to support social activities, however they said when they could they offered sensory activities, such as hand massage and manicures or spent time chatting with people. On the second day of our visit the registered manager said they had gained agreement to implement a designated activity person for six hours a week to work specifically with people in their rooms. They had a staff member who would take on this role and would start the week following our inspection. The registered manager was already getting things together to help ensure this was structured so people had session which were meaningful to them.

People had access to the provider's complaints policy. There had been two complaints received by the registered manager since our last inspection. The registered manager had followed the provider's complaints procedure in response to these complaints. People said they knew how to raise a complaint or concern if they were unhappy with any aspect of the service. Comments included, "I would speak with the nurse or manager", "I would tell the staff if anything was amiss", "The manager and the office staff here are good. You can make a complaint or anything" and "In all honesty if there's an issue I'm content to talk to someone. They're quite interested."

One person told us that they had raised issues with the registered manager regarding their room not being suitable, being too hot and that they wanted a larger room. The registered manager said they had offered alternative rooms in the past which had also not been appropriate. They had recorded, the week before our visit, that they had discussed this with the person. We asked the registered manager what actions they had taken to ensure the person's comfort as they were feeling the room was quite hot. On the second day of our visit an air conditioning unit was in place.

The service had received many compliments from relatives whose family members had used the service. These compliments demonstrated the support and care people had received. Comments included, "… outstanding, lovely, very professional and caring. Thank you…", "We would like to sincerely thank all staff and management for the wonderful way my father was treated…" and "…family would like to thank you for the excellent care and attention given…"

Good

Is the service well-led?

Our findings

At our last inspection, there was a breach of the regulation. This was because the provider had not identified areas of concern through their quality assurance systems. Following the inspection we were sent an action plan setting out the actions the provider was going to take. At this inspection we found the actions had been taken regarding this breach and the requirement had been met.

The culture of the home was open and inclusive. Staff were positive about working at the home and said they worked well together as a team and there was good communication.

The registered manager was supported by two clinical lead nurses who together dealt with the day to day running of the service. Several people knew the registered manager by name and said she was always around should they need to speak with her. Comments included, "She (registered manager) is very nice and has time for people…", "Sometimes, most weeks (registered manger) comes" and "Manager is downstairs, she's very good, very polite." One person did not feel they were listened to by the registered manager. However we saw that things had been actioned in response to concerns they had raised.

Staff said they were well supported by the registered manager and that they could approach them at any time with any concerns or requests. One staff member said, "(The registered manager) is very fair. She tries to accommodate our requests"; another said, "… (The registered manager) does her best to keep the team happy…" A third said they felt the registered manager ran the service well and described a good working relationship with her. Their comments included, "(The registered manager) is open and approachable and I can discuss any concerns with her."

The care management staff team consisted of nurses and a new role of team leader which had been put in place since our last inspection. The two team leaders had extended duties which included writing and reviewing care plans and working alongside the nurses to oversee a floor and report to the nurse working on the opposite floor. They oversaw care staff and ensured people were receiving their required care by working alongside care staff and checking monitoring documents were completed.

There were established systems in place to monitor the quality and safety of the service. These included a combination of daily, monthly and quarterly audits and checks in all areas of service provision. For example health and safety; infection control; and care plans. Where deficits were found action was taken, for instance, equipment such as hoist slings had been replaced. The infection control audit highlighted some areas which required additional attention from the cleaning staff. This had been completed. The provider's operations manager visited the home monthly or six weekly, to monitor the quality of the service. They spoke with people, staff and visitors and reviewed care plans and documents and developed and action plans which the registered manager completed. They reviewed these actions at their next visit to ensure they had been completed.

People who used the service and their relatives were asked for their views about the care and support provided. The majority of people said they felt the service was well run. Regular 'residents' and relatives'

meetings' were held which provided people with an opportunity to discuss the service and share ideas and concerns. The registered manager said they encouraged a 'resident' to chair the meetings so people could feel free to express their views. The meetings were advertised on the notice board and in the newsletter. Minutes of the meeting were available for people who did not attend, so they were kept informed of developments. The main topic of conversation at the last meeting was menu planning and activities. Where suggestions had been made about improvements, for example, the menu, these were actioned. People had requested chicken drumsticks and these were on the menu. Following the inspection, the registered manager sent us feedback from the meeting held on 23 May 2017 in between our visits. Minutes showed people were satisfied with their bedrooms; the food; activities and they found the staff "nice and polite". All at the meeting agreed they received a good level of care. People said they were aware of the residents meetings and could attend if they chose.

The provider described in the Providers Information Return (PIR) 'We belong to NAPA (National Activity Provider's Association), to support our activities development." NAPA is an organisation that's aim is to support providers so "every care and support setting …full of life, love and laughter.'

Satisfaction surveys had been used to obtain feedback from people about the food and activities in 2016. Responses were positive overall. A catering survey completed by 16 people in February 2017 showed people were satisfied with the choice, quality and presentation of food.

A quality assurance survey had been sent to relatives and friends in November 2016, which covered most aspects of the service. Most areas were rated as 'good' or 'very good'. Where areas were rated as 'fair' or 'poor' relating to meals and activities by one person the registered manager was unable to identify them in order to discuss their comments. However regular meetings were held to discuss these issues and more recent feedback showed good satisfaction levels.

A monthly overview of falls, accidents and incidents was kept and reviewed by the registered manager and provider's operations manager. This enabled the management team to identify trends and for staff to take action to identify when people required aids or intervention to prevent a further incident. For example, following a fall, additional measures were considered as ways to reduce the risk, for example the use of equipment such as bed rails or crash mats, or an increase in staff monitoring checks. Information about the location and time of accidents and incidents was added to a monthly analysis completed by the registered manager which assisted with identifying the root causes.

To improve staff morale and acknowledge good staff performance, the registered manager had introduced a 'heart and soul award'. People using the service, their relatives and staff were invited to nominate staff for the award. The registered manager explained this would be a quarterly initiative and staff would receive a small token of thanks. On the second day of our visit we saw photographs on display of the first presentation, where the winner had been awarded along with a runner up from the housekeeping team also recognised. There had been 43 nominations received.

Accidents and incidents were reported to and reviewed by the registered manager and nurses to identify ways to reduce risks as much as possible. The provider had a document called "procedure for examination following a fall" which staff referred to and completed following an injury. These included a list of indicators which might require urgent medical advice, signs of a head injury, painful extremities and a check of vital statistics including the persons pulse and blood pressure.

In November 2016 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service was awarded a four rating with the highest rating being five. The provider had taken

action regarding the concerns identified and when they were re-rated in May 2017 they achieved the highest rating of five. This showed the provider was working to ensure good standards and record keeping in relation to food hygiene.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.