Care Quality Commission

Colten Care Limited

Court Lodge

Inspection report

Court Close
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Court Lodge is registered to provide accommodation for persons who require nursing or personal care for up to 43 older people, some of who may be living with dementia. On the day of our inspection 40 people were living at the home.

Accommodation at the home is provided over two floors, which can be accessed using passenger lifts. There is a large garden and patio area's which provide a secure private leisure area for people living at the home.

The home had 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.

On the day of our inspection the registered manager was on leave. The home was being managed by the head of care who was supported by the provider's quality assurance manager and operations manager.

Summary of findings

Staff understood the needs of the people and care was provided with kindness and compassion. People, relatives and health care professionals told us they were very happy with the care and described the service as excellent.

People told us they felt safe and they enjoyed living at Court Lodge. Staff had received training in how to recognise and report abuse and had a good understanding of what to do if they suspected any form of abuse occurring.

The home had a robust recruitment and selection process to ensure staff were recruited with the right skills, behaviours and experience to support the people who lived at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection applications had been submitted by the managing authority (care home) to the supervisory body (local authority) and had yet to be authorised. The head of care understood when an application should be made and how to submit one. They were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People's care plans and risk assessments were person centred. They were reviewed regularly to make sure they provided up to date and accurate information.

Staff were appropriately trained and skilled to ensure the care delivered to people was safe and effective. They all received a thorough induction when they started work at the home and fully understood their roles and responsibilities.

The registered manager or head of care assessed and monitored the quality of care consistently involving people, relatives and professionals. Care plans were reviewed regularly and people's support was personalised and tailored to their individual needs.

People and relative's told us they were asked for feedback and encouraged to voice their opinions about the quality of care provided.

People and relatives knew how to make a complaint if they needed to. The complaints procedure was displayed in the home. It included information about how to contact the ombudsman, if they were not satisfied with how the service responded to any complaint. There was also information about how to contact the Care Quality Commission (CQC).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Systems were in place for recording and managing risk to ensure people who lived at Court Lodge were safe.

People received their medicines when they needed them and by a suitably trained member of staff.

Robust recruitment practices were followed to ensure staff were suitable and safe to work in the care home.

Is the service effective?

Good

The service was effective. Staff were supported in their role, and they had received an induction into the service. Staff received regular supervision, annual appraisal and training.

People were supported to maintain good health and had access to on-going healthcare support.

The registered manager and head of care had a good understating of their duties under the Mental Capacity Act 2005 and had appropriately referred on to the local authority if they thought a person had been deprived of their liberty.

Is the service caring?

Good

The service was caring. Staff interacted well with people were kind and compassionate.

Staff knew people very well and respected people's privacy and dignity.

People were involved in the support they were receiving and staff encouraged people to remain as independent as possible.

Is the service responsive?

Good

The service was responsive. People received individualised and person centred care which was regularly reviewed.

Activities were innovative, interactive and meaningful to the people who lived at the home.

The home had a system for reporting and acting on any complaints or suggestions received and had received many compliments about the service they provided.

Is the service well-led?

Good

The home was well led. There was strong leadership and systems were in place to monitor the quality of the service.

People and staff were actively involved in the development of the service.

The registered manager and staff promoted people's wellbeing, choice and individualism through friendliness, kindness and honesty.

Court Lodge

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 took place on 27 July 2015 and was unannounced.

The inspection team consisted of two inspectors 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.

Before our inspection we reviewed all the information we held about the service. The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also checked to see what notifications had been received from the provider. Providers are required to inform the CQC of important events which happen within the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 14 people living at the home and nine relatives. We also spoke with the head of care, the quality assurance manager, operations manager, learning and development business partner, two nurses, one student nurse, nine care staff. the chef, two kitchen assistants, three housekeepers, the activities coordinator and the maintenance person. We looked at four people's care records, four recruitment files and records relating to the management of the service. Following our inspection we contacted one General Practitioner (GP) and one Community Nurse to obtain their views on the homes delivery of care.

Good

Is the service safe?

Our findings

People told us they felt safe living at Court Lodge. One person said, "I feel very safe. It's very good." Another person told us, "I like it here and I like the people around me." We spoke with one person walking in the courtyard area who told us they felt safe in the enclosed garden area. They told us "I think this is a good idea. I wouldn't like to get lost". One person told us, "I came here from hospital, as I had nowhere else to go. I wasn't happy about it, but they have made me so comfortable and safe, I have settled in".

Relatives we spoke with during our inspection all told us they felt their family members were safe living at the home. A GP told us, "I have been associated with Court Lodge for many years. I have no concerns at all. I would choose it for my own mother if I had to".

Staff told us they had received training around the importance of protecting people and keeping them safe from potential harm. Staff knew how to recognise and report any possible abuse. Training records confirmed staff had undertaken training in protecting people who might be at risk of abuse. Staff confidently described the signs that would give cause for concern and they knew the procedure to follow to report any incidents. A poster was displayed in the staff room and in reception which gave a telephone number staff could call with a concern, and several staff told us about this.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff told us they would feel confident raising any concerns with the manager. They also said they would feel comfortable raising concerns with outside agencies such as CQC if they felt their concerns had been ignored. Staff understood the whistleblowing procedure and told us they would not hesitate to refer poor practice to managers and other relevant agencies if necessary.

We saw risk assessments in each of the four care files we looked at in detail, assessing the risk to the people who lived at the home around falls, mobility, nutrition, medication and the use of wheelchairs. Risks had been assessed and actions had been taken to minimise any risks identified. Risk assessments were undertaken based on people's individual needs. For example, when one person lost weight, a risk assessment was carried out to determine their risk of becoming malnourished. To reduce this risk the person was provided with a high calorie diet and weighed more regularly. A range of other assessments were carried out. For example, the risk of people falling or developing pressure sores. A community nurse told us, "The staff all know what to do and care for people very well. I certainly have no concerns".

The operations manager told us all incidents were recorded by staff and passed to the registered manager or head of care for analysis. For example, one person had a history of un-witnessed falls. The local falls team had been contacted for advice and guidance regarding the on-going safe management of the person to reduce the number of falls and possible injury. The GP had also been involved and medication prescribed to reduce the risk. Sensor mats had been placed in the person's room which would alert staff immediately if the person fell.

There were enough skilled staff deployed to support people and meet their needs. We observed staff providing care and one-to-one support at different times. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staff and people told us there were enough staff to meet people's needs. One person who lived there and who chose to spend most of the time in their room told us, "They always come in and ask me how I am, and do I need anything. They come and check on me regularly". We also asked relatives whether they felt there were enough staff to care for their relative. One relative told us "There is always plenty of staff to keep an eye out". Staffing levels had been determined by assessing people's level of dependency and staffing hours had been allocated according to the individual needs of people. Staffing levels were kept under review and adjusted based on people's changing needs

Recruitment practice was robust. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw a Disclosure and Barring Service (DBS) check had been obtained before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with children and adults to help employers make safer recruitment decisions. Checks

Good

Is the service safe?

to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored in a locked medicine trolley that was secured to the wall in the nurse's office on the first floor. A second medicine trolley was located on the ground floor. This was also secured to the wall. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily. Regular checks and audits had been carried out by the registered manager to make sure that medicines were given and recorded correctly.

Only staff who had received appropriate training for handling medicines were responsible for the safe administration and security of medicines. Each person had a record of homely remedies that could be given. The list had been authorised by the GP and was reviewed annually or as needs changed. This ensured that medicines were handled and given to people safely. Medicine administration records were appropriately completed and staff had signed to show that people had been given their medicines.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs and were stored securely and records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. We checked a sample of the drugs held against what had been administered and found the quantities to be correct.

Safety checks had been carried out at regular intervals on all equipment and installations. Fire safety systems were in place and each person had a personal emergency evacuation plan (PEEP) to ensure staff and others knew how to evacuate people safely and quickly in the event of a fire. The provider ensured the premises and equipment were maintained. Health and safety records we looked at confirmed regular environmental checks were undertaken and any issues swiftly remedied.

The home had an automated external defibrillator (AED). An AED is a portable electronic device that is used to restart the heart following a cardiac arrest. This was checked daily to ensure it operated effectively. The AED pads were also checked and found to be 'in date'. This would ensure the pads would adhere to the chest effectively in a medical emergency.

Good

Is the service effective?

Our findings

People told us staff were able to provide the support they needed. One person told us, "I think they're very good at their jobs". Another person described the staff as, 'excellent'. A visiting community nurse told us, "I work closely with the staff and management at the home to ensure people remain well. I have a very good relationship with the home and support them when needed. The staff are well trained and I have every confidence in them".

People told us that staff sought their consent and acted in accordance with their wishes. One person told us that they needed some assistance with their personal care and staff asked for the person's consent before, 'Doing anything'. Another person said that had spoken to the manager together with their family about their care and end of life wishes. They told us, "I know the staff will help me and keep me comfortable. That's all I want. I know they will do it".

Staff were supported in their role and all had been through the provider's own corporate induction programme. This involved attending training sessions and shadowing other staff. Staff told us they received regular supervision and an annual appraisal. We spoke with the learning and development business partner who showed us the providers updated induction programme which embraced the 15 standards that are set out in the Care Certificate. The Care Certificate replaced the Common Induction Standards and National Minimum Training Standards in April 2015. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. They told us their own corporate induction would run alongside the Care Certificate which would not only meet, but exceed the standards of care people could expect.

The provider had systems in place to ensure staff received regular training and could achieve industry recognised qualifications and were supported to improve their practice. This provided staff with the knowledge and skills to understand and meet the needs of the people they supported and cared for. For example, staff were seen to interact with people in a caring and respectful manner because they understood issues relating to dignity and we saw staff supported people to move around the home in appropriate and safe ways. One member of staff told us they could have all the training they wanted. Another member of staff said, "Training is really good. I've done so many courses and really feel it has helped me in my role".

Staff were provided with regular one to one supervision meetings as well as staff meetings. Staff told us they could bring up any concerns they may have. Supervision records, confirmed staff were able to discuss any concerns they had regarding people living at the home. The head of care told us, "We have regular supervision meetings with staff and try to make them meaningful. We have recently introduced 'themed' meetings where we talk about specific things. For example, dementia awareness and parkinson's disease. One member of staff said, "I have the opportunity to discuss the ways that I work and any areas I feel I need to develop. It's a two way conversation and I enjoy them".

We asked the head of care what training had been undertaken to support the needs of the people at the home. They told us and staff training records confirmed for example, that 85% of staff had received training in dementia awareness, 98% had received training in the Mental Capacity Act and Deprivation of Liberty Safeguarding, and 83% in wound management and pressure area care. Staff were supported by the provider to gain the knowledge and skills to enable them to care for people living at Court Lodge.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes and supported living are looked after in a way that does not inappropriately restrict their freedom. Nobody living at the home currently had a DoLS in place however 14 applications had been submitted by the home to the local authority for authorisation and were waiting assessment.

Staff understood the principles of the MCA and what to do if a person lacked capacity around their care needs. They gave us examples of how they supported people to make choices about what they wanted to wear and what they wanted to eat. Another example given was for a person who had their room cleaned when they were being supported to have a bath, as they did not like to be disturbed when they were in the room. A member of staff told us, "A person has a right to make their own decisions and we respect that. We work around them. Some like to

chat and interact and that is nice for both of us. For other people they prefer that we wait until they are not in the room". Another member of staff told us how they work with families in partnership. "Sometimes they want something but the resident wants something different. We work with the family, but follow the resident's wishes".

We looked at the care plan and risk assessments for four people who had safeguards in place to keep them safe. This contained the relevant assessment information. For example, best interest meetings with appropriate health care professionals and people who knew the person well. These also included how the home would ensure any deprivation was minimised and the least restrictive options put in place, together with a review date. We observed the safeguards put in place for one person by the home being followed during our inspection. For example, the person wanted to go for a walk in the garden, but it was not safe for them to do so without support due to their dementia and mobility. A member of staff supported the person to access the gardens and ensured they were able to do as they wanted whilst maintaining their safety.

People's care plans related to each aspect of their individual needs for health and well-being and there was evidence of other professionals' involvement. For example, where reviews of medication were required, GPs visits were recorded and we saw the home worked well with visiting professionals, such as district nurses. The head of care told us that everyone's health care needs are reviewed monthly or as their needs change.

People were supported to maintain good health and had access to on-going healthcare support. People were able to access appropriate health, social and medical support when they needed it. Visits from doctors and other health professionals, for example, Tissue Viability Nurse (TVN), Occupational Therapist (OT) and Community Psychiatric Nurse (CPN) were requested promptly when people became unwell or their condition had changed. Local GP's attend the service regularly to see anyone who wished to see a doctor or anyone the service was concerned about.

People were supported to have sufficient drinks to minimise the risks of dehydration. There was a plentiful supply of water and fruit juices in all communal areas of the home and in people's rooms. Throughout the day staff replenished these as and when required. People who had been identified as 'at risk' had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's GP's, specialist nurses and dieticians. People were provided with special diets. For example, soft diet, gluten free and diabetic. Staff were able to tell us who required a special diet and the reasons why. Staff helped people while eating to ensure risks of choking were reduced.

People were complimentary about the food. The menu for the day was displayed in the home and people confirmed that they made their choices from the menu. However, if they wanted something different this was provided. They told us that there were cooked breakfasts available for those who wanted them, three choices of lunch dishes, with alternatives if necessary, plus home-made cakes daily. One person said, "We get tea and coffee several times during the day and not at set times. If I fancy a cup of tea or coffee at an odd time they always make it for me. Nothing is too much trouble". Another person told us, "The food is very good, I used to find it difficult to enjoy anything, but there were always alternatives and my appetite has come back, it's much better now. The chef takes care to find out what you like".

Lunchtime was a sociable event. Seventeen people sat down to eat lunch in the dining room. The tables were laid with place mats, condiments and table napkins. Each table had fresh water and glasses. People chose to sit where they wanted and enjoyed talking with staff and each other. Some people enjoyed glasses of wine or sherry with their meals whilst others preferred water, fruit juices or tea. Two people were being supported to eat by staff. Staff took time talking to people, asking them what they wanted to eat next and ensured they had safely swallowed food before offering more.

Good

Is the service caring?

Our findings

People told us they were well cared for. One person said, "The staff are all lovely. Anything I need, I just have to ask, they are very kind". Another person said, "Sometimes I think I might fall and they are always there to help me". Whilst another person said, "I think you'll find it's all good, they look after us well". One person told us, "This is my palace. I love it. I will never leave. I don't want to leave". We spoke with one visitor who told us, "Staff here are marvellous, they really care about people. It's not the easiest of jobs but they do care. They always make me feel welcome and I can visit whenever I like, it's always the same, very friendly".

People were involved in their day to day care. People's relatives were invited to participate each time a review of people's care was planned. A relative told us, "I get invited to all my husband's care reviews. I always know what's going on. The manager is very good at keeping me informed". People's wishes and the decisions they had made about their end of life care were recorded in their care plans when they came into the service. When people had expressed their wish regarding resuscitation this was clearly indicated in their care plan and the staff were aware of these wishes.

People told us staff would sit and talk to them about their working life and family and we saw this happened frequently throughout the day. We observed staff actively listened to people, particularly when someone was requesting something, clarifying what they wanted.

Staff told us people's feelings of well-being were paramount, and every effort was made to make people happy, confident and independent in their daily lives. They told us they attempted to make the home as 'family-friendly' as possible, with open visiting and making people feel welcome. The service had its own minibus and there were regular trips out. There was an attractive and well-maintained garden for people to sit out in fine weather. One person told us, "I visited friends when they came here. I observed while I was here. When I needed a place myself I chose this home. I'm perfectly happy here, completely satisfied. Help comes freely and quickly. The people they employ here I find are very kind".

Staff engaged with people in a caring and compassionate way. Staff spoke with people patiently and respectfully. Conversations were held at face level and staff used effective communication, such as appropriate touch to reassure people if they were sad or anxious. There were good relationships between staff, people who lived there and visitors. One person said, "People here are nice. They give me the help I need when I get dressed, and whenever I ask. The manager comes in nearly every day".

Staff responded sensitively when people were restless or agitated and spent time trying to help them feel more settled. For example, one person was clearly upset and staff gave plenty of reassurance, engaging in ways to help calm the person's anxiety, such as stroking their hand and offering a cup of tea. Staff we spoke with said they were aware that sometimes people needed attention and conversation and they tried to include this as much as possible. We saw in one person's care plan that talking to them offered reassurance and helped them to feel calm and we saw staff facilitated this effectively.

Staff respected people's privacy and we saw they knocked on people's doors before being invited to enter. Staff were discreet when delivering personal care and they were sensitive when offering support or assistance. One member of staff told us they ensured they maintained people's dignity and respect by always ensuring no one could come into the room whilst the person was receiving personal care.

We asked how the staff maximised people's independence. They told us they tried to encourage people to do as much as they could for themselves. They would prompt the person to do the activity for themselves rather than doing it for them. One member of staff told us, "I never 'take over'. I always ask people what they are able to do for themselves and what they would like me to help them with. If you don't give people the opportunity to be independent you are effectively taking away their dignity and self respect".

We looked at the file kept of compliments received. The comments were all very positive. A typical example was, "Your work is invaluable. We applaud and thank you for doing it with such dedication". Other comments included, "Thank you to everyone who contributed to my stay. I certainly left feeling a lot better than when I arrived. Thank you all". "We always get a cheerful reception and you all have time for us" and "The time, patience and professional care of all the staff which you gave to her made things so much easier to bare and I want to acknowledge all your dedication and the work everyone has contributed. I couldn't have managed without you".

Good

Is the service responsive?

Our findings

Staff knew people well and understood their needs and preferences. For example, we asked staff about people they were working with that day and how they preferred to be supported. All knew about people's needs and preferences in detail. For example, one member of staff described how one person would eat better in the dining room, or if staff sat with them. One person told us, "Oh yes they know me well. They know what I like and what I dislike. They are very good". Another person told us, "They ask me several times a day how I'm feeling and if I need anything. When I do need them to help with something they are always very swift".

Staff told us they put the person at the centre of everything they do. We looked at four people's care records and saw there was clear information about people's physical and emotional needs. Detailed assessments had been completed before people came to live at Court Lodge. The risk assessment and care plans were split into sections with a separate section for recording assessments and care planning around mood, activities, personal care, skin, medication, nutrition, hydration, mobility and continence. Staff had received training in how to be person centred in their approach and how to record information in a person centred rather than task focused way.

Care plans contained detailed information about the person life history. For example, their favourite things, what they didn't like, things that made them laugh, something you might like to know about them. Staff recorded information such as their favourite food and about the person's family. The head of care told us they regularly updated the information as they learnt more about people whilst undertaking activities with them. For example, staff had informed us about one person who had recently been in hospital and we saw their care plan and risk assessments had been updated to account for any changes to their health as a result of this.

People's daily decision making and ability to choose was recorded in the daily logs. For example, one record we looked at referred to the choices made on what to wear, and what the person had chosen to eat for breakfast.

People's bedrooms were personalised and furnished with their belongings, such as their own furniture, photographs and ornaments. The home worked with people and their relatives to ensure that their own environments were personal to them.

The head of care and operations manager told us that meaningful, purposeful activities played an important part in daily life at Court Lodge. The home employed two activity co-ordinators which enabled them to cover weekends to ensure activities happened every day. We spoke to one activities coordinator who was passionate in their approach to activities and was aware that meaningful activities should not focus solely on events and timetabled activities. Daily activities included, plate painting, garden maintenance, flower craft, boules, minibus trips and visits from a pets as therapy (PAT) dog.

Another example of an activity was the compilation of the Court Lodge 'Daily Values' book which was in the reception area. The book was a record of activities people had been involved in. For example, residents had been involved in making handmade gifts to support Romanian orphans, baking and cake decoration, arts and crafts, birthday celebrations and activities away from the home such as the Lymington carnival and trips to the beach.

For people who did not wish to join in with activities, or for those people who had specific welfare needs social companions were deployed by the home for one to one personal support. Social companions are specifically tasked to ensure the risk of social isolation is minimised for people who chose not to, or who cannot join in activities. One person told us, "I'm not a great mixer. I enjoy my own company but I do get a visit every day asking if I want to be involved in the activities. I refuse most days but the carer (social companion) always has a chat and brings me a cup of tea which I look forward to".

Residents' meetings are held every two to three months and are attended by between 10 to 15 people including relatives. We saw some recent minutes from one of the meetings and saw handwritten notes in the margins by each item, noting action taken, or about to be taken, to deal with these issues. When we mentioned residents meetings to people living at the home, most were aware of them and actively supportive, telling us they "usually attend".

Good

Is the service responsive?

The complaints procedure was displayed on the notice board in the reception area at the home. It included information about how to make a complaint and also invited people to contact other agencies if they were not satisfied with how the service responded to any complaint. For example, the providers Director of Operations, Local Authority, Local Government Ombudsman Service and the Care Quality Commission (CQC). The complaints log showed that there had been seven complaints in 2015. All complaints had been investigated and responded to in a timely way. Written responses with the outcome of investigations had been sent to the complainants.

Good

Is the service well-led?

Our findings

People told us there was a 'good feeling' in the home and the registered manager was approachable and available if they wanted to speak with them. One person said, "You can speak to the manager or head of care when you need to. If they are busy you sometimes have to wait but they will always find time for you". Staff were confident they could speak to the registered manager or the provider if they felt they needed. One staff member said, "I feel confident in raising any issues". Staff told us they had confidence to question the practice of other staff and would have no hesitation reporting poor practice to the registered manager. Staff said they felt confident concerns would be thoroughly investigated. A visiting GP told us, "This home is managed very well. I have confidence in all the staff. The manager leads them very well".

Each morning at 10am the registered manager or head of care held a '10 at 10 meeting'. All heads of departments and senior nursing and care staff attended. The meetings were designed to discuss and communicate any concerns that had arisen during the previous 24 hours and to talk about any impending issues into the next 24 hours. Staff told us they found this a good way to communicate 'what was going on in the home' and enabled them to keep up to date with the day to day running of the home and people's changing needs.

Staff meetings were held on a regular basis and we saw from the meeting minutes that staff were kept informed of developments to the service. People and relatives told us the manager was active in the home throughout the day and engaged with people, staff and relatives in a warm and friendly manner. A relative said, "She is always running about the home doing things and talking to people. She leads by example".

Staff told us they thought the home was well led. One member of staff told us they "loved working here" and said "we all work as a team it's really good. Another member of staff told us there was a friendly open culture in which they felt they could approach managers at any time to discuss relevant matters.

Quality assurance systems were in place and we saw evidence of surveys carried out in May 2015 for relatives and people who used the service, results of which were positive. This asked people who lived at Court Lodge questions about staff and care. For example, food choice, cleanliness of the home, dignity and respect shown by staff, call bell response and having a say and about their quality of life. Forty two resident surveys were given out and 24 responses were received. Overall 32% rated the quality of care as 'excellent' whilst 64% rated it as 'good'. Eight relative survey questionnaires were returned of which 63% rated the service as 'excellent with 32% rating the service as 'good'.

The provider had other systems in place to monitor the quality of the service. This included monthly audits completed by the registered manager. The management support team visited the home frequently and spent time discussing the service with people and staff. They recorded what they found and an action plan of any issues that needed addressing was put in place. The audits covered areas such as training, care plans, management of medicines, infection control and staffing and supporting staff. These were reviewed as each audit was completed. Action plans clearly stated the required action to be taken and a date by which it should be completed

Premises checks were maintained and we saw documentation in respect of gas and fire safety. Reviews of accidents and incidents had been carried out and 'lessons to be learned' manager's investigation forms were completed.

The provider's values were outlined in their philosophy of care which was on display in the home and a copy given to each member of staff. The philosophy of care statement promoted people's wellbeing, choice, rights, individualism, fulfilment and privacy under the headings, friendliness, kindness, individuality, reassuring and honesty. We asked the head of care what their vision was for the service. They told us they wanted people living at Court Lodge to have the best care possible and to have meaningful and purposeful everyday lives.