Cole Valley Care Limited

Cole Valley

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on the 15 and 16 February 2017. Cole Valley Nursing Home provides nursing care and support for up to 44 older people who may also live with dementia. At the time of our inspection 41 people were residing at the home.

We undertook a comprehensive inspection of this home in February 2015. We found that the home had steadily improved since our last inspection. We found that the home was compliant with the requirements of the law and meeting people's needs well in four of the five key questions we looked at. The registered manager needed to continue to make improvements to ensure people had the support they needed to eat and drink and to ensure that people's human and civil rights were upheld. This inspection identified that while people received mainly safe care that they were satisfied with, improvements had not all been maintained and continued.

The home has a registered manager who has been in post for 13 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe. However we identified some incidents had occurred between people where people had hurt each other. These incidents had not been identified by staff as possible abuse, and the required support had not been obtained and no review of people's care had taken place. This meant people were not fully protected from the risk of a similar event re-occurring. Since our inspection we have received feedback about the action taken to improve on this.

Staff had been trained in adult safeguarding and when we spoke with them they showed a good level of knowledge about possible signs of abuse and the action they would take in reporting any concerns. However staff had not applied this knowledge into practice as they hadn't identified and reported the incidents identified during our inspection.

People received their medicines safely and there were effective systems in place to monitor medicines administration.

The feedback we received about staffing was mixed. For the majority of the time we observed adequate numbers of staff on duty, and saw people's needs and requests being met promptly. People were not left for long periods of time without access to staff. However feedback from people and relatives was that this was not always the case, and we were informed that sometimes people did have to wait for care and support, which at times caused them distress. Staff told us they had received induction, sufficient training and on-going support. There were handovers between staff at each shift change.

Staff had some knowledge of the Mental Capacity Act (MCA) (2005) and described how they supported

people with making choices. Restrictions to people's liberty had been identified. When necessary the relevant applications had been made and kept under review. Further work was needed to ensure the required legal notifications were sent to the commission, and that alternative, 'less restrictive' options were considered when making decisions with people.

People had access to regular healthcare and specialist healthcare advice. The nursing care provided was generally good and followed published good practice guidelines.

People's feedback about the food provided was mostly positive. Some people really enjoyed the food and other people thought it was acceptable. We observed that people were supported in a dignified and respectful way when they required help to eat and drink. The provider was taking part in a local good practice project that promoted fluids for people at risk of not drinking enough.

We received consistent feedback that the quality of care provided by individual staff was good and people told us that staff were kind and caring. People told us they appreciated the friendship and relationships they had developed with nurses and care staff as well as the domestic and housekeeping team, kitchen staff and the home management team. Relatives told us with pleasure about the relationship they and their loved ones had with members of staff. Staff told us that they enjoyed working at the home. Many of the staff we met had been in post for a long time and they demonstrated that they knew the people they supported well. During our observations we saw some good staff practice that ensured people were treated with dignity and respect.

People told us that they had some opportunities to be involved in planning their care to meet their individual needs.

People and their relatives were supported to think about and plan the care they would like to receive at the end of their life. Staff were experienced at supporting people with compassion, and they received good support from other local health professionals.

There were opportunities for people to join in group activities held in the homes lounges. People were also able to sit in their bedrooms, and quieter lounges. There were some opportunities for people to have one to one time with staff.

People were generally satisfied with the service and there had been a low number of complaints. Feedback was that the management team were very approachable and that people could approach them at any time if they had concerns.

People and their relatives all told us the management team were approachable and that they led the home well. They told us they felt able to approach them with concerns or feedback. The systems in place to monitor the quality and safety of the service had not been entirely effective. Whilst numerous developments and improvements had been achieved since our last inspection the checks failed to identify certain improvements that were required within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Incidents of harm and potential abuse were not always identified as such, and action was therefore not always taken to report it, or provide people with the support required.

Risks people were exposed to had been assessed, but the control measures were not consistently applied. The majority of staff followed good, safe working practices, however unsafe practice was not always challenged.

People could be assured their medicines would be well managed and administered as prescribed.

People were not always supported by adequate numbers of staff. The staff team knew people well, and had been recruited following robust checks.

Is the service effective?

Requires Improvement

The service was not always effective.

The food and drinks provided were of good quality and met people's dietary needs well, however the facilities to store and serve hot breakfasts required improvement. People received compassionate support to eat and drink.

People mainly received good nursing care and people could be certain that changes in their health would be identified and support from the relevant health professional obtained.

People's human and civil rights were not consistently protected. People were offered choices and the chance to remain as independent as possible.

Is the service caring?

Good

The service was caring.

Individual staff provided kind care and support. The culture of the home was to support people and their relatives and trusting

relationships had been formed.

Staff worked to protect the privacy and dignity of people, however people had not always been supported with personal hygiene as frequently as they expressed they would like.

Is the service responsive?

Good

People were supported by staff that knew both them and their needs well.

A range of individual and group activities had been provided to offer stimulation and enjoyment.

Complaints and feedback were well received, and people could be confident their concerns would be taken seriously and investigated.

Is the service well-led?

Requires Improvement

The home was not always well- run.

The registered manager had not stayed up to date with some relevant changes to her role.

The system of audits and checks had been somewhat effective at ensuring quality and driving forward improvements. However they had failed to ensure the environment was maintained to a good standard.

The culture of the home was welcoming and inclusive. It made people feel comfortable and valued.

Cole Valley

Detailed findings

Background to this inspection

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

This unannounced inspection took place on the 15 and 16 February 2017. The inspection team consisted of one inspector and an expert by experience. An expert by experience is someone who has experience of caring for someone who uses this type of care service.

As part of the inspection we looked at the information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to help us determine the areas we wanted to focus our inspection on. We also received feedback from the local clinical commissioning group, and the local authority who monitor the quality of the service.

We visited the home and spoke with seven people. We met all the other people who lived at the home. Some people living at the home were unable to physically speak with us due to their health conditions. We used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spent time in communal areas observing how care was delivered.

We spoke with the registered manager, deputy manager, three registered nurses, the chef, four care assistants and two housekeeping staff. We also spoke with thirteen relatives. We had feedback from four healthcare professionals. We looked at records including parts of four care plans and the records kept to show the care and support people had been offered. We looked at medication administration records. We looked at three staff files to assess the providers recruitment process. We sampled records from training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People we met told us they felt safe and had no worries for their own safety or their possessions. People we spoke with told us, "I am happy with all things here", and "I have no worries or fears." Relatives we spoke with confirmed that people were safe. One relative we spoke with told us, "I come unannounced at all different times. They [the staff] always welcome me, and are happy for me to see things just as they are." Another relative told us, "'As soon as I walked in I liked the vibe. The staff were friendly and honest." Staff we spoke with told us people were safe. They explained, "Yes, people are safe because staff work as a team, communicate people's needs and changes in their conditions well." Another member of staff told us, "Yes, people are safe. Everything is done well. Equipment is checked, there are enough staff, if we require something it is provided."

Our observations found that for most of the time the atmosphere in the home was calm, and although people were not always under constant supervision, they mostly did receive the support they required when they needed it. In one lounge we observed and heard one person verbally abusing and being aggressive to another person. Staff were not in the area at the time this occurred, and no support was offered to either person. Our inspection identified some records that documented unsettled incidents between another two people living at the home. Although these had been observed by staff and recorded in people's care notes, staff had failed to follow the process in place for reporting the incident. This meant people had not reviewed the support they required, their care had not been reviewed and the relevant agencies had not been informed. This practice would not protect people by reducing the risk of a repeat occurrence happening again.

The management team were aware of their responsibilities to report any safeguarding concerns that may arise. Notifications had been sent to the local authority and Care Quality Commission (CQC) as is required. Staff told us they had received safeguarding training in their induction and on-going refresher training. This ensured they had been made aware of current processes to follow and the signs to be aware of. One member of staff told us, "If I saw bruises or marks on someone I would get advice form the nurse. I'm confident the nurse or the manager would act on it." Despite staff confidently describing how they would recognise and report abuse, our inspection identified occasions when this had not occurred and people were not fully protected by a staff team that followed the registered providers procedure and local reporting guidelines that they had been trained to follow.

The risks people chose to take, or were exposed to by their medical and other needs had been identified and assessed. The assessment tools for medical risks such as developing sore skin, malnutrition, mobilising, or falling, had all been completed, kept under review and the staff we spoke with were able to describe the action they had to take to protect people. Some people needed the support of staff or specialist equipment to help them move. We observed staff supporting people to stand using safe techniques. Staff offered people reassurance when they supported them in the hoist, and it was positive that each person had their own sling. This is a way of reducing the risk of infections being passed between people. We observed three manoeuvres where people were transferred in wheelchairs that did not have foot plates. There is evidence to show doing this increases the risk of people receiving an injury to their feet, ankles or legs. This practice

was contrary to staff training and risk assessments and did not protect people from the risks associated with using a wheelchair.

We looked at the action taken to protect people from developing sore skin. We saw that people were regularly supported to change their position, to sit or lie on the correct specialist equipment, and that staff were aware of what to look for to prevent people experiencing sore skin. One member of staff told us, "When I'm getting people ready I always check their skin, pay particular attention to their bottom, back, elbows, and bony places. If I see anything of concern I call the nurse." We observed that staff prompted people who were able to walk independently to get up periodically to stretch their legs and to move around the home. This was a way of maintaining their mobility and reducing the risk of developing sore skin. The very low number of people that had developed sore skin showed these measures were being effective. We found that risks had been identified and assessed well, however the control measures were not consistently applied and unsafe practice was not challenged.

Records showed that when accidents or incidents had occurred immediate checks had been made on the person's well-being. The staff had reported the incidents appropriately and this had enabled a review of trends to take place. This enabled the provider to take action that could reduce the chance of similar events happening again.

We observed people being supported by adequate numbers of staff, however the feedback we received was that this was not consistently the case. Our observations showed that the staff team were constantly busy, but that the delegation of people and tasks meant that staff worked purposefully and clearly understood where they working and who they were responsible for supporting. For the majority of the time we saw that people in communal areas of the home had staff in close proximity to them, which meant they could attract the attention of staff if they required help or support. Staff we spoke with told us, "We have a good system of delegation. The nurse in charge confirms who will work where. It works well. "Another member of staff told us, "There are enough staff here. The leave is always covered unless it is last minute sick leave. I am able to enjoy working here, the residents [people] are the priority, that is the message we always get" One person we spoke with told us, "I don't think there could ever be enough staff. I'm not saying that as a criticism. Staff are always busy and sometimes you have to wait, it's one of those things." One relative we spoke with told us they were unhappy with the staffing arrangements and told us, "What I don't like is that [name of person] has to wait a long time. It needs two people to move her and so if one worker turns up she says 'my partner's having a break so you have to wait' – she has to do a lot of waiting. Sometimes she is desperate to go to the toilet but is kept waiting." Another relative told us, "Sometimes yes and sometimes no. [in response to a question about adequate numbers of staff.] When they have jobs to do, I would say no. At the weekend they get agency staff. There are fewer staff after two pm and fewer in the evening." The number of staff on duty was not always adequate to ensure people's safety or to ensure their needs were met when they needed support.

We looked at the recruitment records for three members of staff. Robust checks were made before offering potential new staff a position in the home. These included checks of people's character and experience. Undertaking these checks is a way of protecting people from staff that may be unsuitable to work in Adult Social Care.

People living at the home required support to receive their medicines safely. We observed some parts of several medicine rounds and saw that staff approached people kindly, explaining that it was time to take their medicines. When appropriate the staff explained what the medicines were for, and checked if the person needed any 'as required medicines'. People we spoke with confirmed they were happy with the management of their medicines. Comments we received included, "I'm in constant pain, but they [staff]

never forget my pain killers. They bring me the tablets and a big glass of water."

Some people were prescribed controlled drugs to manage their pain. Controlled drugs are medicines that require extra records and special storage arrangements because of their potential for misuse. The records we looked at showed that these people were getting their medicine on time. The medicines were stored securely and recorded correctly.

Some people had medicine prescribed that was to be taken "when required". Information was available to staff on why the medicine would be needed, how much to give, and when. This would help staff to administer the medicines consistently and appropriately. When people needed to have their medicines administered directly into their stomach through a tube information was in place to inform staff on how to prepare and administer these medicines.

We checked the medicines available in the home against records maintained by the nursing staff. This is a way of determining if people have received the correct doses of prescribed medicines. Our checks showed that people had received the correct amounts of medicine. This helps the medicines to work effectively to control the symptoms and conditions they have been prescribed for. People could be confident that their medicines would be well managed and given as prescribed.

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave us positive feedback about the ability of the staff to support people effectively. Comments from some people and their relatives included, "The person I visit has particularly complex needs. I am confident that the staff look after [name of person] well, and they go the extra mile to help." Staff we spoke with were able to describe people and their needs well, and were aware of things that were important or which could be unsettling to people. Many of the staff we met had worked at the home for a long period of time. One member of staff told us, "The continuity and longevity of many of the staff means people are cared for everyday by at least some staff that have known them for many years. People and their family always tell us what peace of mind that gives them."

Records we looked at showed that a wide range of training that covered both safe staff practice and the specialist needs of the people the staff team were supporting had been provided. Staff told us they felt well trained and supported in their role, and their comments included, "The training we have done recently about diabetes and dementia has made me feel more confident about what we do, and why we do it." Another member of staff told us, "I feel able to do my job well."

Registered nurses are required to undertake continuous professional development to meet the requirements of the Nursing and Midwifery Council (NMC) and to ensure that they maintain current, best practice knowledge. The NMC is the governing body for nurses and midwives. Nurses we spoke with confirmed training that would help them meet this requirement as well as support with their revalidation was provided. Staff told us they received support from their peers, from the nurses and the homes management team. Staff told us, "I feel well supported," and "We get good support."

Recently recruited members of staff that we spoke with told us they had received an induction and the opportunity to shadow more experienced members of staff. Staff that are new to care are required to undertake a nationally recognised induction called the Care Certificate. This ensures the staff are provided with the skills and knowledge they need to care for people safely and following good practice guidelines. When staff required this, it had been provided. The provision of staff training and support meant that people were supported by experienced and qualified staff that could meet their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People told us that when they wished and were able they had been asked or involved in planning or reviewing their care. Staff had received training on the MCA and had relevant knowledge of how it applied to people living at the home. Staff explained that they did involve people in daily decisions about their care and had knowledge of best interest decisions. Staff we spoke with gave examples about involving people in choosing their clothes, about what they would like to eat or drink and about which room or which position in the room they would like to sit in.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Where people had identified restrictions on their care the registered manager had applied for DoLS appropriately, some of which had been approved. It is a requirement to notify the commission when a DoLS application has been approved. The registered manager had not undertaken this, but during the inspection ensured this would be done for all future notifications starting immediately. The majority of staff we spoke with were aware of who had a DoLS approved and how this impacted on the person's care. There were systems in place to review and if necessary re-apply for DoLS before they expired to ensure the person continued to receive the support they required.

Some people had bed safety rails in place. There are a number of different ways to protect people from the risks associated with falling out of bed, and it was not evident that the bed rails were the least restrictive means to protect the person from falling out of bed. The level of knowledge and practice within the home did ensure people were offered choice and the opportunity to be independent, but people's human and civil rights were not always fully upheld, and the requirements of the law were not always met.

People's feedback about the food provided was positive. One person told us, "There is a good selection of food," and another person told us, "They [staff] do different things. You're not going to get gourmet food in a place like this. It's okay." A relative we spoke with told us, "The food always looks and smells nice, and staff show a lot of patience when they are feeding [name of person]. Another relative told us, "I have it [the food] sometimes. It's okay. They do offer a choice but to an extent they know what my [name of person] likes. The chef is very willing to make anything extra, for example if a person says 'I don't like this', he'll make something else for them." The food we saw looked nice, however we were concerned to see that the breakfast meal was served from an unheated trolley. We followed the progress of one trolley throughout the service of breakfast, and although the staff prioritised serving the hot food first, by the time this was served to people, it was not always piping hot or pleasant to eat. We shared this feedback with the registered manager who agreed that this should be further explored and that the one heated trolley was not adequate to serve breakfast throughout the home.

We looked in detail at the support some people received to eat and drink. Overall people's mealtime experience had improved. We saw staff patiently helped people to eat when they required assistance. People were provided with adapted cutlery and crockery to promote their independence. We saw people received consistent support from the same member of staff throughout their meal. People had the opportunity to sit at a table or to eat from a small table in their bedroom or lounge. Throughout the day people were offered both hot and cold drinks. Snacks and fresh fruit were provided for people in the afternoon. The registered manager understood the importance of ensuring people had adequate amounts of fluid. The home was taking part in a project that helped to ensure people at particular risk of not drinking enough had were encouraged to take extra fluids. The staff we spoke with were all aware of the purpose of the project, how it was working and were able to describe some of the positive benefits to people.

People told us they were happy with the healthcare they received. One relative told us, "They [staff] are very prompt at getting the doctor in if required." We looked in detail at the nursing care and support offered to a number of people and found with the exception of supporting people at risk of constipation, that this had been effective at ensuring people's conditions improved or stabilised. The monitoring tools for people at risk of constipation had not been effective at ensuring staff brought to the attention of the registered nurse or GP anyone who required additional support with this area of care. The registered manager accepted this feedback and agreed to make improvements to the recording and monitoring systems in place. Overall the

care delivered followed good practice guidelines. Records we viewed showed that people were supported to see the relevant healthcare staff when their needs changed. The health professionals we spoke with told us that staff called them appropriately and followed the guidance they provided. The registered manager and staff had worked closely with the local GP, to ensure that the wishes of people and their family were known, and that where possible people had the opportunity to die at the home if this was their expressed wish. Staff we spoke with were aware of people's support needs and the support they needed to maintain good health. People could be certain they would receive the support they required to stay healthy.

Good

Is the service caring?

Our findings

People and their relatives gave us consistent feedback that the staff worked with kindness and compassion. We overheard staff offer a friendly greeting such as "Good morning, how are you?" as they went into people's rooms, or saw them around the home. Many of the staff had a relaxed and friendly manner, and we saw people enjoying their company. One person told us, "I like all the staff they are helpful and kind." Another person told us, "I have only just moved in, but I have been made to feel very welcome. Staff have all been kind and friendly." Relatives told us, "The most notable thing about the home is the general attention and kindness the staff show the residents." Another relative told us, "Everyone has been very kind. All the care staff and nurses as you'd expect, but also the domestics, cleaners and kitchen staff." Staff told us they enjoyed working with the people who lived at the home, and that this was the hi-light of their work. Comments from staff included, "The residents are good, and we get feedback from people and their relatives that they are happy. That is the best part of the job."

One of the people living at the home told us there had been a number of people pass away recently. They told us, "There have been a number of deaths recently. The staff come and tell me, and sit with me because they know I will be sad." We met a relative of a person who had recently passed away while living at Cole Valley Nursing Home. They praised the kindness, compassion and support of all the staff to both them and their loved one. They described staff providing discreet support so the family could spend time together at the end of the person's life. People and their relatives could be confident that they would be treated with kindness and compassion.

People and their relatives had been involved in planning their care. Involving people ensured they had a chance to state how they wish to be supported. Care plans we viewed showed that people's views and preferences had been sought People or their relative had the chance to inform care staff about their loved ones career and earlier life experiences to get a full picture of them as an individual. We heard staff refer to this knowledge to help them connect with people about things that were important to them.

When people had been unable to make decisions about their own care and support needs the staff had consulted with other people that knew the person well. When required the registered manager had sought the support of advocacy workers. Advocates are people independent of the home, who have been trained to help people make decisions.

We asked people if they had the opportunity to maintain their culture and faith. People told us that ministers did visit the home, and they could see them if they wished. The chef explained that food of different cultures were sometimes offered on 'theme nights' and if people had a specific request for food that reflected their culture this could be requested and when possible accommodated. Staff we spoke with had some knowledge about people's cultural and religious needs. Records that we saw contained information about people's needs and preferences (assessment documents) and detailed people's cultural and religious needs. One person whose care we looked at in detail had specific needs and wishes relating to their faith and culture. It was evident that their dietary needs, and the wishes of the person around their death had been considered with them. The person had the opportunity to celebrate religious days relevant

to their faith. This ensured the home met their needs and wishes in this area well. People did have opportunities to express their individuality, faith and culture.

People we met were wearing clean clothes, had fresh bedding and attention had been paid to ensure people's skin was clean. People we met told us that they were helped to stay clean. One person told us, "I have a shower and a hair wash every Friday. That is when I like it." A relative told us, "Every time I go, she is always well cared for, clean and fresh." We observed that the majority of men had not been supported to shave, and we asked the registered manager about this. We were informed that some people lacked the equipment to shave, and that some people found this a stressful part of their personal care. We looked at records that had been completed when people had been offered and had been supported with their personal care. The records showed that people were supported to wash every day, but the number of showers and baths people had been offered were inconsistent and infrequent. While no person we met complained about this, this was significantly less than people had requested in their care plans. The current arrangements were not adequate to ensure people's preferred on going personal hygiene

Staff we spoke with described the actions they took to ensure people's dignity was maintained. These actions included closing doors and blinds when providing personal care and where possible offering people staff of the same gender to support them. We observed many interactions where staff did promote people's dignity, including covering the legs of ladies when hoisting them.

Good

Is the service responsive?

Our findings

Staff we spoke with were able to describe people's current needs and we saw staff providing care that was consistent with the descriptions they gave us about people. Either people or their relatives had completed documents that provided information about the person in their earlier life, such as information about their career, or family members for example. The staff we spoke with and observed had knowledge of people's life experiences and we heard them talking with people about things that were of specific interest to them. One of the relatives we spoke with told us, "I feel they know [name of person] really well. It feels that they like him, and know him. They are genuine with him."

We asked people and their relatives if they had been involved in developing their care plans. We were informed that they were involved in drawing up the care plan when they first arrived. A visitor to the home told us, "The care plan was reviewed with us only last week." The people we met were living with health conditions that had changed over time, and we found that the written plans had been adjusted to meet people's changing needs. This ensured staff had access to up to date information about the person's current care and support needs.

People told us that they enjoyed the activities available to them. We saw that people had been provided with things of individual interest to them, that offered them comfort or engagement. These included handbags, a book or some knitting. Other people enjoyed the group activities and on one day we saw a music and movement session take place. We were informed other similar group activities were planned and provided on certain days each month. Activity staff worked individually with people to manicure their hands or paint their nails. Other people told us they enjoyed the regular Kareoke sessions the home organised. Some people enjoyed going outside the home, and we saw that people who were able could leave through a level access door into the garden. Chairs had been provided outside for people. There were long periods of each day when people were able to rest, or sat listening to music or the television. However activities were provided that offered the opportunity for stimulation and enjoyment.

Systems had been developed to ensure staff were kept up to date about changes in people's care, Between each shift there was a 'handover' of events that had occurred during the shift. This is a way of ensuring information is passed from one shift to another. It ensures staff have the most up to date information about people and promotes safe and continuous care. The staff we spoke with told us this was helpful, and their comments included, "Hand-over is always good. It means I have up to date knowledge about each person, and it is a way to catch up after days off or annual leave" This was a way of ensuring good communication and consistency between each shift.

We looked at the systems for raising concerns or complaints. People told us they would feel able to raise any concerns. The registered manager and home owners undertook regular audits of the home. These included obtaining feedback from people and their relatives about their experience of the home. People we spoke with were not always aware of the formal complaints procedure but told us they did feel confident to raise any concerns. One person told us, "Her [the registered manager] office door is always open. I can have a right laugh with them. I never felt I couldn't talk to them about anything." Without exception relatives that

we spoke with told us they could and would be happy to speak with the registered manager about any concerns. They described her as "Approachable", and "Available." They described seeing the registered manager regularly around the home including sometimes in the evening and at weekends. One relative told us, "If I have any questions the staff respond really well, and find out the answers for me." Another relative told us, "The registered manager always says to me, 'If there is anything you are unhappy with, please come and talk to me.'" There had been one formal complaint since our last inspection. Records showed this was investigated and resolved to the complainant's satisfaction. This demonstrated an open culture to complaints and feedback. On display within the home was a large number of cards and letters of thanks from people who had been pleased with the care and support offered by staff working at the home. People could be confident their concerns would be taken seriously, investigated and detailed feedback provided.

Requires Improvement

Is the service well-led?

Our findings

People, relatives, health professionals and staff gave consistent positive feedback about the management team and their relationship with them. People told us they felt able to speak with any member of the management team and that interactions with them were positive and compassionate. One of the relatives we spoke with told us, "The communication is good. I trust them. They always call if [name of person] is unwell or has a fall for example. I feel the culture here is very open." Staff told us, "The management team are all approachable and I would feel confident to raise anything with them," and "The registered manager is practical and approachable." A member of agency staff told us, "I come here to work as often as I can. I am made welcome. There is no differentiation between agency and regular staff. We are treated with the same respect. That says a lot for the culture of a place."

The registered manager demonstrated that they had acted on feedback from our last inspection, and other monitoring visits undertaken by contracting agencies. A number of systems to monitor the quality and safety of the service had been utilised on a regular basis. However we found that the registered manager, deputy manager and a large number of the staff had worked at the home for a number of years, and had an in-depth knowledge of the service, and were able to describe areas they knew required improvement or attention. The registered manager and home owners undertook a full audit of the home every three months. While this had been effective in many areas, it had failed to identify and address the need for cyclical redecoration and refurbishment of the home. A number of bedrooms, bathrooms and communal areas we observed had been well cleaned, but had become excessively worn and needed attention. We identified an offensive odour from one lounge carpet. We observed tables and chairs that had been well used and were now worn out. In some bedrooms the décor and furnishings including some bed linen had worn very thin, and this could start to cause discomfort for people if not replaced. We shared our observations with the registered manager who was supportive of the findings and agreed to address this with the home owners.

Organisations registered with the Care Quality Commission [CQC] have a legal obligation to notify us about certain events. The registered manager had ensured that notification systems were in place and that staff had the knowledge and resources to do this. We identified that some applications to deprive people of their liberty had been granted, however the CQC had not been informed of these. The registered manager was unaware of this requirement, but agreed to ensure all future notifications are made as required.

We asked the registered manager and deputy manager about their knowledge of a recent development in Adult Social Care, The Duty of Candour. Although no reportable events had occurred in the home the management team were unaware of their responsibility in this area. They explained that learning would be accessed to ensure they updated their knowledge.

All organisations registered with the Care Quality Commission are required to display the rating awarded to the service. The registered manager had ensured this was clearly on display within home.