Peter Allen Investments Limited

Clevedon Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Clevedon Court Nursing Home provides accommodation for people who require nursing or personal care for up to 50 people. During the inspection there were 36 people living at the home.

The accommodation is arranged over two floors, with bedrooms on both floors all with en-suites. The home has various lounges and sitting rooms, offices, a medicines room, kitchen facilities, communal bathrooms and toilets.

At the last inspection, the service was rated Requires Improvement. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Clevedon Court Nursing Home on our website at www.cqc.org.uk. The provider provided an action plan of how they were going to address the shortfalls found during that inspection.

At this inspection we rated the service as Good.

People were not having their views sought for the purposes of continually evaluating and improving such services.

People felt safe and staff were able to identify abuse and who to go to.

People were supported by adequate numbers of staff to meet their individual needs.

People received their medicines safely although some records required improving.

People had a personal evacuation plan in place in case of an emergency. Care plans contained risk assessments and support plans confirmed people's individual needs.

The service was working within the principles of the Mental Capacity Act. Capacity assessments were in place including best interest decisions if required.

People had mixed views on the meals provided at the home. We observed people having choice and different meal options, however, there was little opportunity to sit at a dining table due to their being minimal tables and chairs in the dining rooms.

People had referrals made when their health needs changed and most records confirmed people's individual daily intake of fluid although one person didn't have an accurate record of their fluid output.

People felt supported by staff who were kind and caring and who respected their privacy and dignity.

People were given choice about how they spent their time and we observed people spending time in their

rooms, the communal areas and visitors were free to visit when they wished.

Care plans contained important information relating to people's like and dislikes, their previous occupation, families and routines. Pre-admission assessments were undertaken prior to people living at the home. Where complaints were raised these were investigated although the providers complaints policy needed updating.

Quality assurance systems identified shortfalls and actions required. People and staff were happy in the home and all felt it was a homely positive environment.

Notifications were made when required and people were encouraged to remain independent.

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.

People received their medicines safely and when required although some records required improving.

People were supported by staff who had checks undertaken prior to starting work.

People had risk assessments and support plans in place.

People felt staff and staff had a good understanding of abuse and who to go to should they have concerns for people's safety.

Is the service effective?

Good

The service was effective.

The service was following the principles of The Mental Capacity Act and people's rights were respected.

People were supported by staff who had received training and supervision and an annual appraisal.

People's nutritional needs were assessed and care plans confirmed people's individual needs. Some people were not happy with the food the registered manager was reviewing this experience for people.

Is the service caring?

Good

The service was Caring.

People felt staff were kind and caring and staff demonstrated this approach during the inspection.

People received care that was dignified and private.

People were given choice about how they spent their time and visitors were welcome within the home.

Is the service responsive?

Good

The service was Responsive.

People received an initial assessment and care plans contained important information relating to people's care needs although people were not familiar with their care plan.

People had access to a complaints policy although this required updating with accurate information.

People's end of life wishes were recorded.

Is the service well-led?

Good

The service was Well-led.

The provider was not displaying their rating at the time of the inspection although action was taken following the inspection.

People's views on the service were not always sought.

The home had a quality assurance audits in place and an action plan confirming shortfalls to be actioned.

Staff were happy working at the home and people felt the management were good.

Clevedon Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 8 & 9 May was unannounced on the first day. The inspection was carried out by two inspectors, an expert by experience and a specialist adviser. 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. We also reviewed if the service was displaying their rating.

Some people at the service may not be able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

During the inspection we spoke with 14 people living at the service. We also spoke with four relatives, five members of staff including the registered manager. We received feedback from one health and social care professional. We reviewed six people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Good

Is the service safe?

Our findings

At our last inspection we found people were not fully protected from the risks associated with incomplete and inaccurate records. At this inspection we found improvements had been made.

At the last inspection we found records relating to medicines management were inadequate. At this inspection we found improvements had been made. The home had moved to a new electronic system for recording of medicines. On reviewing the electronic system there were no medicines that had missing signatures recorded. The registered manager confirmed the new electronic recording of medicines had been effective in reducing medication errors. These records were also used as part of the fortnightly GP round, this enabled medication reviews to be undertaken at the same time. Where staff were administering creams and topical medicines most records confirmed people had received them although one person who was refusing their topical medicines had no record they had refused two of the three applications prescribed each day. It is important to have an accurate record that confirms why the medicines were not administered including if the person is refusing.

People received their medicines safely. People told us, "I always get my medication on time and staff are kind to help me with this". Another person said, "Staff support me with my tablets, they don't rush me and it is fine". Another person said, "I get medication reminders from staff so I never forget them, and I don't have to worry about remembering".

Medicines were stored within the recommended guidelines in people's rooms and within the optimum temperatures. Medicines which required greater security were stored according to guidelines. Following the home's last inspection a new treatment room had been built. The room had a controllable air conditioning unit in place and ample cupboard space, shelves and work surfaces. This room was well organised, clean and tidy.

At our last inspection we found records relating to people skin care and pressure ulcerations were not accurate or up to date. At this inspection we found improvements had been made. For example, people had a skin integrity risk assessment and a care plan in place. Where people required specialist equipment this was available. One person felt due to the care they had received from staff, their lower limb condition was improving. Records confirmed interventions given so that information could be shared with health care professionals. Where people's skin was not improving as expected, records clearly recorded what treatment was given. Along with the current situation so that alternative treatments could be discussed with the GP or other health care professionals. During the inspection staff supported people with changing their positions including walking people and standing them up.

At our last inspection we found food and fluid intake charts were not always being maintained. Therefore, it was not clear if people had adequate hydration and nutritional provided. At this inspection we found improvements had been made. There were detailed risk assessments and care plans in place relating to people's nutrition and hydration needs. For example, one person required a specialised diet and their drinks to be thickened. Their care plan had guidelines that confirmed, portion size, head tilt angle and appropriate

thickening in accordance with the recommended health care professionals assessment. Staff knew how to prepare these drinks appropriately. However, one person had no record of their fluid output being recorded. Their care plan confirmed their recommended daily intake and their records confirmed they were below this recommended amount. This person also required support from staff with their personal care however there was no record of the persons fluid output. The registered manager confirmed staff were recording this on the person's daily living chart. This meant it wasn't clear what the person had drank including their output due to the information being recorded on different charts.

At our last inspection we found people's care plans and risk assessments did not provide staff with information on what care and support people required. At this inspection we found improvements had been made. People's care plans had information that identified risks and what measures were in place to address those concerns. For example, if people were at risk of falls, risk assessments confirmed what equipment the person required and any support. Where people required bed rails, risk assessments were in place including if the person had capacity. We found one person with bed rails who had been assessed as having capacity. Their bed rail was raised on the wall side of the bed and half raised on the other side. Staff confirmed the person preferred their bed rail like this. However there was no risk assessment and documentation to support the person preferred their bed rail like this. Their bed rail assessment confirmed the person did not require bed rails. During the inspection the risk assessment was updated to reflect the person's wishes relating to how they liked their bed rails.

People, relatives and staff felt the service was safe. People told us, "It is a lovely home. I feel safe because staff are always around to help". Another person told us, "I do feel safe here, everyone [staff] is around here". Relatives said, "I am not worried about [Name] safety." One relative however was concerned about the security of the home. They told us, "I was concerned about the security of the home, as there was a man wandering around without a lanyard, or ID card. I wasn't sure who he was. Though I have since found out this is the Handyman. I think it would be good if everyone entering the service had an ID badge, or lanyard. I have raised this with the Manager who is looking into it". The building was secure and staff were responsible for checking people's ID before entering the building. Visitors were expected to sign in and out of the building so there was an accurate log of who was in the building at any time. All care staff during the inspection were observed wearing their ID badge.
Staff were able to demonstrate a clear understanding of abuse and what they would do if they suspected this. One member of staff told us, "The types of abuse are, physical, financial, sexual, and verbal. I would raise concerns with the floor manager and the trained nurse as well as the manager. I could also go to CQC, the police or North Somerset, [Care Connect]".

People had electronic personal evacuation plans in place (PEEPs). These confirmed the support and assistance the person required in an emergency situation. The home had a 'grab box' for use in the event of an emergency. This contained important information such as the building plan, fire risk assessment and who was in the home including their level of risk and what room they were in. There was also an overview of the level of risk the person presented should there be an emergency however there was no specific details of what support or assistance the person might require. This was recorded within people's computerised individual personal evacuation plans. The registered manager following the inspection confirmed PEEPs were now available in the 'grab box'.

People were supported by staff who had recruitment checks undertaken prior to starting their employment. Staff files contained an application form, references and terms and conditions of employment. Records showed that a range of checks had been carried out on staff to determine their suitability to work with vulnerable people. This included a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing a check on the person's suitability to work with vulnerable

adults. This ensured people were supported by suitable staff.

People were support by sufficient staff to meet their individual needs. During the inspection we heard calls bells answered quickly and people felt happy with the support they received. People told us, "If I need anything the staff are always around to help me so I am never left for long." Another person told us, "If I press my buzzer someone comes to me quickly, I am never left waiting for a long time." Another person told us, "[staff] is around here, when I push the bell someone comes to me." Staff we spoke with were happy with the staffing levels at the home. One staff told us, "Staffing levels are okay some days we struggle but we work together. Sometimes it's because people have become poorly".

Incidents and accidents were recorded and logged onto the electronic computer system however there was no overview of the trends so that a detailed analysis could be undertaken. The registered manager undertook a review of the incidents and accidents by reviewing the overall number of incidents per person. However the registered manager was unable to review what type of incident had occurred to the person as this information was not available. The registered manager was fully aware of what incidents had occurred including actions had been taken however this wasn't available within the report of incidents. This is important as by having an overview of incidents and accidents means that any trends relating to the management of the service and care could be quickly identified and actions taken. The registered manager confirmed they would review the system.

People were supported by staff who had effective infection control procedures in place. Staff had access to liquid hand soap and paper towels in people's rooms. Staff were able to confirm how they ensured people's laundry was handled safely and washed within the recommended guidelines. Staff had access to personal protective (PPE) clothing at various points throughout the home. During the inspection we observed staff access PPE before they supported people.

The provider had up to date certificates relating to portable appliance testing (PAT), Electrical and legionella's checks. Water checks were undertaken in line with recommended guidelines.

Good

Is the service effective?

Our findings

At our last comprehensive inspection of the service we found the provider had not ensured records accurately reflected people's current needs relating to their nutrition and hydration. At this inspection we found improvements had been made to meet the regulations.

People had access to food and drink throughout the day. People had jugs of water in their rooms and snacks were available in the communal areas of the home and people could help themselves. We reviewed people's dining experience. People were given choice and various different meal options. However we saw the home had limited tables and chairs available for people to sit and eat their meals at. Most people sat in the same chair they had been sat in all morning. Their lunch was then placed onto a tray in front of them. We observed one person whose tray was too high and their chair too low. They were trying to make themselves comfortable by moving their food around on the tray but this didn't improve their dining experience. The next day we observed them sitting at a table within the lounge area. They sat comfortably at the table awaiting their meal in a relaxed and happy posture. We fed this back to the registered manager who confirmed they were able to provide more tables and chairs should people want this.

The registered manager reviewed people's weights once a month this was recorded on the person's electronic nutritional screening assessment. Any changes to people's weight that raised concerns were identified within the registered manager's monthly report. However the detail of the concern was not always clear for example how much weight the person had lost and what action was being taken. The registered manager sought advice during the inspection on how the report could improve the quality of information. They confirmed there was an additional part of the electronic system they could use that would enable them to see this information. They confirmed this was now something they were aware the system could do and they would ensure their monthly reports covered this.

People's health was monitored and referrals were made when required to a range of specialist health care professionals. The registered manager confirmed that the GP carried out fortnightly visits to the home along with the elderly community nurse. Staff sought advice from professionals when required. For example, people had specialist dietary assessments in place to manage their individual needs this included input from speech and language therapists who gave guidance to reduce the risk of choking. Where people required a specific textured diet these were provided. Kitchen staff were familiar with people's individual needs including their dietary requirements. They told us, "We prepare some sugar free meals for people with diabetes and we use their thickener in drinks as required". Kitchen staff also told us that, "People are offered two menu choices for their lunch but [people] can change their mind if they don't fancy it or can't remember what they chose". Another member of staff confirmed, "People can request food that is not on the menu and the kitchen staff would be happy to prepare it". During the inspection we observed people being assisted when required to eat and drink.

People's feedback about the meals was mixed. Some people told us they enjoyed the food others told us they did not. One person said, "I have a special diet, they always offer me a choice of foods if I can't find the food I want." Another person said, "I like eggs on toast for breakfast, they are very nice. I like most of the food

here". Another person said, "I am able to choose what I would like to eat, if don't like what is offered I can ask for something different." However other people told us, "I don't like the food here very much, the meat isn't very good they serve thin cuts of meat. I like meat and two veg, but we seem to get a lot of casseroles that I don't really like. I have asked for different food but it doesn't seem to change". Another person told us, "The food is terrible here" however they were unable to give any further explanation as to why. Due to people's views not being sought by the service it was not clear what percentage of people were not satisfied with the food at the home.

Where people lacked mental capacity to fully consent to their care, the provider had followed the principles of the Mental Capacity Act (MCA). Two people had fluctuating capacity but the mental capacity assessment did not record this important information. The registered manager confirmed the two people had no formal diagnosis, but they occasionally presented as confused. This information was not made clear on their MCA assessment. It is important to have clear information to tell what staff should do if the person presented themselves in this way so they are able to support the person adequately and as required.

The 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. During the inspection people had their consent sought before care was provided. Staff were able to demonstrate a clear understanding of the MCA and how they protected people's legal rights if they lacked capacity. One member of staff told us, "People are different. They should be given the chance to choose for themselves and if they can't choose they should be helped to make their decision".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made applications when required.

People received care and support from staff who were trained and competent to meet their needs. The provider's training matrix confirmed staff had received training in equality and diversity, nutrition and hydration, moving and handling, infection control, first aid, safeguarding and mental capacity and deprivation of liberty. Where staff had been identified as needing refresher training this was recorded as the planned date when the member of staff was due to attend. Staff were happy with their training. One member of staff told us, "My Training is up to date. I have had end of life training, diabetes, nutrition and hydration, common illnesses, Parkinson's and arthritis". Another told us, "Had training and completed the care certificate. First aid, dementia, moving and handling, safeguarding, mental capacity and Dols." Staff had access to bespoke training such as end of life training, dementia, diabetes and pressure care. One staff told us how beneficial this had been for them. They told us, "I can now do a good job, I can be there for people until the end. Treating them with the dignity they deserve". One relative told us, "I think the staff are very well trained". Another said, "Staff are well trained here".

New staff received training which was aligned with the Care Certificate. The Care Certificate is an industry recognised set of standards which sets out the knowledge and skills required to fulfil a role in care. Staff told us that they shadowed a more experienced member of staff for a minimum of five days or until they were assessed as competent to work unsupervised. This meant staff had the opportunity to become familiar with people's care and support needs. Staff spoke positively about the induction process. One staff member said, "The induction is good, after the induction I felt quite happy to go out on my own because, I knew how people wanted to be supported".

People were supported by staff who felt well supported and who had regular supervision and an annual appraisal. Supervisions and appraisals were an opportunity to discuss any necessary support, issues, concerns or development needs. Staff all felt the management of the home was accessible and approachable and there was an open door policy should any concerns arise. We observed during the inspection staff raising queries and questions with the management of the home.

Good

Is the service caring?

Our findings

At our last inspection we found people did not received care that was dignified or private. At this inspection we found improvements had been made.

During the inspection we observed people's doors were shut and people were suitability covered to protect their dignity. The environment was respectful with no incontinence pads left on chairs. People had cloth napkins provided at lunch time and staff spoke respectfully to people who required support and assistance with their meals. During the inspection we observed staff knocking on people's doors. We also saw staff lowering themselves to speak to people so that people could hear what staff were saying and that conversations were private.

Visitors were able to visit throughout the day and all people we spoke with felt happy with the care they received.

People and relatives felt staff were supportive, kind and caring. People told us, "Oh yes, staff are all very helpful they seem to care about me." One person told us how the service had put up an important picture in their room. They told us, "Staff are caring, I asked for a picture of my [relative] and it has been put up my the Handyman". Another person said, "It is a lovely home". Another person said, "Staff are so friendly and happy."

People felt staff had a polite and attentive manner and that they spent time with them if they needed it. One person told us, "Staff are always polite and take their time, they are always ready to listen". Another told us, "Staff always listen to me, they ask what I want to wear and get me a drink if I ask". One person described staff as knowing just what they liked, "Staff just seem to know what I like. I struggle to cut my food up because I have arthritis but staff know. They cut it up so I can use a spoon to eat it. It just makes everything easier." We observed staff were patient and calm. When a difficult situation arose staff supported people well, by talking to them about what was upsetting them and then providing reassurance.

People were given choice about where they wished to spend their time. One person said, "I can spend quiet time in my room if I choose. It is my preference as I like my own company. Nobody forces me to come out if I don't want to". We observed people spending time in their rooms, the communal lounges and the dining area. Following the last inspection the home had built a new kitchen on the first floor. This area was used to promote people's independence by enabling them to make their own drinks. We observed one person drying some mugs up. Staff confirmed where people were able to undertake tasks themselves they were encouraged to do this. The registered manager confirmed that in the future they hoped people could help themselves to a buffet style lunch which would improve people's independence and dining experience.

The service had received various compliments in the 12 months. One comment said, "Staff was always so cheerful and respectful that every time I left after a visit I was always humbled by their manner and energy". Another compliment said, "I would like to thanks you for the exceptional care that you all gave to my [Relative]."

Good

Is the service responsive?

Our findings

At our last inspection the provider had not met the regulation of having accurate and complete records in relation to people's care plans. This was because care plans lacked detailed individual preferences or guidance around people's individual specific needs. We also found that people were not always fully involved in their care plans and reviews.

At this inspection we found improvements had been made to the details within people's care plans although people felt they were not familiar with their care plan. People told us, "I know they have all of the information they need about me, though I haven't seen my care plan". Another person told us, "I haven't seen my written care plan. I wouldn't know what it looks like. If I am unhappy with my care I can ask for it be changed, and they will do it so I don't worry." Although some people felt they were not involved in their care planning people did feel happy with their care and they had choice and control. For example, one person told us, "I can have breakfast in bed if I choose, I like that."

We observed nurses undertaking pre-assessments with people who were considering living at the home. A member of staff who was responsible for undertaking these pre assessments showed us an initial enquiry. The initial enquiry was taken either over the phone or in person and covered information such as if the person paid for their own care, what support they were looking for, rooms available and other relevant information. This initial information was then used as part of the assessment process where a member of staff from the home undertook a face to face visit. The assessment then covered greater information including the current support the person required, if they had capacity, where they were currently living and if the person had someone with authorised power of attorney or if the person had any advanced directives.

People's care plans were individual and person centred. Care plans covered people's support needs such as 'my daily routine', personal hygiene, nutrition and hydration, cognition, communication, religion, mobility and speech and hearing. Care plans also included medical support and conditions such as any skin care needs, wound care, catheter care and end of life wishes. Where people had been identified as requiring individual support there was a support plan and risk assessment in place that identified what support the person required from staff and guidelines on how staff should provide this support.

Care plans also detailed the persons individual communication needs, if they needed glasses or a hearing aid. People's care plans explored the person's individual preferences and any relationships important to them. Care plans confirmed the person's sexuality, if they had a spouse any children and their life histories such as where they had lived and what occupation they had. People's care plans also contained people's hobbies and interests. For example one care plan included, that the person enjoyed reading a newspaper and which one and that they enjoyed walking. Another care plan confirmed the person liked crisps and chocolate and a vegetarian diet.

People's end of life wishes were within their care plans. For example one care plan confirmed the person's end of life wishes and choices including those of the family. There was a Treatment Escalation Plan (TEP) in place with a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision documented however the

TEP had not been updated to reflect new information. The registered manager confirmed the GP or elderly care nurse specialists were the only professionals authorised to update the TEPs. Both had been on holiday recently. Having a TEP that had old information could mean incorrect treatment could be provided. The registered manager was due to update the elderly care nurse specialist on the day of the inspection. Another care plan had a partly completed section in the person's end of life wishes. This person lacked capacity but we found no evidence that the person's relative or next of kin (NOK) had been involved in any conversations.

People spoke positively about the singing activities however when asked they provided little feedback on other activities within the home. During the inspection two planned activities were cancelled. One was cancelled because the musician could only be booked for one session that month and the other activity an outing was cancelled due to the mini bus driver not being available. The registered manager confirmed a new activities co-ordinator had started the week of the inspection. They confirmed activities were in the process of being reviewed especially for those who wished to spend more time in their rooms. We observed an arts and crafts session where people could make themselves a crown which could be worn for an up and coming event. Other planned activities for the month were; board games, a day trip, gardening club, and exercises. The activities co-ordinator also confirmed they were about to start setting individual goals for one person to walk a greater distance and that they would also be growing vegetables and sunflowers over the summer.

The provider during the inspection was in the process of finishing an outside garden area. People and relatives were able to use this outdoor flat seating area. This seating area was accessible to people who lived at the home including anyone who might use equipment such as a walking frame or wheelchair. There were various tables and raised flower beds and these were planted with various plants and flowers. The provider was also undertaking decorating to rooms unoccupied.

People's rooms were personalised and individual. People were able to have pictures put up and during the inspection one person told us, "I asked for a picture of my [name] and it has been put up by the handyman."

People and relatives felt able to raise a concern with the management of the home but were not familiar with the compliant process. People told us, "If I am unhappy with my care I can ask for it be changed, and they will do it so I don't worry". Another said, "I like it, it's a nice place. I have no complaints". Two relatives told us, "Yes, if I wanted to make a complaint I would feel happy to do this and would feel happy speaking to any of the staff. I am not sure of the complaints process", and , "I would feel comfortable and happy to make a complaint if needed".

Where complaints had been made there was an overview of the complaint and date received. Records confirmed the date the complaint was concluded however we found not all outcomes were recorded. We fed this back to the registered manager who confirmed the missing recorded outcomes and that future outcomes would now be documented. Whilst reviewing the providers complaint policy we found the policy had old and misleading information within it. We fed this back to the registered manager for them to take the necessary action.

Good

Is the service well-led?

Our findings

At the last inspection the service had been in breach of the regulation good governance. This was because systems in place to monitor and improve the quality of the service had been ineffective and records were incomplete and inaccurate. At this inspection we found improvements had been made to the quality assurance processes and records, but improvements were still required to ensure people's feedback was sought for the purposes of continually evaluating and improving such services. These had not been carried out since 2015.

At the time of the inspection people's views were not being sought. Although relatives had been sent an annual questionnaire, people who lived at the home had not been sent a questionnaire since 2015. Gaining feedback from people is important as it can improve people's care experiences. Feedback had been gained from 18 relatives and was mostly positive. Where relatives had raised comments actions had been taken. For example, where relatives had said they were unfamiliar with the management of the home, the registered manager had printed a picture of themselves including the days they worked. They had also taken action following some poor experiences with the laundry in the home. Actions had been recorded in the staff minutes. The registered manager also confirmed they were in the process of sending out people and staff satisfaction surveys.

We found the provider was not displaying their rating at the time of our inspection. This is a legal requirement from 1 April 2015 where the provider must display their rating conspicuously online if they have a website. On the second day of this inspection we identified this failing to the provider. Following the inspection the provider sent additional evidence that confirmed they had taken reasonable steps to display their rating and had done so until recent problems on their website.

Quality assurance systems included personnel file audits, health and safety, infection control audits, hand hygiene quality improvement audit, medication audit, catering department audit. Monthly checks were in place for the building and weekly checks on the maintenance. A monthly overview audit was undertaken of care plans. Where audits had identified a shortfall there was an action plan in place that confirmed actions required. For example, the catering audit April 2018 identified the dining experience for people 'needed to be enhanced overall. The "Butterfly Approach" is slowly being taught to the staff which will hopefully improve the dining experience for the people. The recent care plan audits identified some shortfalls with people's mental capacity assessments. The audit confirmed, 'some mental capacity areas identified'. This meant quality assurance systems were effective at identifying shortfalls within the service.

Following the last inspection the home had under gone a change in the management and staff team. A new registered manager was in place during this inspection. 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. They were supported by a deputy manager, a clinical lead, floor managers, a house manager, a team of nurses, senior care staff, care staff, auxiliary staff and office staff.

People and relatives spoke positively about the management of the home although some people said they were not sure who the manager was. People told us, "I haven't met the manager yet though I have only been here a few days, I am still finding my feet". Another person said, "I am sure I have seen the manager, though I can't remember who [they are] or what [they] might look like". One relative said, "I feel the service is well run, we know the manager and have a good relationship with them. [Name] is very approachable". Another said, "I think the service does well. I think it is quite well organised everything seems quite calm". Another relative said, "We have a good relationship with the manager , and good communication so we feel reassured".

Staff attended regular meetings. Meetings were held in staff groups for example, nurse meetings, senior care staff, carers and ancillary staff. Minutes confirmed areas discussed included training, communication, supervisions and appraisals, people's care needs including pain management, managing medicines, team building events and laundry. Where there was learning to prevent similar incidents occurring these were discussed with staff and what actions to take. One area the registered manager was working on with all staff was to focusing on their responsibilities and work. Minutes confirmed what was expected of staff and their conduct however the way this had been recorded was in a derogatory manner. We raised with the registered manager as this could affect the culture of the home.

Staff described the home as a happy place to work with their being a positive empathises on team work. One staff told us, "I am very happy in the group I am in. The floor manager is very very helpful and very good". Another said, "I like it, it is a nice place. Very very well managed. The floor manager is really fantastic we all work well as a team". One confirmed the culture of the home was, "Very Good. It's a nice pleasant place."

The service aimed to provide a homely atmosphere that enabled people to achieve their maximum potential. The registered manager told us, "To provide individual care in a homely atmosphere to enable the [person] to attain his/her maximum potential and to maintain a good quality of life". One member of staff confirmed, "We give people choices allowing them options". They also demonstrated giving people independence with tasks they could do themselves throughout the day. This meant the service aimed to encourage people to maintain their independence.

The registered manager was submitting notifications to the Commission when required. A notification is information about important events which affect people or the service. The registered manager had completed and returned the Provider Information Return (PIR) within the timeframe allocated and explained what the service was doing well and the areas it planned to improve upon.