Stonehaven (Healthcare) Ltd

Chollacott House 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

This unannounced comprehensive inspection took place on 14 and 15 June 2017. We returned to the service on 8 August 2017 as a serious safeguarding incident had been reported and we wanted to ensure the safeguarding plan was being fully implemented in order to protect people. We found that actions had been taken to protect people. There was an on-going police investigation and the registered manager and provider were fully co-operating with that investigation.

Chollacott House is a nursing home which provides nursing and personal care for a maximum of 42 people, many of whom have complex nursing needs. This includes people who have had a stroke, or who have long term medical conditions such as diabetes and dementia. The home also provides care for people convalescing or needing a short period of respite as well as people needing end of life care. Drake unit, part of Chollacott House and based on the first floor, has nine beds and provides care for people with neurological conditions such as Huntington's disease, Muscular Dystrophy, Motor Neurone Disease and head/brain injuries. 35 people were living at the service at the time of this inspection. The provider is Stonehaven (Healthcare) Ltd, and there are eight homes in the group.

The last comprehensive inspection took place on 7, 13 and 18 April 2016. At that time we found four breaches of regulations and the service was rated as 'requires improvement.' Concerns found related to safe care and treatment (including the management of medicines); dignity and respect; consent and quality monitoring systems. We took enforcement action in relation to the quality monitoring breach, by serving a warning notice on the provider and registered manager. This required the provider to make urgent improvements in this area by 30 September 2016. This was because the provider's quality monitoring systems were not effective. The provider submitted an action plan to show when and how improvements were to be achieved.

On 16 November and 23 November 2016 an unannounced follow up inspection was undertaken. The focus of this inspection was to follow up whether the service had met the warning notice and check on the safety of people living in the service. We found improvements had been made in relation to consent; cleanliness and infection and the management of medicines. However, two ongoing breaches of regulations were identified at this inspection relating to safe care and treatment and quality monitoring systems. We took enforcement action by issuing a condition of registration. This meant the provider had to send the Care Quality Commission (CQC) monthly reports on the actions that have been taken to ensure people were safe and appropriate care and support was provided. We also met with the provider to discuss our concerns.

Monthly reports were received by the CQC, which demonstrated action had been taken to reduce the risk of unsafe care and treatment. At this inspection we found improvements had been made and maintained since the last inspection.

The service has 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.

Quality assurance checks and audits carried out by the provider; registered manager and senior staff were in place and had been completed at regular intervals to monitor the safety and quality of the service. This was an improvement since our last inspection in November 2016, and had resulted in better outcomes for people using the service. Feedback from people using the service, those acting on their behalf, professionals and staff was positive about the management of the service.

People were positive about their experience of living at Chollacott. They said they felt safe and liked the staff. Relatives also spoke highly of the staff and the care provided to their family member. They had no concerns or complaints about the service. Health and social care professionals had no concerns and felt people were well cared for.

There were sufficient staff to keep people safe and their needs were met in a timely manner. The registered manager and staff were aware of their responsibility to report any abusive or unsafe practice. The recruitment processes were robust and pre-employment checks were carried out to ensure staff were of good character and were suitable to work at the service. Staff understood their roles and responsibilities in keeping people safe and protecting them from harm.

Risk assessments were in place, which identified risks relating to people's health and wellbeing along with the measures needed to minimise the risk. Medicines were managed safely and people were receiving their medicines in line with the prescriber's instructions.

Staff had undertaken training to ensure they had the skills and knowledge needed to carry out their roles. Staff said they were well supported by the registered manager and senor staff and received supervision meetings to discuss and monitor their performance.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

People had access to a range of health care professionals to help maintain their health. People enjoyed their meals. A varied diet was provided for people, which took into account their dietary needs and preferences so their health was promoted and choices could be respected.

Staff were kind and caring. Staff knew people well and there were positive relationships between people and all members of the staff team. People were treated with dignity and respect and staff were mindful to protect people's privacy.

Care plans were detailed and person-centred. The care plans we reviewed were all up to date and contained a good degree of information about the person, including their personal history, medical conditions and preferences.

There was a programme of activities. These were varied and people said they enjoyed the activities provided. There had been trips out, as well as activities within the service.

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 said they felt safe, and relatives told us they felt their family members were safe in the service.

Risk assessments identified risks specific to each person and there were clear measures in place to keep people as safe as possible.

Appropriate arrangements were in place for the safe storage, administration and disposal of medicines.

Sufficient levels of staff were provided to meet people's needs. Effective recruitment was in place to ensure staff were suitable to work at the service.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained and supervised to provide care and support to people who used the service.

The service was gaining consent for care in line with the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were in place to ensure people's rights were protected.

A varied menu was provided to people and they said they enjoyed the food. People nutritional needs and preferences were met.

Staff took appropriate action to ensure people received the care and support they needed from healthcare professionals.

Is the service caring?

Good

The service was caring.

People said staff were very caring in their approach. Staff respected people's privacy and dignity and knew people's preferences well.

Staff encouraged and supported people to be as independent as they were able.

Is the service responsive?

Good

The service was responsive.

People's care plans contained a range of information and had been reviewed to keep them up to date. Staff understood people's preferences and support needs.

People were confident in reporting concerns to the registered manager and felt they would be listened to.

Is the service well-led?

Good

The service was well led.

New robust systems had been put into place to monitor the quality and safety of the service.

The registered manager was experienced and people expressed confidence in the management of the service.

People using the service and their relatives had been asked their opinion about the service and their suggestions had been acted upon.

Staff felt they were part of a good team. They found the registered manager and senior staff were approachable and communication was good within the service.

Chollacott House 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.'

The inspection took place on the 14 and 15 June 2017, the first day of the inspection was unannounced. The inspection team comprised of two adult social care inspectors and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service.

Before our inspection we reviewed the information we held about the service, which included the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service about deaths, accidents and incidents. Statutory notifications include information about important events which the provider is required to send us by law.

Some people using the service were unable to provide detailed feedback about their experience of life there. During the inspection we used different methods to give us an insight into people's experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on their experiences. Our observations enabled us to see how staff interacted with people and see how care was provided.

We met or spoke with 18 people; and eight visitors/relatives of people using the service. We also spoke with 16 members of staff including the registered manager; deputy manager; clinical lead nurse and care staff. We spoke with nine health and social care professionals to obtain their views of the service; including two

commissioners of the service; a community dietician; a tissue viability nurse; a GP; discharge co-ordinator; two Huntingdon disease specialists and a palliative nurse specialist.

We reviewed the care records of seven people. We looked at a range of other documents, including medication records, five staff personnel/recruitment files and staff training records, and records relating to the management of the service.

Good

Is the service safe?

Our findings

At the last inspection in November 2016 we found improvements had been made to ensure medicine management was safe and cross infection risks related to cleanliness of equipment had been addressed. However, other safety risks for people were identified at that inspection which meant there was a continuing breach of legal requirements. These related to inconsistencies and a lack of sufficient detail about measures needed to reduce risks, in relation to nutrition/hydration and pressure ulcer risks. A condition was imposed on the provider's registration, which required them to submit a monthly report to CQC on the actions taken to ensure people were fully protected from these risks.

We received monthly reports from the provider demonstrating that regularly auditing and monitoring was being undertaken. Actions had been taken to ensure pressure relieving equipment was used correctly; accidents were monitored and analysed for trends; call bell faults were monitored; risk of malnutrition/dehydration were monitored and daily monitoring of food /fluid intake was in place where necessary.

At this inspection we found improvements had been made and the above issues had been addressed.

People using the service, their relatives and professionals said they felt the service was safe. Comments from people using the service included, "I do feel safe here. Staff are amazing. They always come quickly if I need them"; "Staff help me" and "I get on with everyone here. It is a lovely place to be. I feel safe with the staff; they do everything they can to help you."

Family members supported this view and all said they were confident their relatives were safe. One relative explained the service had given them their life back as they "no longer needed to worry about mum". Another relative said, "I'm a better person because I am not worrying about mum, I'm completely relaxed". Professionals also expressed confidence in the service.

Individual risk assessments were completed and care plans written for any needs identified. For example, people at risk of malnutrition, dehydration, with choking/swallowing risks or those at risk of developing pressure ulcers. Improvements had been made to ensure people at risk of pressure damage were protected. For example, daily checks of pressure relieving equipment were made to ensure mattresses were functioning and correctly set for each individual's needs. People were regularly repositioned to further reduce the risk of pressure damage. A tissue viability nurse specialist (who provided support and advice about wound care and prevention) said the service was proactive and consulted them appropriately and worked well with them. They had no concerns about preventative skin care. They added, "Definitely, utilise us appropriately."

Improvements had been made to ensure people at risk of malnutrition and dehydration were protected and received the diet and fluids needed to maintained their health and well-being. Since the last inspection the registered manager and clinical lead, together with external professionals had reviewed those at risk. At the time of the inspection two people required monitoring of their daily food and drink in-take. New fluid charts

had been introduced since the last inspection with the recommended daily fluid intake calculated. Fluid charts were reviewed and totalled at 6pm each day and staff reported to the nurse in charge if a person had not had the recommended fluid intake. Nurses then advised on appropriate action to be taken. Charts showed good fluid intake and regular food. However, on two nights after 6pm, there was no record that one person was offered or accepted a drink after 6pm until 7am the next morning. There were no sign this person was dehydrated. This was discussed with the registered manager and it was concluded this was due to a lack of recording rather than a lack of diet and fluids. A community dietician told us they had no concerns about people's nutrition or hydration. They said, "They (people using the service) are well looked after. They (staff) always follow advice and do their best. Staff use their initiative and are proactive. They keep in contact with us regularly."

People at high risk of falls had been identified and measures were in place to reduce the risk. For example, people had been assessed for the use of equipment, such as walking aids; low rise beds; bed rails and pressure mat, which alerted staff to people's movements. Relatives said where falls had occurred these were well managed and they had been contacted without delay. They had been informed of how the accident had occurred and what measures were being taken to prevent reoccurrence. The relative of one person explained their family member had a fall shortly after they moved to the service but they were satisfied it was a matter of the person over balancing and not caused by a trip or anything at the service. They added their family member was "quite poorly" when they arrived at the service but now their health had improved; the person was more stable on their feet. The relative was grateful to the staff for speed with which they contacted them to let them know what had happened.

When people had accidents, incidents or near misses these were recorded and monitored in order that developing trends could be identified and addressed.

Everyone we spoke with (people using the service; relatives and professionals) said there were sufficient staff on duty to provide the care and support people required. People confirmed staff responded quickly when they requested help. Staff were present in communal areas and on the corridors to ensure people's needs and requests were responded to quickly. The registered manager undertook regular audits of call bell response times across 24 hours and no issues had been identified about waiting times.

The registered manager used a dependency tool to calculate staffing needs based on an assessment of people's needs. The registered manager said there was always an excess of the recommended hours to cover unplanned sickness and leave. The provider's preferred staffing levels were; six care staff and a nurse on Chollacott, with two care staff and a nurse on the Drake Unit during the morning. In the afternoon there were five care staff for Chollacott and two care staff on the Drake Unit. On some days of the week there were two registered nurses working on the afternoon shift; one on Drake and one on Chollacott. We spoke with the registered manager about why the number of registered nurses varied in the afternoon. There were 30 people living at the service who required and were funded for nursing care. The registered nurses explained the afternoon shift could be very busy with up to 30 people for one registered nurse. Following our discussion with the registered manager, she arranged for two registered nurses to be on duty from 8am until 8pm throughout the week. 18 hours of clinical lead nurse time was allocated between two registered nurses to oversee the nursing and clinical aspects of people's care needs.

At night there was one nurse and two care staff on duty. Since the last inspection in November 2016, the clinical lead nurse and deputy manager worked with night staff to review the staffing. The staffing levels at night were found to be satisfactory. However, two busy times were acknowledged; between 7am and 8am and between 8pm and 10pm. As a result of the staffing review, one member of staff now started work at 7am to assist with the busy early morning period; and an additional member of staff worked from 8pm until

10pm to assist with the busy evening period. The registered manager and staff felt this was working well but would be kept under review. Any gaps in staffing were met by existing staff working extra shifts or by the use of regular agency staff. There was always a senior member of staff on-call out of hours should staff on duty require advice or assistance.

The service did not have any vacancies for care staff, but recruitment was on-going to fill 60 hours of registered nurse time. Two overseas nurses had been recruited and were waiting for confirmation of their UK registration. In the meantime they were working as senior care staff. The service used regular agency nurses to cover this shortfall. We spoke with one agency nurse during the inspection, who said they received a comprehensive handover and good support for the registered nurses and care staff when they were working at the service. They added, "I like working here. It is well organised and staff are well trained to support service users."

The nursing and care team were supported by the full time registered manager; deputy manager and an activities co-ordinator. Sufficient numbers of ancillary staff were also employed, such as housekeeping; kitchen staff, and maintenance staff to undertake cleaning, laundry and the preparation of meals. The different staff teams interacted well together. There was a good atmosphere of team work and good communication between staff. People using the service felt all the staff worked well as a team.

Recruitment and selection processes were in place. Appropriate checks were undertaken before staff began work at the service. All pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However we found some deficits in the employment histories for staff. Following the inspection the registered manager contacted us to confirm that employment histories were discussed at interview and that records of full employment histories were now in place.

People's medicines were managed and administered safely. Medicines were stored safely, securely, and at appropriate temperatures, including medicines which required refrigeration. There were suitable arrangements for the storage and recording of medicines which required additional safe storage. Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. Where medicines had not been administered the reasons why this had happened, was recorded. For example if a person declined the medicine, Where medicines were prescribed "as required" there were instructions about when these should be used and records of what had been given, when and why. Some people were prescribed topical creams and records showed these had been used as prescribed. A GP said they had no concerns about the management of people's medicines at the service and that staff were good at requesting medicines reviews where needed.

The registered manager confirmed there had been five minor medicines errors at the service in the past 12 months. Errors related to the late ordering and delivery of one medicine; stock tallies for one homely remedy; and recording issues. The errors had not caused harm to people using the service. We discussed with the registered manager the actions taken and lessons learnt following errors, as there was no record of these. The registered manager confirmed they would record this information in the future should errors occurred.

Medicines were administered by staff trained to do so in a calm and unrushed manner, ensuring people received the support they required. An external pharmacy audit completed in May 2017 showed good standards were in place in relation to medicines management. Minor recommendations had been made as a result of this audit and action had been taken to address these.

Staff had received training and demonstrated a good knowledge of safeguarding procedures and knew who to speak with if they witnessed abuse or poor practice, or if an allegation of abuse was reported to them. The registered manager was aware of their responsibilities and had informed the local authority safeguarding team and the Care Quality Commission (CQC) about potential safeguarding concerns. Where safeguarding investigations had been undertaken by the local authority the registered manager had worked in partnership with them to resolve issues. There was one on-going safeguarding process in place. A social care professional said the registered manager had responded appropriately to the concern and was working well with the safeguarding team and appropriate actions had been taken to ensure people were protected.

Personal Emergency Evacuation Plans (PEEP's) were in place. These informed staff and the emergency services about the level of support each person needed in the event of an emergency evacuation of the building.

There was a programme of ongoing repairs, maintenance and redecoration of the building. Potential health and safety hazard had been addressed. Radiator covers were fitted to reduce the risk of burns to people. The temperature of the hot water supply was controlled and was within the 44 degrees limit recommended by the health and safety executive (HSE). Windows we checked on the first floor had been restricted to reduce the risk of people falling.

There were effective systems in place to ensure equipment at the service was safe and in good working order For example, fire safety equipment was checked and serviced regularly. Hoists were serviced regularly, as was the passenger lift. Gas and electrical checks were carried out at the required intervals.

Systems were in place to ensure the service was clean and that people were protected from acquired infections. Sufficient housekeeping staff were employed and we found the home was clean and odour-free. Staff confirmed there were always sufficient supplies of protective equipment such as gloves and aprons. Bathrooms and toilets contained liquid soap and paper towels to promote hand hygiene. The laundry had sufficient equipment; it was clean and well organised. There were systems in place to safely deal with any soiled linen and reduce the risk of cross infection.

The last environmental health visit had awarded the service a top rating of five, which confirmed good standards had been maintained in respect of food hygiene.

Good

Is the service effective?

Our findings

At the comprehensive in April 2016 we found some people's legal rights were not upheld in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, as people's capacity to make an important decision had not always been assessed.

We found improvements had been made at this inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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).

Mental capacity assessments had been completed in order to identify whether people lacked the capacity to make decisions in a particular area. For example, about nursing or medical interventions; or the use of certain equipment, which may impact on people's movements. Where a person lacked capacity, best interest meetings were held with the person's relatives (where appropriate) and/or relevant professionals. For example, where equipment was used to monitor a person's movements in their room, a best interest decisions had been made with the family and a professional that the equipment was necessary for the person's safety.

Daily records confirmed staff had sought people's consent prior to delivering care and support and people confirmed staff sought their permission before assisting them with daily tasks, such as personal care or mobilising.

Some people using the service were not free to leave and were under constant supervision. As a result, Deprivation of Liberty Safeguards applications had been made to the local authority in relation to several people and the registered manager explained they were awaiting a decision. The registered manager and nursing and care staff had completed training relating to the MCA and DoLS and demonstrated a good understanding of how this impacted on their daily practice. This meant the service was acting to protect people's legal rights.

Staff were supported with appropriate training and supervision and had the skills, knowledge and understanding needed to carry out their roles. Staff received a range of training and training records showed staff had completed all core training. For example, moving and handling; infection control; first aid; health and safety; and fire safety. Additional training was provided to assist staff with their understanding of people's needs and conditions. For example training related to Huntington's disease; Parkinson's; end of life care; catheter care; and pressure area care. Registered nurses had received additional training in relation to venepuncture (for the purpose of obtaining blood samples); verification of death; and the management of

PEG tubes (commonly used to provide a means of feeding when oral intake is not adequate). Staff were supported to undertake diplomas in care at levels 2, 3 and 4. The deputy manager has achieved level 5 in leadership and management in the last 12 months. Staff were positive about the training and support they received. Comments included, "Lots of training, very good"; "It's great here. Always asked what training we would like…" and "Anything we are not confidence about, training is organised." People using the service, relatives and professionals felt staff were well trained and did a good job. Comments included, "The staff are brilliant and have helped me a lot"; "I have every confidence in their professional ability to look after my (relative)" and "Staff are interested in learning and attend training sessions." A specialist professional described delivering training at the service to both staff and people using the service about a specific health needs. The professional said, "They (staff) have acquired a fair amount of expertise. I have confidence to recommend this service."

New staff were supported with induction training, which followed the 'care certificate' (a nationally recognised tool for staff induction). They also 'shadowed' experienced staff to help them become familiar with people's needs and help them to work safely with people. Where one member of staff had not completed their induction in a timely way the registered manager had written to them to reiterate the expectation that the care certificate must be completed, along with timescales to achieve this. Staff undergoing induction had two weekly supervision to discuss their progress. A probationary period was in place to ensure staff had the right attitude and skills.

Staff were supervised and supported to carry out their roles and responsibilities. Staff had the opportunities to attend regular supervision and staff meetings, to enable them to discuss issues about work or training, and to receive feedback about their performance.

People's dietary needs and preferences were documented and known by the chef and staff. People said they liked the food and were able to make choices about what they had to eat. Comments included, "The food is very good"; "You can't complain about the food. We get plenty and can always ask for something different" and "The food is usually very good," The menu was varied and offered a balanced diet, and alternatives were always on offer. Drinks and snacks were available at all times.

People's weight was monitored and where concerns were identified about weight loss this was discussed with the GP. Some people were prescribed dietary supplements, and records showed these had been given as prescribed. A GP said the service was good at contacting the surgery when they had concerns. They added, "Staff have a good knowledge of service users and the care is good there."

Some people required their nutrition to be delivered via a special tube as they were unable to maintain adequate nutrition with oral intake. The community dietician had been involved in the people's care and regimes had been established to ensure they had sufficient nutrition and fluids. Records showed people were receiving the necessary hydration and nutrition. A community dietician said they had no concerns about people's nutrition or hydration and that the service was proactive and kept in regular contact with them.

All the food was sourced locally where possible and all meals were 'home-cooked' on the premises and fresh cakes were made daily. People could choose where to eat their meal. Those people who required assistance with meals were fully supported; assisted by one member of staff and assisted at their own pace. Staff did not rush people. Staff were attentive to people's needs at meal times and made the occasion sociable by chatting as assisting people. At the end of the meal the nurse came to the dining room and was given a verbal report on how much each person had eaten during the meal. People had drinks with them whilst sitting in their chairs throughout the day. At lunch they were offered a drink of squash at the start of

the meal and tea or coffee at the end of the meal.

People had access to relevant health and social care professionals. For example, GP; dentists; dieticians; speech and language therapists; mental health professionals and specialist nurses, such as tissue viability and palliative care nurses. People were confident their health needs were being met. One person told us they had "terrible leg ulcers"; they said the nurses washed their legs and bandaged them regularly. The person was pleased they were, "All healed up thanks to care of staff here."

Two relatives described the considerable improvements in their family member's health since moving to the service. One said their relative was, "A changed woman since being here." All health care professionals contacted expressed their confidence in the service; they confirmed they were alerted to any changing needs and staff welcomed their advice and implemented any recommendations. One nurse specialist said, "This is a very welcoming and open service…they are very good…" Another said, "The manager and nurses engage really well with me. We get timely referrals; phone calls when advice is needed and they keep us up to date with any changes."

Good

Is the service caring?

Our findings

At the comprehensive inspection in April 2016 we found a lack of attention to detail adversely affected some people's quality of life. As a result we issued a requirement and rated this domain as requires improvement.

At this inspection we found improvements had been made.

People using the service and their relatives felt all the staff were very caring and respectful. Comments from people included, "Yes I'm looked after alright"; "Staff look after me very well" and "Yes I'm very happy, care is excellent, they are all very nice and very good." One person explained having found themselves at Chollacott House they were confident in the care being received. They had good communication with the management team and said they would be reluctant to move to anywhere else.

All family members spoken with were keen to praise the service and the staff. They felt their loved ones were respected and treated as individuals, and that they were safe and happy. One relative said, "Some individuals (staff) are very, very good and compassionate." Another commented, "Staff work with a smile. That makes such a difference. We have a partnership of care. They trust me and I trust them (staff)." Another told us, "I can go out of here and get on with my life now everything is settled down. I can have quality time with (family member). It is a 'home from home' – happy and cheerful".

Positive relationships had been developed between people using the service and staff; and friendships had developed between people using the service. One person said, "The staff are amazing. They have helped me with my ability and confidence…staff work really hard and are very caring." A visiting 'befriender' said there was a good rapport and trust between them and the person they supported and with the management of the service.

During the inspection we observed staff interacted with people in a warm and kind manner. They took time to speak with people and they enhanced verbal communication with touch and by altering the tone of their voice appropriately; providing reassurance where necessary. For example, one person was confused and became distressed about the time of their relative's visit. A staff member engaged warmly with the person, talking with them; holding a hand and reassuring them. The person smiled and touched the staff member's face gently, showing their appreciation. People were greeted by staff with a smile and addressed by name. Staff knew people by their preferred name, which wasn't necessarily their first name.

Staff showed concern and understanding for people's wellbeing in a caring and meaningful way. For example, one person thought Chollacott House was their own residence and that staff worked for them and other people using the service were visiting friends. The staff were able to respond appropriately to the person's disposition and requests and made them feel comfortable and respected whatever disposition presented. The person liked to do things and was encouraged and supported by staff to do some dusting or other light chores around the communal areas. Sometimes the person considered they were paying 'their staff' to do the work so didn't think they ought to be doing chores themselves. Staff adapted their approach to suit the person's current temperament.

One family member described the improvements to their relative's well-being since moving to the service. When the person arrived at the service they were very withdrawn; however the relative said the person had a new friend at the service and they were now inseparable. The relative added the person was very happy, relaxed and contented at Chollacott House.

The provider information return (PIR) showed relationships were supported in many ways. Family members and friends were encouraged to visit with no time limits; telephone calls to and from relatives were supported and video links had been used to enable people to keep in contact with families who lived abroad. Family members were emailed with updates and photographs (where appropriate) and minutes of 'relative and friends' meetings were shared with them.

People's privacy and dignity was respected by staff. Personal care was provided in private and any visits from health or social care professionals were also conducted in private. People were well presented, with groomed hair; clean clothes, and clean and painted nails. Several females were wearing jewellery. During the inspection the hairdresser was visiting. This was an enjoyable activity for several people and obviously impacted on people's self esteem in a positive way. One person said how much they enjoyed having their hair done; they added, "Makes you feel good again!" One relative proudly showed us a photo of their family member after they had had a visit from the hairdresser. They said their relative was "very pleased" to be able to have their hair done. The hairdresser visited weekly and told us how much they enjoyed their work at the service and how well organised staff were to ensure all those who wanted to see the hairdresser were able to do so.

People's private rooms were highly personalised. They were able to furnish their rooms with items from their homes and many had personal items; knick-knacks, soft toys and lots of family photos around them.

We did find continence products on some people's bedroom floor and furniture, which was not very discreet. We discussed this with the registered manager, so that alternative storage could be arranged and people's privacy and dignity could be maintained.

People's independence was supported and encouraged. One person spoke about how the registered manager and staff were supporting them with their aim of moving to independent living within the community. They said staff had helped them when dealing with social workers and correspondence. They added, "(Registered manager) is brilliant and staff are very supportive, they are helping me to get back into the community and live more independently…"

One person was supported by staff to make their bed and tidy their room. They were particular about how the bed should be made and staff respected this and assisted them to ensure they were happy. Another person said they were able to wash their own hands and face and brush their teeth and staff only help with bits they couldn't manage. They said, "I'm getting better."

Another person was supported to keep their small dog with them, which was very important to them and had a positive impact on their well-being. They explained on good days they could walk their dog in the gardens or outside of the service. When they were not feeling so well, staff walked the dog and ensured they were fed.

Aids and adaptations were available to support people's independence, such as walking aids and height adjustable electric beds for those who needed them. One person told us of the adjustments that had been made to allow them to eat more easily from their wheelchair. An adjustable table was used at mealtimes enabling them to be more comfortable as the table could be raised above the arms of the chair and

therefore the food was closer to them but still at a comfortable height. Another person had a vanity mirror at a level suitable for when sitting in their wheelchair. Personalised Signage was in place in an en-suite bathroom for a person living with dementia; reminding the person how to flush the toilet, promoting independence. Some people had pictures outside of their rooms, which were meaningful to them and helped them find their room.

The registered manager and staff team demonstrated a commitment to providing a good standard of care at the end of people's life. Five staff had completed a comprehensive training programme with the local hospice, and three others were in the process of completing the course. The 'Six Steps Programme' was a series of workshops developed by the St Luke's Hospice education team, designed to provide care homes with a toolkit to provide quality end of life care. Trained staff became end of life care champions, enabling them to share knowledge and skills with peers and colleagues. As Chollacott House had achieved two or more end of life care champions and had met the criteria, they received a plaque and certificate from St Luke's showing they had met and maintained the expected standards of the programme. Staff described this training as "fantastic".

A palliative care nurse specialist said they received timely and appropriate referrals and staff who had completed the end of life care programme had a very good understanding of people's needs and end of life care. They added, "Symptom control, such as pain control, is managed really well. I am confident they use medicines appropriately and adhere to our advice. Staff are very caring, supporting relatives too…with have a good working relationship with the service."

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

The service had received many 'thank you' letters sent by relatives following the death of their loved one. The cards, letters and emails expressed family members' gratitude for the care delivered and commented on how well the service had work to ensure people were as comfortable as possible; and to thank staff for the support they too had received at their difficult time.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. Before people moved to the service an assessment was undertaken of their needs and preferences, to ensure they could be met by the service. A professional who facilitated discharges from the local hospital said the service was "always responsive, the registered manager always returns calls, she is reliable and helpful when planning discharges." They went to say comprehensive assessments were carried out prior to people moving to the service. The discharge team carried six weekly reviews following admissions and no concerns had been raised with them. They added, "Our experience with them is positive. We have confidence in the manager and the service."

People and their family members agreed it took a little time to settle in, but once this was achieved all concerned were extremely pleased with the care and support given by the registered manager and the staff team. One relative said they carried a number of leaflets about the service in their vehicle so they could 'spread the word'. One person, who had lived locally, explained they "really looked forward to coming here" when they knew they needed residential/nursing care. A relative said the service had been recommended to them and they were "so glad" they had followed up the recommendation. Comments from people using the service included, "It's a lovely place, the young ones (staff) are all so friendly"; "The staff are all wonderful" and "I'm perfectly happy here."

Since the last inspection new electronic records had been introduced. Feedback from staff was that this was working well and staff were positive about the change. Care records were detailed and written in a respectful, sensitive and personalised way. They were well organised and included comprehensive information about each person. For example, information about individual's health conditions and how these should be monitored; their mobility needs: level of communication and cognition, their emotional and social needs, dietary requirements and their likes and dislikes. People's personal history and important family details were included in care records, giving staff a real sense of each individual.

The service kept a paper copy of electronic care records as well, which were easily accessed by staff, agency staff and visiting professionals; ensuring important information was readily available. Daily notes were completed by staff each day and reflected the care plans and showed that people had received care which met their needs. These records included information about food and fluid intake; personal care, and repositioning for people who were at risk of developing pressure damage.

People and/or their family members, where appropriate, were involved in the planning and delivery of their care and reviews of their care needs. They said they had been asked all about their health and care needs and their preferred routines.

There was a system of communication between staff to ensure continuity of care. Staff handed over information about people's care to the next shift. Information included any changing needs, referrals to healthcare professionals, and outings and appointments. Staff said the handovers provided clear useful information.

People said they had a range of activities they could be involved in. An enthusiastic activities co-ordinator worked five days a week. They had developed a weekly activities programme, based on people's interests, preferences and abilities. The programme was flexible depending on people's mood and interest on the day. Regular activities included gardening; tranquil moments; film afternoons; target practice, cooking; pampering sessions and karaoke. The activities person explained that music was a big part of most days and the service had a large collection of music from 1940's and 1950's. Many people told us they liked music and singing. Four local entertainers visited the service on a regular basis. During the inspection a local choir came to sing with people. Several people and their relatives enjoyed this session and sang along. Where people preferred to stay in their room, staff and the activities co-ordinator spent one to one time with them to avoid social isolation. For example, chatting, reading and giving manicures.

Consideration had been given to people's spiritual beliefs. A regular communion service was held at the service.

The service had access to a shared minibus which was able to take a couple of wheelchairs as well as more mobile people. Regular trips were organised to local places of interest. Recently they were taken to visit a local supermarket, where many had not visited for a very long time. They also had a picnic by the river and were able to paddle their feet in the cold river water courtesy of a couple of buckets. Visits were organised to the local pubs for lunch, afternoon tea and alcoholic drink if people wished.

Family members and friends were invited to social occasions, such as a Macmillan coffee morning and fireworks party. A bi monthly newsletter. A "coffee shop" area was provided for when larger groups of family and friends visited so they had privacy and space to spend time with the people. The local befrienders group was accessed and visited people regularly to support them to take part in activities both inside and outside of the service. One befriender said they really enjoyed the one to one time they spent with the one person, who appreciated their time together. They said the person was always ready and waiting for them to arrive and they would then go off for a drive and do normal everyday things like shopping or going to the local tip. They generally had a meal out before returning to the home.

There were accessible garden spaces, where people could stroll about safely. There was a Pergola for shade and nice seating areas. During the inspection people accessed the gardens throughout the day with family and friends. People and their families happily mingle together and were supportive of each other.

People were supported to get involved with gardening and tomatoes had been planted and were growing in waist height planter. One person on the Drake unit had asked the registered manager and provider if they could develop a sensory garden for the unit. A budget had been allocated and the person was supported to plan the planting and seating spaces. The person was very pleased with the outcome, which had transformed a rather overgrown and under used space into a pleasant outdoor space for people on Drake. The space had been planted with fragrant herbs and flowers; climbers; fruit trees and bushes and some vegetables. The person explained, "The garden was my passion and I couldn't have done this alone. The maintenance person is very good and helped a lot. (The registered manager) is fantastic and very supportive of the idea. I am so glad they let me do this. It has made a difference for people and their families."

The provider had a complaints procedure in place and people said they knew how to make a complaint if necessary. People said they would speak with the registered manager or a member of staff should they have any concerns. All felt sure any concerns would be listened to and resolved. The PIR showed there had four complaints in the past 12 months. We reviewed these. Three complaints related to different staff members not following care plans as directed causing concern to family members. Once reported the registered manager investigated the concerns fully and responded to the complainants in a timely way. Where

necessary additional training was provided or disciplinary action taken. Each complaint was resolved so each party was satisfied. This meant the manager took information of concern and investigated it thoroughly and in a timely manner to ensure the safety and welfare of people who lived at the service.

The service had received 32 compliments in the past 12 months from people who had used the service or their families. Themes included the caring nature of staff and the standard of the care and support provided. The Care Home UK website uses feedback from people and relatives to rate providers. Chollacott had achieved a score of 8.5 (maximum of 10). Three comments had been posted since the last inspection. These comments and ratings were independently verified by Care Home UK. All of those responding described the care and support; activities and staff attitude and approach, and other aspects of the service as excellent or good.

Good

Is the service well-led?

Our findings

At the last inspection in November 2016 we found improvements were needed to ensure the systems in place to assess and monitor the quality of the service provided were fully effective. We took enforcement action, which required the provider to submit monthly reports on the actions that have been taken to ensure people were safe and appropriate care and support was provided.

Monthly reports were received by the CQC, which demonstrated action had been taken to reduce the risk of unsafe care and treatment. There was a quality assurance system in place. Through this system, CQC reports and audits from the local authority, the provider had developed an action plan and we saw from this, work was in place to address identified issues. At this inspection we found improvements had been made and maintained since the last inspection. However, we found recruitment records were not formally audited as part of the quality assurance system. Since the inspection the provider has introduced regular audits to ensure that the correct checks were made at the point of recruitment.

There were systems in place to ensure people at risk of developing pressure damage were protected. A comprehensive wound management audit had been completed in June 2017, which showed no specific concerns. We reviewed the wound care plans of seven people. All were very detailed and no issues were highlighted. The plans showed evaluation of treatment and whether improvements had been made. This helped to ensure people were receiving effective treatment.

Improvements had been made to ensure people at risk of malnutrition and dehydration were protected and received the diet and fluids needed to maintained their health and well-being. Since the last inspection the registered manager and clinical lead, together with external professionals had reviewed those at risk and there was clear advice and instructions for staff to follow to keep people well-nourished and hydrated.

At the last inspection, monthly audits of care records had failed to identify and address the concerns we found in relation to risks. At this inspection we found improvements had been made to people's records and the auditing system. A care plan audit completed in June 2017 was comprehensive and identified where some risk assessments were out of date. This enabled staff to take the appropriate action to review and amend the records to ensure they were accurate. This meant the auditing system was more effective.

At our previous inspection we found that, although accidents/incidents were monitored to identify themes or trends, the reports seen did not show information such as times of day or night. Although this data was gathered it was not included in the overall reports and might have been useful in considering individual risks and staffing needs. At this inspection we found monthly accident/incident audits were detailed and showed times, as well as the immediate actions taken and longer term actions taken. Audits showed that where necessary the person's GP was notified and advice sought and additional observations were in place.

Monthly medicines audits were undertaken and where actions were required these were addressed. For example, fridge temperatures showed some out of range so a new medicines fridge was purchased.

At the inspection in November 2016 we found some call bells were not working so people were unable to alert staff to their needs. We also found staff were not familiar with the codes displayed on the call system which might indicate a fault. This suggested some staff needed more training/instruction on the call bed system in use. At this inspection we found staff had been given further training to understand the call bell system and reminders were in the staff room and nurses office about the various codes displayed on the system. Staff spoken were able to explain call bell system. The system had been checked and serviced.

The registered manager and provider had developed a 'service development plan', which covered all aspects of the service, including recruitment and retention; staff training; safe working practices (including health and safety issues and premises maintenance) and the provision of care and support. The provider's representative visited the service monthly and completed a comprehensive audit of the safety and quality of the service. Where improvements were identified they were addressed in a timely way. For example repairs or reviews of care records. This showed systems were in place to monitor and improve the quality and safety of the service and appropriate control measures were in place to mitigate risks or potential risk of harm for people.

People, their relatives, staff and professionals expressed confidence in the registered manager. People knew the registered manager as they were visible and during the inspection people and relatives freely approached them. People using the service and their family members said they considered themselves 'very lucky' to be at the service and would happily recommend it to others. A relative said, "I have every confidence in the manager. She runs a tight ship, she is fair and disciplined. They (staff) work as a team and get on with the job. The manager is always responsive to my requests or suggestions."

Staff said they were well supported and the team worked well together. Staff knew what was required of them; they understood their roles and responsibilities and confirmed they had resources and support available and if they needed 'advice' it was given in a way that was constructive. One member of staff said the registered manager ran a "tight ship".

The service was supported by the management structures in place. The registered manager was supported by an experienced deputy manager. Professionals and staff spoke highly of the deputy. One staff member said, "(The deputy) is always willing to help or give advice…" Another said, "(The deputy) is easy to talk to and always has time for us."

The service promoted a positive culture. People described an ethos within the service where they could confidently make suggestions or request different things. Health and social care professionals described an openness and willingness from the service to work with them and carry out their recommendations.

People who used the service and their relatives were asked for their views about the care and support provided. Satisfaction questionnaires had been sent to those using the service and their relatives in November 2016 and the registered manager had analysed the results for themes and then discussed suggestions made with people individually and at 'residents' meetings'. Where people had made suggestions, for example the introduction of card games or film afternoon/evening, these had been actioned. Comments from people returning surveys included, "I am well looked after"; "Staff are nice"; "Staff always go the extra mile" and "The staff and management go above and beyond."

Questionnaires were also sent to staff and professionals to obtain their views of the service. 13 staff surveys had been returned. The results were shared and discussed in team meetings to "celebrate the positives and promote changes within the team." The staff survey confirmed staff felt valued and worked well as a team and with the management of the service. Comments included, "We all work well to make Chollacott a happy

place." Responses from professionals' surveys were positive; showing good working relationships had been established with them. Comments included, "The manager's total professionalism and approachability is very evident" and "Everyone (staff) was very keen to learn how to help their residents."

Regular meetings were held to enable people and their relatives to share their experience, thoughts and ideas and to hear about planned changes at the service. Regular staff meetings were held to discuss people's changing needs; staff; roles and responsibilities; health and safety issues and training. Records of staff meetings were available so that staff not able to attend were aware of what had been discussed.

People benefitted from the partnership working established with other professionals This ensured people received appropriate support to meet their health care needs. the service had accessed a community befriending service, which people benefitted from.

The provider had achieved an Investors in People Award, which was valid until 2019. The Investors in People is a nationally recognised benchmark of good people management practice.

The registered manager was aware of their responsibilities to notify CQC about certain events, such as deaths, serious injuries or allegations of abuse. This enables CQC to monitor the rates of these incidents at the service and how these incidents were being dealt with.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 registered providers have a legal duty to display the ratings of CQC inspections prominently in both the care home and on their websites. The current CQC rating was displayed in the home's reception area and on the provider's website.