Craven Nursing Home Limited

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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

Craven Nursing Home is situated in a semi-rural setting on the outskirts of the market town of Skipton. The home is registered to provide nursing care and accommodation for up to 68 people. The home is separated into three units. One of these units cares specifically for people living with dementia. At the time of our inspection there were 54 people at the service.

This comprehensive inspection took place over two days. 24 February 2017 was unannounced and 9 March 2017 was announced. At the last inspection in December 2014 the service was rated as Good.

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

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. There were appropriate systems in place to make sure that people were supported to take medicines safely and as prescribed. Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were a sufficient number of staff on duty to make sure people's needs were met. Recruitment procedures made sure that staff had the required skills and were of suitable character and background.

Staff were supported by a comprehensive training programme and supervisions to help them carry out their roles effectively. Staff were led by an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with sufficient amounts of food and drink. Where people required support with eating or drinking, this was appropriately provided, taking into account people's likes and dislikes.

People told us that staff were caring and that their privacy and dignity were respected. Care plans showed that individual preferences were taken into account, although the information about this in care plans sometimes lacked detail. Care plans gave directions to staff about the support people required to have their needs met. People were supported to maintain their health and had access to health services if needed.

People received good care at the end of their lives. Staff were well trained in this area and sensitive to the needs of people, their friends and relatives.

People's needs were regularly reviewed and appropriate changes were made to the support people received. People had opportunities to make comments about the service and how it could be improved.

The registered manager had good oversight of the service and there was a clear ethos of care. The registered manager had made improvements at the service since they started in post. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

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.

There was safe management of medicines which protected people against the associated risks.

Staff used safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005. Relevant legislative requirements were followed where people's freedom of movement was restricted.

People were supported to maintain good health and were supported to access relevant services such as a doctor or other professionals as needed.

People were provided with sufficient amounts of freshly cooked food and drink.

Is the service caring?

Good

The service was caring.

People told us that they were looked after by caring staff.

People were treated with dignity and respect whilst being supported with personal care.

People, and their relatives if necessary, were involved in making decisions about their care and treatment.

People at their end of life were provided with good support which was sensitive to their needs and those of their loved ones.

Is the service responsive?

Good

The service was responsive.

People received care which was responsive to their needs. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People could take part in a range of activities.

People knew how to make a complaint or compliment about the service.

Is the service well-led?

Good

The service was well-led.

The registered manager had good oversight of the service and had plans in place to make improvements.

There was a positive, caring culture at the service.

There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

There were opportunities for people to feed back their views about the service.

Craven Nursing Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 24 February and 9 March 2017 and was unannounced on the first day. The inspection on the first day was carried out by one adult social care inspector, an inspection manager, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of supporting someone living with dementia. The specialist advisor had a professional background working with older people and mental health. On the second day the inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also sought feedback from North Yorkshire County Council Quality Monitoring Team, Healthwatch and the local Clinical Commissioning Group.

During this inspection we looked around the premises, spent time with people in their rooms and in communal areas. We looked at records which related to people's individual care. These included seven people's care planning documentation. We also reviewed other records associated with running a care service which included four recruitment records, the staff rota, notifications and records of meetings.

We spoke with two people who received a service, four relatives and a visiting friend. We met with the registered manager and deputy manager. We also spoke with four care staff, the activity coordinator, cleaner, chef and maintenance person. One visiting doctor talked to us about their experience of the service.

Because we were unable to communicate effectively with a number of people at the service, we carried out a Short Observational Framework for Inspection (SOFI) on the second day. This was a set period of observation to assess how staff supported people and the interactions that took place.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe living there. One person said, "Yes, I feel safe. I have a buzzer. I can't get out of bed by myself, so I use my buzzer. I get help" Another person said, "Yes. I feel surrounded with people who look after me. I am a nervous person and I feel relaxed here".

The friend and relatives we spoke with all thought that people were safe. A friend of a one person told us, "[Name] has an alarm and the staff are very attentive. He is not mobile and relies on staff for everything. Yes, he is safe". A visiting relative added, "Because of the staffing, there are plenty of nurses here. [Name] wasn't safe at the last home. Here there is a buzzer and pressure pads". A pressure pad alerts staff that people at risk of falls had moved from their chair or bed. Another relative told us, "Everyone who comes into the home has to pass reception and have to sign in and out. Staff know who is in the home".

Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being. Staff confirmed they had safeguarding and whistleblowing information. There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected.

There were up to date risk assessments in people's care plans. This detailed any risks to the person's well-being and gave guidance on how to minimise them. For example, some people were at risk of falls or skin breakdown. Each person had a Personal Emergency Evacuation Plan (PEEP) in their care plan which explained how to support them in the event of an emergency, such as a fire.

Records showed that any incidents or accidents were logged and appropriate action taken. Accident reports went to the manager to review and assess if further action needed to be taken. Any serious incidents or concerns had been reported to other authorities as required. Two safeguarding concerns had been reported in the last year and records showed there had been proper investigations with actions noted to prevent future incidents. The provider had signed up to the 'Herbert protocol' with the local police. This meant that people who were at risk of leaving the home unattended were registered with the police in the event of a disappearance.

We asked people if they thought there was enough staff to meet there needs. One person told us, "Yes I can't speak highly enough of them", although another person felt, "They [staff] are run off their feet and are worn out". Relative comments included, "I think there are times when they are very busy but I have never found them too busy to speak or to see to mum", "Definitely enough staff" and "I do think there is enough staff".

Throughout the inspection we observed there were sufficient members of staff to attend to people, keep them safe and meet their needs. The registered provider was not using any agency staff which meant there was a consistent and familiar team of staff. There were occasions where people were left in lounges without a member of staff for a short while which meant, if someone needed help, they might not receive it in a timely manner. We spoke with the registered manager about this who said they would remind staff about making sure a member of staff stayed in the lounge areas. The provider used a dependency tool to assess

staffing levels. This was reviewed every two weeks to make sure staffing levels were sufficient.

Recruitment records showed that staff completed an application form which was discussed at interview. Interview notes were recorded and showed why applicants were deemed suitable for a position. References were sought prior to employment and checks were carried out on each applicant's suitability. A criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.The provider kept records to confirm that nurses had current registration with the Nursing and Midwifery Council (NMC).

The registered manager took steps to make sure the environment was safe. The service had generalised risk assessments associated with ensuring the health and safety of people using the service, staff and visitors. The fire alarm system was regularly checked to make sure it operated effectively and there were up to date inspection reports for electrical wiring and gas safety. We spoke with the staff member responsible for maintenance. They showed us records which demonstrated repairs and checks were carried out promptly.

We observed that all the bedrooms, bathrooms and communal areas were clean and tidy and that they smelt fresh, with no odours. People and their relatives confirmed it was a clean environment. Comments included, "There is never a smell. I think there is a policy about pads being left in the bathrooms, so there is never a smell" and "Always clean and tidy when I visit. The room is well maintained. Curtains, carpet, bathroom all clean".

We observed staff maintaining hygiene standards. Hand sanitising gel was available throughout the service and personal protective equipment, such as gloves and aprons, was available when required.

People told us that they got their medication on time. One person said, "Because I am able to, I take my own medicine. They bring it to me daily". A relative told us, "Yes, [Name] gets it every day on time".

We checked the systems in place to ensure people received their medicines safely. The service used a monitored dosage system (MDS) with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of doses, as prescribed by the person's doctor.

Each person's medication administration record (MAR) had a photograph of the person and details of any allergies they had. We sampled these records and saw that medicines had been administered as prescribed. However, we identified occasional gaps in the recording of one person's cream and another person's fortified drink. This was raised with the staff member responsible for administration who said that it would be addressed. The temperatures in the medication room and refrigerator, used for the storage of medication, were recorded daily to ensure medicines were kept at the correct temperature.

We checked the systems in place for the safe storage of drugs liable to misuse, called controlled drugs, and saw they were stored in an approved wall mounted, metal cupboard and a controlled drugs register was in place. We completed a random check of stock against the register and found the record to be accurate.

We asked people about pain relief and if it was given when needed. One person told us, "If I need medication because I am in pain it's usually paracetamol". We asked if they got it quickly when needed and they said, "Yes straight away". A relative commented, "[Name] gets it. I have all the confidence in the world with the staff here".

We observed the lunch time medicine round on one unit. A do not disturb tabard was available for the nurse in charge however they did not wear this. Medicines were given as required and people were informed about what was happening. The nurse gave people time to take their medicines at their own pace.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained and are able to meet their needs. One person said, "Yes, I used to visit my husband here so I got to know the staff well. This is why I chose to live here". Another person commented, "Excellent personal care". A relative told us, "[Name] is much happier since she has been here". They went on to say that their relative sometimes went into other people's bedrooms and explained, "What I like about the staff is they never force [Name] to come out of people's rooms. They treat her kindly and hold her hand and lead her out of the bedroom. This is why I think they are well trained".

Staff got the training they needed to work effectively and expand their own professional development. Areas of training undertaken by staff included moving and handling, safeguarding and infection control. One staff member felt that they would benefit from 'challenging behaviour' training. This was because some people could have aggressive outbursts. The staff member felt training was necessary due to the increase of incidents. We raised this with the registered manager who was aware of the issue and showed us a training pack they were planning to use. New staff members received a suitable induction when they started working at the service. This included shadowing other staff and attending key training sessions. The majority of staff had completed, or were completing, the Care Certificate. This is a set of minimum standards that should be covered as part of induction training of new care workers.

The registered manager supported nurses in their continuous professional development so that they had the required experience to revalidate their registration. They told us that to support this, two nurses attended a revalidation workshop last year and then cascaded the information to the rest of the nursing team.

Care staff had opportunities to discuss any work issues in a regular, confidential meeting with a manager. Yearly appraisals also took place. These gave staff an opportunity to review their strengths, weaknesses, achievements and targets. The care staff we spoke with all told us that they felt supported in their roles.

We observed breakfast and lunch in the dining rooms. All the dining rooms were light and airy with well laid tables that were nicely set with table cloths, cutlery, napkins, condiments and a vase of flowers. There was a choice of drinks available to cater for people's preferences. We noted there were no menus visible in the dining rooms but staff informed us that a choice was given. A staff member explained, "Residents are asked the day before what they would like to eat and we fill in the meal sheet for them".

We saw there was a good atmosphere and lots of interaction from the staff in the dining rooms. Care staff were seen to check people were alright and make friendly conversation, such as, "Did you enjoy your breakfast?" and "Would you like anything else to eat? Scrambled eggs or poached eggs?". Where people required support this was given at an appropriate pace. One person was being assisted to eat with a spoon. The member of staff was sat with them and gently encouraged them, talking politely.

We asked people if they liked the food and if they had a choice. Comments included, "I think the food is very good. It is well flavoured and nicely cooked" and "Yes, I would ask for what I want and it is done". A relative

told us, "The choice is good" and another said the food was, "Fine" and went on to say, "If [Name] chooses not to eat it that would be up to him. Every meal he is offered is nutritious. I believe there is plenty of veg".

We spoke with the main chef who told us they operated a four week menu which was changed every six months. They explained, "Any residents can have anything they like really". The chef was very aware of people's preferences and food requirements and said, "I cook individually for people if required. Pureed foods are kept separate and shaped to make the meal more attractive. I am made aware of people who are losing weight. I will raise it as an issue if I have any concerns of my own. I also get feedback from residents in questionnaires".

Diet sheets for each person were held in the kitchen. These gave information about allergies and special diets, such as fat free or gluten free. The chef showed us they held information from the food supplier about allergy risks.

Where there were concerns about weight or food intake, support was provided by the local Speech and Language Therapy (SALT) team and local doctor. For those people at nutritional risk, a professionally recognised assessment tool was used to monitor weight loss and prompt appropriate action. Methods of recording and monitoring food and fluid intake were being used. We saw people had food and fluid charts and these were recorded accurately.

The registered manager told us they weighed people regularly and those with significant weight loss were referred to specialist health professionals. They said that there was a problem in getting dieticians to come out in their area but that the SALT team would come out. Records showed that action was taken where weight loss was a concern. However, we noted that one person had lost 2.7kg in the last month but there was no evidence that this had been acted on. We spoke with the nurse on duty who acknowledged this and said they would review the records.

People were supported to maintain their health and had access to health services as needed. Care plans contained clear information about peoples' health needs. Some of the people who used the service had complex health needs and we saw that the service made effective use of advice and support from other professionals. The service had good links with the community matron, doctors and other health specialists. The registered manager explained that other professionals to come to the service included a podiatrist and dentist.

The care plans we looked contained clear guidance on health needs such as skin care, weight and mobility. Information reflected the advice and guidance provided by external health professionals. We spoke with a visiting doctor who told us they have had a positive experience with the home. They said, "This all results in a very low incidence of hospital admissions and doctor call outs. Any calls for assistance are always valid, relevant and well managed. There are no issues with medicines management and no concerns at all about supporting the service".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person

of their liberty were being met.

The manager and staff were aware of the principles of the MCA and DoLS procedures and had received training in this area. DoLS referrals had been made as required where people were restricted in their movements. The registered manager told us there was difficulty in getting DoLS reviewed and re-authorised in a timely manner. This was because of local authority delays. Records showed that requests for review had been submitted as required. Where needed, up to date assessments of capacity were evident in people's care records. These demonstrated why people did not have capacity to make a particular decision and that a decision would need to be made in their 'best interests'.

Redecoration was taking place on one unit to make it more dementia friendly. However, the staff we spoke with had a limited understanding of the impact the environment could have on people living with dementia. During our inspection we observed there was no signage around the building to help people find their way around. We found it difficult ourselves to find our way round the building. There was also a lack of contrasting colours to assist people visually. We fed this back to the registered manager who said that they were aware the environment could be improved and had taken this into account with the plans for redecoration.

We noted one unit had a secure, sensory garden, that was fragranced with herbs and flowers. This provided a safe, outside place for people living with dementia.

Good

Is the service caring?

Our findings

People told us it was a caring service. Comments included, "It's nice here. I like it" and "It's fine. I'm looked after".

We observed numerous occasions where staff showed a caring attitude to people. In one of the communal areas we observed two care staff having a friendly and humorous conversation with a group of people. A staff member got down to one person's eye level in order to better communicate. They had a warm and friendly chat. When the staff member was asked by a colleague to help with something, they said they would be a minute, as they were in a conversation. This demonstrated respect for the person they were talking to.

We spent time in the communal areas of the home. There was a calm, positive atmosphere throughout our visit. We saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and often humorous. Staff approached people in a sensitive way and engaged people in conversation, which was meaningful and relevant to them. We noted that staff had completed a training pack in dignity and respect as part of their induction.

We asked people if they thought staff showed respect towards them. One person said, "They are always friendly. They always knock on my door". Another commented, "Yes, they do they help me with my personal care. Nothing is too much trouble. Always kind and respectful and always knock on my door". One visitor told us that their friend liked to have the door open and explained, "When I have visited and [Name] needs personal care, I have left the room and staff have closed the door so they can assist with care in private". Another visitor commented on the support provided to a relative; "Everything is totally their choice. Anything they want. The door is closed or opened if he wants it". They went on to say their relative liked to be called by a shortened name by people they liked; "[Name] tells which staff he wants to use his short name". The visitor said that this was respected by staff.

People and told us, and we observed, that they were involved in day to day decisions about what they did and how they were supported. For example, in the lounge in one unit we observed care staff moving a person from a wheelchair into an armchair, using a hoist. The two staff spoke kindly to the person, informed them of what they were doing and asked permission to move them. Permission was given and they covered the person's legs with a blanket before moving .The person was lifted carefully and professionally.

People's agreement to provide personal care was sought before being given and, where possible, independence was promoted. For example, one person asked to move nearer the window. A member of staff assisted with this whilst encouraging the person to help themselves, by using a walking frame.

There was a very caring approach to how the service supported people approaching the end of their lives. Where required, people had an end of life care plan which gave clear guidance for staff about how best to support them. Well written advanced care plans were in place which included an emergency health care plan and, where appropriate, details of a legally appointed person to manage their affairs.

Relatives were closely involved in the care and were supported to visit as often as they liked. Overnight accommodation was provided if needed. One visitor to the service, whose relative used to live there, described their experience. They said, "I don't think [Name] could have been at a better place", adding that their relative was supported by, "A good, core group of staff".

A visiting doctor considered the service outstanding with regard to their palliative care expertise and delivery. They described it as entirely person centred and flexible to the needs of the individual. The doctor added that the positive experience of being involved with the service made their work there, "Pleasurable and rewarding".

The registered manager told us that they tried to make people at the end of their lives as comfortable as possible. They described how one person very much wanted to see their old dog before they died. This was arranged by the service and the registered manager said it provided the person with a lot of comfort.

The registered manager had good links with other support services, such as the local hospice, who they met with every month. An end of life facilitator also visited the service to carry out training for staff. The facilitator also delivered training for qualified staff in syringe driver competency. A syringe driver is a way of giving a person pain relief medicine, when they are unable to take orally. The registered manager explained that it was important to plan ahead and consider who may be approaching their end of life, in order to make sure resources were in place. They told us that they also completed 'reflective accounts' on some people who had died to help identify what had gone well and if anything could have been done better.

Good

Is the service responsive?

Our findings

Prior to admission, people were assessed to make sure the service was able to meet their needs. From the assessment information a care plan was developed which showed how the service would meet their needs.

We asked people who used the service and their relatives if they knew about care plans and were involved in making decisions about their care. Most people knew about their care and how it was managed. Comments from people included, "Staff deal with that (the care plan). I am asked about it" and "They have a book and ask me questions. They keep a note". One relative told us, "Very much so. I have just been talking to the nurse about this as we are going away next week. They will ring me if there is a problem" and another commented, "There is communication over [Name's] care".

The care plans we looked at were up to date and reviewed as necessary. Areas covered included health, nursing needs, mobility, personal care and medicines. Care plans were regularly reviewed to make sure that any changes in a person's needs were identified promptly and information was updated. Each person had a life story document which gave details of their personal history. This provided staff with an insight into the background of people so that they had a better idea of their personality, likes and dislikes. However, life story documents varied in detail and further work was required to make sure they were a useful, working document.

People received person centred care which was responsive to their needs. Person centred care is about treating people as individuals and providing care and support which takes account of their likes, dislikes and preferences. We reviewed people's records and saw they were mostly person centred. For example, one person had a body temperature care plan which stated they liked to have a blanket over their legs when sitting in an armchair. We observed that this happened in practice. However, some information was not as detailed as it could be to support staff in providing personalised care. For example, one person's record had no information about what the person could do for themselves with regard to personal care. Another person's behavioural plan stated, "Keep a safe distance as [Name] can sometimes strike out at people", but gave no further detail or how staff could best manage this. Care staff were aware of individual preferences but it was not always recorded. We discussed this with the nurse on duty who agreed care plans could provide more detail. However, we did not find that this had impacted on people, because there was a stable staff team, who knew people well.

Daily progress notes were kept for each person. These were professional in content and well written with relevant entries. Progress notes demonstrated the care and support was delivered in line with care plans.

We asked people if there was enough to do at the service and if they enjoyed joining in the activities. One person told us, "Yes. I join in whenever I can. I am always sorry if I have to miss a session". Relative's and visitor comments included, "I do think there are enough activities. This is one of the reasons I chose this home. The little concerts and boat trips, [Name) gets involved and enjoys them", "The activities staff interact really well with [Name]" and "At Christmas I saw my friend in a wheel chair in the lounge when the singers were here. When the weather gets better they will take him out into the garden".

We spoke with one person who was unable to get out of bed in their room. We asked them if they liked their room and they said, "It would be nice if I could see out of the window. "Their bed was very low down and they were unable to see the view of the canal, ducks and the barges that passed their window. We raised this with the manager who agreed to look into ways to solve the issue. There were two activity co-ordinators employed at the service. We spoke with one of them who told us that they scheduled one to one time for people that preferred to stay in their rooms. This provided social interaction for people who may otherwise be isolated.

On the day of our inspection we observed an exercise class for people with movement difficulties. The class consisted of six people, the activities organiser and the instructor. The class involved clapping, touching knees and shaking heads. The instructor gently encouraged people to move and talked them through the exercises. Some people found this very difficult because of movement difficulties, but they clearly enjoyed it as they were all smiling.

An activity board displayed the programme of activities for the week ahead. These included an accordion player and Easter egg painting competition. There was a full programme of events. An activity coordinator told us that there were no restrictions on pets and sometimes a 'pets as therapy' dog visited the service. Although people were supported to attend organised activities, there was a lack of appropriate stimulation for those people who chose not to attend, particularly for people living with dementia. We spoke with the registered manager about this who said they would talk to the activity coordinators to explore options. A member of staff told us that in the warmer weather people living with dementia are encouraged to participate in gardening activities or sit out in the sensory garden.

The registered manager told us that people were supported to get out in to the community and said, "The staff are always willing to take people out shopping or just along the canal for a walk". They talked about some of the occasions they had supported people to attend events. For example, one person, who usually stayed in their bed, was assisted by staff to attend a wedding after having been given a pampering session in the morning.

The people and relatives we spoke with all knew how to complain and who to go to if they had a concern. They knew who the registered manager was and felt they could approach them with any problems they had. The registered manager told us that complaints guidance was always given out with a service guide when people first started using the service. People told us that they felt they would be listened to and action would be taken. One person told us, "I know the manager and all the staff are nice. I'm sure I would be listened to" and another added, "I would go to the office if I needed to. I haven't seen anything that I need to complain about".

We looked at the record of complaints received over the last year. One complaint had been received in the last year. Although this had been properly investigated, the file was not well organised and it was difficult to find a clear audit trail. The registered manager acknowledged that the file required review. We noted that the file was very full with large thank you and appreciation cards and notes from relatives.

Good

Is the service well-led?

Our findings

People who used the service and relatives made positive comments about the leadership of the service. Comments included, "Any concerns she listens to us and acts on it immediately", "The manager is always here, except at weekends, when once she gave me advanced warning she wouldn't be here at the weekend. She gave me the name of the person who would be there to help if I needed it". A visiting doctor told us, "The other really positive area is leadership. The strengths and skills of the manager and her consistently high standards together with an established and dedicated nursing team and care workers". A member of staff said the registered manager was "Supportive. Very nice".

The registered manager had been in post for two and a half years. They spoke knowledgeably about the service and had a clear understanding of the requirements of the Regulations. They were able to respond to our questions about individual people's care and support promptly and without reference to records.

The registered manager explained their ethos for the service, "Anybody who comes here, it's their home. We strive for a homely atmosphere, respect people's privacy, ask people what they want to do. We [Staff] are the visitors here". The registered manager demonstrated a commitment to promoting dignity and respect, and ran a session on the topic for new staff during induction. They told us, "I do a round every morning and evening. I don't stay in the office. I like to keep an eye on things. At meals I insist on tablecloths and flowers. I want it to be homely. Overall, staff need to be caring and empathetic".

The registered manager said they were supported by the registered provider who visited the service most days. We noted that the registered provider came to visit during our inspection. The registered manager told us that they had regular one to one meetings with the registered provider for support and to discuss the development of the service. The registered manager talked about some of their plans for the future. Priorities included improving dementia care practice and continued development of the provision of end of life care. They added that dementia awareness training would be mandatory and further training on this topic was planned for the near future.

The registered manager was keen to establish professional relationships with other local services. For example, there was a monthly meeting with the local hospice to discuss end of life care. They also attended Craven Support Group which was a meeting of local health and social care managers.

There were systems in place to monitor and review care practices in the service. The registered manager had a schedule of audits for different areas of practice. This included, for example, audits of medicines management and accidents. A care plan audit was completed every two or three months, where a sample of care plans was reviewed. Audits clearly identified if there were any actions needed to make improvements and showed when these had been completed. For example, an error with the naming of a document had been noted and rectified. We noted that most records we looked at were well maintained and ordered, and kept up to date. Confidential records were kept securely as necessary.

The service was signed up with Commissioning for Quality and Innovation (CQUIN) which promotes

partnership working and sharing information in order to improve services. As part of this the service produced a quarterly report which highlighted any issues and trends in areas such as nutrition, infections and incidents. We looked at the last report which was very detailed and specific to the service. The registered manager told us this was a useful tool which helped to identify where action was needed to make improvements.

There were opportunities for people who used the service and relatives to feedback their views. A recent relative survey was almost entirely positive. There were also 'relative/resident' meetings three times a year, where people could raise issues and discuss events at the service. One relative confirmed they had been to these meetings and said, "Someone raised an issue about another person. I thought the manager handled it well". The registered manager told us that a DVD about dementia was shown at the last meeting. We noted as that a monthly newsletter was produced and given to each person. This included news about the service as well as information about activities and staff.

There were regular meetings where staff could share any concerns or suggestions and comment on any plans for the future. As well as full team meetings, there were individual unit meetings, night staff meetings and nurse meetings. A staff survey was completed by the provider in December 2016. An action plan had been developed from this to address any issues raised. This showed that staff had opportunities to feed back their views and be involved in service development.

We noted that the provider was displaying their previous inspection rating at the home and on their website. Notifications were submitted to CQC as required and in a timely manner.