Nellsar Limited

Loose Valley Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 inspection took place on 10 May 2016 and was unannounced.

Loose Valley Nursing Home is registered to provide nursing care for up to 39 older people. Most bedrooms are for single use, but shared rooms are available. Accommodation is provided on two floors, with a passenger lift providing easy access between floors. It is situated just outside Maidstone town centre, and offers easy access to local amenities and public transport links. There is a garden to the rear of the building. At the time of our visit, there were 29 people who lived in the home. People had a variety of complex needs including communication difficulties, physical health needs and mobility difficulties.

There was a registered manager at the home. 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.

Medicines had not always been given to people as prescribed by their doctors and adequate records were not always kept.

One to one staff supervision had not been consistent. There were gaps in supervisions which showed that staff had not sometimes had supervision for six months or more. Yearly appraisals were inconsistent. We have made a recommendation about this.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. However, staff felt hurried or rushed and when people requested care or support, this was not delivered quickly. We have made a recommendation about this.

Systems were in place to enable the registered manager to assess, monitor and improve the quality and safety of the service. However, some shortfalls identified in medicine management had not been identified by the registered manager.

The provider had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the home; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager. Relatives felt their people were safe in the home.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's

individual risks and were able to tell us about the arrangements in place to manage these safely.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and the home complied with these requirements.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. The chef prepared meals to meet people's specialist dietary needs.

People were involved in their care planning, and that staff supported people with health care appointments and visits from health care professionals.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice, and to go out into the community as they wished.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

During this inspection, we found breaches of regulations relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely and appropriately recorded.

There were enough staff employed to ensure people received the care they needed and in a safe way. However, there is need to review current staffing levels.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

There were effective recruitment procedures and practices in place and being followed.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to meet people's needs. Staff supervision and annual appraisals were not up to date. However, there were plans in place to update these.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and their relatives were included in making decisions about their care.

The staff in the service were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The home had an open and approachable management team.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There were systems in place to monitor and improve the quality of the service provided.

Loose Valley 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 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 10 May 2016 and was unannounced.

Our inspection team consisted of three inspectors and one expert-by-experience. Our expert by experience had knowledge, and understanding of residential services and of supporting family and friends with their health care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with three people, five relatives, four health care assistants, two senior care staff, the activity coordinator, two domestic staff, deputy manager who is also a registered nurse and the registered manager. We spoke with the operations manager who had the overall responsibility for the home, which were different responsibilities to the registered manager and who was a representative of the provider. We also requested information from healthcare professionals involved in the home. These included professionals from the community mental health team, care managers, continuing healthcare professionals, NHS and the GP.

We looked at the provider's records. These included four people's records, which included care plans, health care notes, risk assessments and daily records. We looked at five staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside spaces available to people.

At our last inspection on 17 July 2014, we had no concerns and there were no breaches of regulation.

Requires Improvement

Is the service safe?

Our findings

Our observation showed that people were safe at the home. One person said, "It is comfortable and safe, look at the side cushions I can't hurt myself when I do move a bit" and another said, "I fell very safe and settled here, I have the best room in the house and they take a lot of care of me".

Relatives felt their family members were safe in the home. One relative said, "The bedroom is very good and the bed is safe so I know he can't fall out and he has settled very well. It makes me feel better to know he is in safe hands". Another relative said, "I am very happy with the care my relative receives here, they know what they are doing and they do it well. He feels safe when they give him personal care and move him which makes me feel he is in good hands".

A healthcare professional commented, 'The home are very proactive in seeking advice if they have any concerns for any residents, and very open in my experience' and 'The home follow the social services process for raising referrals for Adult Protection enquiries and are happy to consult if they are not sure whether something is meeting that threshold or not'.

Medicines had not always been given to people as prescribed by their doctors and adequate records were not always kept. In one person's medicine records, we found Co-codamol 15/500 tablets box. There were 200 at the start of the month. 120 had been administered, which meant that there should have been 80 left. However, we found 112 left. This meant that staff had signed for medicine that had not been given. The registered nurse who carried out the audit with us assured us that this person always has two tablets four times a day but there was no explanation for the discrepancy found. Other examples found included one person fed by Peg (PEG stands for percutaneous endoscopic gastrostomy, a surgical procedure for placing a feeding tube without having to perform an open operation on the abdomen. The aim of PEG is to feed those who cannot swallow), administered lansoprazole 15 mg, 28 came in, 16 were given, 13 were left in pack, and this gave us a total of 29. This showed that one had not been given but had been signed for.

In another case, Warfarin 5 mg 56 tablets came in none were taken, 35 were found in stock which left 21 tablets of warfarin missing. 1 mg 56 tablets came in 12 had been signed for which meant 44 tablets should have been left but we found 56. 1 mg tablets which again showed staff had signed to say that medicine had been given, which had not. Monthly medicine audits were being carried out. However, this audit was not robust enough and had not identified the discrepancies in numbers of medicines that we found. There was no robust procedure to audit all aspects of medicines management. The registered provider's policy relating to the administration of medicine had not been followed by the management team. The policy stated 'Management and supervisors are responsible for regular audit of medication records'.

The examples above showed that the home failed in proper and safe management of medicines. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were given their medicines in private to ensure confidentiality and appropriate administration by the

registered nurses responsible for medicine administration in the home. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. One person said, "I do have some medicines and I know they tell me what they are for". We observed the registered nurse administering people's medicines during the home's morning medicine round. The registered nurse checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely. The registered nurse discreetly observed people taking their medicines to ensure that they had taken them.

Medicines were stored safely. There was lockable storage available for stocks of medicines. There were medicine trolleys, which were locked and secured to the wall. The medicine fridge was locked and a record had been kept of the fridge temperatures, to make sure that medicines were stored safely. The contents of the controlled drugs cupboard and register were checked and these records were accurate.

There were suitable numbers of staff to care for people safely and meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. However, we observed that it took longer time for staff to respond to 'call bells'. In one example, we heard the 'call bell' sounded for over 7 minutes. We traced this sound to the first floor. We found that the person was in bed but required staff assistance to get up. We had to summon a care staff to attend to the person. The care staff told us that they had only 2 staff on the floor in the morning. One staff attending to personal care and the other serving breakfast. We discussed our findings with the registered manager. The registered manager told us that the roster is based on the needs of people. Staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly. This demonstrated that although the registered manager had staffing levels based on people's needs in order to keep them safe, there are periods on a daily basis particularly in the morning when additional staff might be required to meet people's needs safely.

We recommend that the provider reviews staffing levels in the home in order to keep people safe.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. They said that they had completed safeguarding training prior to and after taking up their post in the home. They said that this training was updated each year. Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were specific to each person. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as diabetes. Risk assessments were regularly reviewed and updated in line with people's changing needs. This ensured staff had all the guidance they needed to help people to remain safe.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one person who had had a number of falls. There was a clear plan in place which staff were aware of and used.

Accident and incident forms were completed when people were involved in accidents such as falls. Details of people's injuries were documented and any action taken was recorded. Other information included which staff were on duty at the time, who witnessed the incident, any further action needed and who was informed and when. The records contained body maps which showed where on the body people had sustained their injuries. Outcomes of investigations were documented with any action needed to minimise the risk of the incident happening again set out.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed in 2015. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2016. Fire equipment was checked weekly and emergency lighting monthly. Staff had completed a fire competency assessment.

There was a plan for staff to use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

The design of the premises enhanced the levels of care that staff provided because it was specious, well decorated and had been suitably maintained. Corridors were spacious with good lighting and were very clean and fresh.

Good

Is the service effective?

Our findings

One person said, "The care is good, I always have a lady help me and they let me do some things myself which I want to do. I like the food it smells nice and there is always plenty of it". Another said, "The food is very interesting to look at on the plate (This person had been a cook for many years) and there is always plenty of it" and "I like the food it is very good and I never feel hungry". I wasn't too well when I first came here but I now feel much better and like being here".

Relatives said, "The food is good and well-cooked and he has been weighed recently. It is good to see him settled".

A healthcare professional commented, 'Yes, we have a good working relationship with the home manager who communicates clearly with me whenever needed'.

All staff completed training as part of their probationary period. New staff had provider's induction records which they worked through during their probationary period. Staff told us that they were mentored by both the deputy manager and the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further experience gained from working in the home, and through further training. For example, the induction for registered nurses included competency assessments in relation to the management and administration of medication and observations of key areas of practice, such as wound care and dressings. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the home. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed the management team to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. Nursing staff told us they were supported to attend relevant courses to maintain their professional registration.

The deputy manager is the clinical lead for the nursing home. They supervise the nursing staff and make sure they receive the training they need to maintain their nursing qualification. Nurses do all the training undertaken by the care staff plus specific training they need to undertake there role, for example the treatment of wounds. The nurses we spoke with confirmed that they are given sufficient training to carry out the role and maintain their qualification with the NMC Nursing and Midwifery Council. We checked the nursing staff registration certificates and found these to be up to date.

Members of staff felt supported by the registered manager. However one to one formal supervisions had not

regularly taken place. One person had their supervisions dated 07 March 2016, 28 August 2015 and 27 April 2015. In another person's file, they had supervision on 08 March 2016, 08 May 2014, 30 November 2013, 29 August 2013 and 05 July 2013. In another, we found no records of any formal supervision. The registered manager confirmed that they had identified gaps in staff supervision and were working on it. The registered manager supplied us with their plan. The provider's supervision policy and procedure stated, 'Every employee will be invited to a supervision session with their manager or supervisor at least 6 times a year and more often if there is a particular employment related need'. This showed that the registered manager had not complied with their own procedure regarding staff supervision.

Yearly appraisals had not been consistently carried out. We found in one person's file that they last had appraisal on 19 February 2013. In two others, 04 December 2014 and 08 January 2015. In one person's file, there was no record of any appraisal. Appraisals would have enabled staff to improve on their skills and knowledge which would have ensured continued effective delivery of care to people. We spoke with the registered manager about this and they showed us their plan for bringing these up to date.

We recommend that the registered manager ensures that supervisions and appraisals are kept up to date in line with their policy.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a Deprivation of Liberty.

Before people received any care or treatment they were asked for their consent. Staff interacted well with people, and asked them where they wanted to go and what they wanted to do. They obtained people's verbal consent to assist them with personal care such as helping them with their meals, or taking them to the toilet. Staff were aware of how to treat people with respect and that they allowed people to express their consent to different tasks. There were consent forms in place in each person's care plan. Consent forms had been appropriately completed by people's representatives where this was applicable. The forms showed the representative's relationship to the person concerned, and their authorisation to speak or sign forms on the person's behalf or in their best interests.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. Records of allergies were kept in people's care plans. For example, one person was allergic to egg and poultry. We saw this in the kitchen food plan adhered to by the kitchen staff. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff twice a day and upon request.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and

they are offered snacks and at other times"; "People can get food and drink during the night if they want it, like tea and toast". We observed that people who were awake early in the morning were offered drinks and snacks.

People and relatives were very positive about the quality of the food, choice and portions. One relative said, "The food is usually good and there seems enough of it, no one has lost weight, sometimes it's better than others". We observed lunch in the dining room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as a team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or want something not on the menu. The chef said, "if they do not like what is on the menu, we provide alternatives". There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The chef was aware of the dietary requirements of people and she was very actively involved in the delivery of the food and service. Diabetes food guide was seen on the wall in the kitchen. The chef told us that they provided variety of food and special needs/requests such as soft diet like pureed food and diabetic diet for diabetic people are taken care of. This showed that staff ensured people's specific nutritional needs were met.

People or their representatives were involved in discussions about their health care. Relatives told us they are involved by staff in people's health care needs. They said, "I am involved. They discuss her care needs with me".

The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the home regularly. A healthcare professional said, "Patients receive safe, effective & compassionate care at Loose Valley. I have no concerns about this nursing home".

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing.

Good

Is the service caring?

Our findings

People told us that staff were caring. Comments from people included, "The staff are kind and do not rush me". "I do need a lot of help with everything but they are very kind and do not rush me, they know how I like things done". "I have a good room and the carers are very kind". "The staff are always kind and polite and come and talk to me about all sorts of things" and "The staff are kind and polite, they knock on my door even though it is open".

Relative commented as follows, "The care is good they are kind and welcoming, everything always looks clean and tidy" and "My mum loves it here. They are really good to her".

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. One person became agitated when they wanted to go to the toilet. Staff calmly spoke to the person about what they were doing which relaxed the person. Staff also provided reassurance for a person who was becoming agitated throughout the morning. Staff offered the person reassurance and gave them cuddles when he asked for them. This showed that staff were knowledgeable about how to care for the person.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had a choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. People were assisted with their personal care needs in a way that respected their dignity. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open

or closed and their privacy was respected. Staff covered people with blankets when necessary to preserve their dignity.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever their needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the home.

Good

Is the service responsive?

Our findings

One person said, "I have visitors and can sit in the garden or could go out if he wanted to but is happy and settled here with the care that he receives". Another said, "I enjoy having visitors and can go out and move around, if I wasn't happy I would say so".

Relatives commented, "It is a very calm and homely atmosphere here and the care is very good. If I had a problem I would say so as staff are easy to talk to" and "I feel that everything is done well, particularly the attention given to hoisting, which is good that they get training in that. If I wasn't happy I would tell the staff that".

We asked healthcare professionals if people are supported to maintain good health, have access to healthcare services and receive ongoing healthcare and other support. A healthcare professional commented, 'In the cases I have been involved with this has been well managed by the home, with good contact with the GP's and other health professionals where needed'.

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. A person who experienced falls was provided with equipment that alerted staff when they stepped out of bed so they could provide help and reassurance. People were placed under observation following a fall and their progress was recorded. If needed they were referred to the 'falls clinic'. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a G.P.'s visit and a review of their care. This showed that management and staff responded to people's changing needs whenever required.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone and visits".

People were able to express their individuality. Staff acknowledged people by name as they walked past them in the lounges and corridors. People were responsive to staff and were eager to talk to them. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and suggestions in consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, identification of photographs and reminiscence, bowling, exercise, music, dancing, sparkle and arts and craft. One to one sessions included arms and hands massages, reading aloud and sing-along. The activities coordinator organised activities for each month.

There was a weekly activities timetable displayed on the notice board and people confirmed that activities were promoted regularly based on individual's wishes. Activities folder reviewed showed that activities were a regular feature in the lives of people living in the home. Activities completed with people included planting flowers, bingo, celebrating the Queen's birthday, nail and hair care, supporting visitors to communicate with their relatives, large size jigsaw puzzles, cross words and word searches, and card making. The activities coordinator had worked as a care worker previously for 12 years in the home. This meant that they knew people the supported well in order to engage with them. The activity coordinator meets with the company's other activities coordinators to share ideas.

The provider contacted other services that might be able to support them with meeting people's mental health needs. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the home. The relatives feedback received for 2016 indicated that most people were satisfied with the service being provided.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). We found that there had been no complaints since our last visit.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". We saw complimentary messages sent to the registered manager and staff. These included comments such as, 'We are so pleased that she came to you. She could not have been in a better more caring environment'.

Good

Is the service well-led?

Our findings

Relatives told us that management team in the home are fine and they are happy to work with them. One said, "They always do as we ask".

Staff told us, "Management is approachable, caring and I feel listened to".

The provider had a clear set of vision and values. These stated 'We believe every one of the individuals we support deserves dignity, choice and independence, as these values lay the foundations for a high quality of life'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs based on their assessed needs.

The management team at Loose Valley Nursing Home included the registered manager and the deputy manager. Support was provided to the registered manager by the provider representative who supported the registered manager with the inspection. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the operations manager who provided all necessary resources to ensure the effective operation of the service. The operations manager visited the home at least twice a month. This showed that the registered manager and staff were well supported by the provider.

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the home. The operations manager visited the home every month to carry out a monthly audit. The provider had effective systems in place for monitoring the home, which the registered manager implemented. They completed monthly audits of all aspects of the home, such as medicine, care plans, nutrition and learning and development for staff. They used these audits to review the home. Audits routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken. However, the medicine audit failed to identify the gaps we identified above. We discussed this with the registered manager who showed us and sent us their plan to rectify these gaps in order to ensure that the audits are more robust.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

The home worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we contacted told us that the home always liaised with them. We asked healthcare professionals to tell us what the service does well. One healthcare professional said, 'Person-centred care and multi-agency communication. Well led and good knowledge of policies and procedures across agencies, in order to get the best support for their residents'. This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Management and staff failed in proper and safe management of medicines. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.