Cotswold House Care Home Limited

Cotswold House Care Home

Inspection report

Church Road
Cainscross
Stroud
Gloucestershire
GL5 4JE
Tel: 01453 752699

Date of inspection visit: 13 and 18 August 2015
Date of publication: 18/09/2015

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

Overall summary

This inspection was completed over two days 13 and 18 August 2015. Cotswold House Care Home provides care for up to 48 older people who have nursing needs. At the time of our inspection there were 42 people living in home.

Cotswold House Care Home is split into two areas. The main house and the bungalow. The main house is arranged over three floors and the bungalow is all ground floor accommodation. There is a lift in the main house to enable people access to all areas of the home. There were 44 single and two double (shared) bedrooms, with 38 bedrooms having an ensuite facility of a toilet and wash hand basin.

There was a registered manager working at the service. 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.

Summary of findings

Whilst the home was clean and free from odour. Some improvements were required to ensure people were safe in respect of reducing the risks of cross infection in respect of equipment cleaning and ensuring bathrooms were fit and ready for use for the next person.

Staffing in the home had recently been increased. We found there was a difference in the care delivery on the first day of the inspection. This was because the service was short of staff. This meant the care was not as effective and responsive as on the second day. There was a high usage of agency staff which the provider and the registered manager were actively trying to reduce with the recruitment of new staff. Assurances were given that regular and familiar agency staff were used who knew the people and the home.

Care plans were in place that described how the person would like to be supported and these were kept under review. Some improvements were made during the inspection to ensure risk assessments detailed individual risks and what action staff should take to keep people safe. This was because these were generic and did not focus on the person.

People's medicines were managed safely. People were protected from abuse because staff had received training on safeguarding adults and they knew what to do if an allegation of abuse was raised.

People had access to healthcare professionals when they became unwell or required specialist help. They were encouraged to be independent and to participate in activities both in the home and the local community.

People were treated in a dignified, caring manner which demonstrated that their rights were protected. People confirmed their involvement in decisions about their care. Where people lacked the capacity to make choices and decisions, staff ensured people's rights were protected. This was done through involving relatives or other professionals in the decision making process.

Staff were knowledgeable about the people they supported and spoke about them in a caring way. Staff had received suitable training enabling them to deliver safe and effective care. Newly appointed staff underwent a thorough recruitment process before they commenced work with people.

People's views were sought through care reviews, meetings and surveys and acted upon. Systems were in place to ensure complaints were responded to. People who used the service, their relatives and staff were positive about the management of the home, which was open and approachable.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.<Summary here>

Summary of findings

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.

People were not always protected in respect of infection control with some equipment not being cleaned effectively.

People receiving a service were kept safe from harm because staff were aware of the actions to take to report their concerns. People were supported to manage their prescribed medicines safely.

Staffing levels had recently been increased to ensure people's needs were safely met. People were protected because staff had been through a thorough recruitment process.

Is the service effective?

Good

The service was effective.

People's freedom and rights were respected by staff who acted within the requirements of the law.

Staff had a good understanding of peoples care and support needs. People were supported by staff that had the necessary skills and knowledge. Systems were in place to support staff. People had access to health care professionals when they needed them.

People's nutritional needs were met and this was kept under review to ensure people were having enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with compassion, kindness, dignity and respect. They were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their approach.

Is the service responsive?

Good

The service was responsive.

People had been assessed and their care and support needs identified. Care plans were in place to ensure people received care which met their needs, wishes and aspirations. Some improvements had been made to ensure these were personalised.

Summary of findings

People were supported to take part in a range of activities in the home and the local community. These were organised in line with peoples' preferences.

People and their visitors were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Good

The service was well led.

Staff felt supported and worked well as a team. Some staff and visitors told us this had recently improved. Staff told us they enjoyed working in the home.

People, their relatives and staff commented positively about the management of the home and were confident they were listened too.

There were systems to monitor and improve the quality of the service. Checks were carried out to ensure care was delivered safely and effectively.

Cotswold House Care 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 was an unannounced inspection which was completed on 13 and 18 August 2015. The inspection team consisted of one inspector and an expert by experience who had experience of supporting people with dementia. 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 previous inspection was completed in April 2014 and there were no concerns. There have been two changes to the registration of the service including the appointment of a new registered manager and to remove the regulated activity of diagnostic screening. This was because this regulated activity was not being provided at the service.

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 service, what the service does well and improvements they planned to make. We received this promptly from the provider when this was requested.

We reviewed the information included in the PIR along with information we held about the home. This included notifications, which is information about important events which the service is required to send us by law.

We contacted five health care professionals to obtain their views on the service and how it was being managed. This included three of the five GP practices, an independent assessor in respect of deprivation of liberty safeguards and a tissue viability nurse. We also contacted Gloucestershire Council's quality review team who visited the service the day before our inspection. They had found no concerns during their visit.

During the inspection we observed and spoke with people in the lounge, looked at five people's records and those relating to the running of the home. This included staffing rotas, policies and procedures, three staff recruitment files and training information. We spoke with the 8 people about the care and support they received, 6 relatives and visitors, six members of staff, the provider and the registered manager.

Requires Improvement

Is the service safe?

Our findings

We found that there were a number of infection control risks. We saw there were toiletries in two of the shower rooms and used towels and a razor in another. There was a risk that toiletries could be shared with people in the home. There were clear notices to staff to remind them to return people's toiletries to their bedrooms after use. We followed this up on the second day of the inspection and found this had improved and there were no toiletries in these areas. However, we checked four shower chairs and found that these had staining underneath where they had not been cleaned effectively. One of the shower rooms had brown staining on the floor it was evident that the care staff had not cleaned this area after supporting a person. We also saw two wheelchairs that had not been cleaned and the seat and arms had a sticky residue on them. The registered manager told us wheelchairs were deep cleaned monthly and after each use.

An agency staff was seen carrying dirty laundry through the home with no gloves, apron or in the red bags that were provided for this purpose. Staff confirmed with us the procedure for carrying laundry and showed us where the laundry bags were stored in each person's bedroom. This had not evidently been shared with the agency member of staff and posed a risk of cross contamination to people.

We found that the registered person had not ensured equipment had been adequately cleaned and systems followed to prevent cross infection. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and Equipment.

The home was generally clean and free from odour. Staff had received infection control training. Policies and procedures were in place to guide staff on safe practice. Domestic staff were employed to assist with the cleaning of the home. Cleaning schedules and infection control audits were completed. People and relatives confirmed the home was cleaned to a good standard and there were no lingering odours.

People told us they felt safe with the care and support they received. One person told us, "My daughter organised for me to come into the home, it's very good, it was the best thing she has done for me". Relatives told us they felt people were safe and their medicines were managed well.

A relative told us, "The staff tell me if there are any changes to my wife's condition, whether that is with any medication changes or whether my wife has fallen, I cannot fault the care, she is safe".

Equipment used in the service was maintained and serviced in line with manufacturer's recommendations. This included fire safety equipment, the fire and nurse call alarm systems, the lift, moving and handling items such as hoists and specialised baths, portable electrical items and catering equipment.

A member of staff told us they often had to search for a hoist as there were only two available. We observed staff having to go to the first floor to find the hoist to use for people on the ground floor. We discussed this with the registered manager and the provider who told us there were two hoists presently being used by five people. A further thirteen people used a stand aid of which there were three. The registered manager said they reviewed this frequently with staff to ensure appropriate equipment was available and would review this again.

We observed an unsuitable moving and handling procedure on the first day of our inspection where a person was transferred using a stand aid for an inappropriate distance. This was discussed with the registered manager and staff at the time of the inspection. Assurances were given that this was not the normal practice of staff and the equipment was only used to transfer a person from a sitting to standing position to a wheelchair or arm chair. All other assistance given to people in relation to moving and handling was done safely with clear communication between the staff and the person being supported.

Care plans were in place to guide staff on how people should be supported with moving and handling. This included the number of staff and the equipment required. We observed a person being supported safely using a moving and handling belt. This was not recorded in the care plan for this person. We were told this had recently been introduced and person's care plan would be updated with immediate effect.

There was no trained moving and handling assessor working at the home. The provider confirmed the day after the inspection the care co-ordinator would be attending a train the trainer course for moving and handling on the 12 October 2015. Staff had completed training in moving and handling this was updated annually by an external trainer.

Requires Improvement

Is the service safe?

The service had recently been visited by Gloucestershire environmental health department and they achieved five stars which is the highest rating you can achieve for food safety. This was displayed in the home.

Medicines were kept safely and were stored securely. Staff had been trained in the safe handling, administration and disposal of medicines. The medicines were checked monthly by a designated member of staff. There were policies and procedures to guide staff on the safe administration of medicines. The registered nurses were responsible for administering medicines to people. Some people told us they had to wait for their medicines especially in the mornings. On the day of the inspection an agency nurse told us it had taken them three hours to complete the medicine round and they had completed this at 11:45 am. The agency nurse told us the care staff were supportive and there were up to date photographs to help ensure medicines were given to the correct person. There was guidance on how people preferred to take their medicines.

Staff were clear about what action they should take if they witnessed or suspected any abuse. There were policies and procedures to guide staff on the appropriate approach to safeguarding and protecting people. Staff confirmed they had received safeguarding training and explained how this was reported. Staff were aware of the organisation's 'whistle blowing' policy and expressed confidence in reporting concerns. The provider regularly visited the home to speak with staff and people about the care and support that was in place and any concerns they may have.

The provider followed safe recruitment practices. We looked at the recruitment files for three newly appointed members of staff and found appropriate pre-employment checks had been completed. All members of staff had at least two satisfactory references and had received a Disclosure and Barring (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Checks had been completed on the nurses to ensure they were registered with the Nursing and Midwifery Council (NMC). This meant the provider could be assured the nurses were fit to practice.

Two people raised some concerns with us on the first day about not being supported promptly when they required the toilet. They told us although staff had acknowledged they needed assistance no one returned. One person had to wait an hour which was not acceptable. We observed a person requesting to go to the toilet. Staff again acknowledged the person but they were side tracked by the telephone. We intervened as this person had been waiting 45 minutes. We discussed this with the registered manager and the provider as examples where there was insufficient staff to meet people's needs.

On the first day of inspection, staff were not clearly visible in the lounge areas of the home as they were involved in personal care until lunch time. We were told a member of staff had telephoned to state they were going to be absent and no staff cover could be found. This meant they were short of staff. Staff told us in addition more people were using their call bells than normal to request assistance on this particular day.

On the second day of our inspection the home was fully staffed and staff were present in the lounge areas throughout the morning. The registered manager told us on the first day there were four agency staff working and on the second day there were three and stated this had an impact on care delivery on the first day. The provider told us regular agency staff were used as far as possible to cover any staff shortages. This was confirmed in conversations with staff and the agency staff who told us they regularly worked in the home.

The registered provider described how they kept staffing levels under review to ensure they were meeting the needs of the people living in the home. This included a dependency tool, speaking with the registered manager and the staff. Staffing had been increased two weeks prior to our inspection. This was due to the increased occupancy of the home and the identified needs of the people they were supporting.

There were now nine care staff in the morning, seven in the afternoon and three working nights. There were two registered nurses working throughout the day and one registered nurse working at night. This was confirmed in the rotas seen. There was also an activity co-ordinator, housekeeping, laundry and catering staff. This enabled the care staff to focus on the care of people.

The registered manager told us they were actively recruiting to the staff vacancies and five care staff were planning to start in August 2015. They were waiting for appropriate pre-employment checks to be completed.

Requires Improvement

Is the service safe?

Staff told us the recent increase in staffing had improved staff morale and their ability to support people effectively. Staff told us some shifts were busier than others which then impacted on the time they spent with people engaged in activities.

Good

Is the service effective?

Our findings

People told us they had confidence in the staff that were working at the home. . Comments included, “They are all lovely, cannot fault it here”, “The staff are professional, I have no fault with the staff”, “The nurses are all good, they are kind and help me when I need it” and “The girls are nice, it is better now”. Relatives confirmed the staff were approachable and many told us this had improved over the last few months.

People confirmed they could make an appointment with their GP if they required. The registered manager told us they worked alongside five local GP practices. Where people lived locally prior to moving to the service then to ensure continuity they could retain their existing GP. Records were maintained of health care appointments, including any treatment and follow ups. A visiting GP told us they were confident the staff were knowledgeable and were meeting their patients’ needs and calls to the surgery were appropriate. A further GP responded to our request for information stating, ‘The staff are knowledgeable and we have had no cause for concerns about the quality of the care’. Records showed people had access to an optician, dentist and chiropody.

Care records included information on people's physical health needs, for example people had their weight, blood pressure and nutritional needs assessed monthly. Where people had been assessed as at risk of weight loss, a care plan had been put in place. Staff had liaised with a dietician and the person’s GP. Other health and social care professionals supported people. They included dieticians, physiotherapists, occupational and speech and language therapists and the mental health team. Their advice had been included in the plan of care and acted upon. A GP told us the staff had been proactive in liaising with a speech and language therapist in assessing a person’s swallowing as they were at risk of choking.

Where people were at risk from skin pressure wounds care plans and records were in place to monitor the person’s skin integrity. This included monitoring the healing process of any wounds. Preventive measures were in place to protect people’s skin integrity such as specialist equipment. For example, pressure relieving mattresses and cushions.

People were offered support with regular repositioning to prevent skin pressure from being in the same position for long periods of time. A registered nurse told us where they were concerned with the healing process of any wounds they would access support and advice from the tissue viability team. Some people were not funded for nursing care and so their nursing care needs were met by a district nurse in relation to the treatment of any pressure wounds.

We observed people at lunchtime and saw they had enjoyed their meal. The meal was unrushed and relaxed. People told us they were offered a choice every morning, and if they did not like what was on the menu a further choice would be made available. People told us they could have refreshments whenever they wanted and they only had to ask. One person told us, “I like to stay in my bedroom, the staff are very good, they bring me drinks regularly throughout the day and check on me”, another person told us, “I am fussy but the food is ok actually, no real complaints” and a third person told us, “It was faggots today it was very nice”. The menu of the day was displayed in the dining room on a blackboard. There was a four weekly menu on a notice board. However, this may have been difficult for people to read as it was only available in small print. People told us they were asked in the morning what they would like to eat for lunch and tea.

People’s rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting on behalf of adults who lack capacity to make their own decisions. Staff understood how the MCA 2005 protected people using the service and supported them to make their own decisions. They told us they had received training on the MCA. The registered manager told us, in the provider information return, all staff were in the process of completing training in MCA and Deprivation of Liberty Safeguards (DoLS) to increase their awareness in these areas. Staff were aware that where people may lack mental capacity for some decisions it was still important to involve them in day to day decisions where they were able. People told us the staff would always ask them for verbal consent before carrying out any support and care needs.

The registered manager had been sending us notifications about people who had an authorisation in connection with the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have

Good

Is the service effective?

been authorised by the local authority as being required to protect the person from harm. Where people had been assessed as lacking mental capacity, information was available in their care file about deprivation of liberty safeguards. An assessment had been completed which would indicate an application should be made.

The registered manager told us there had been 26 applications made on behalf of people in respect of DoLS. Three had been authorised and the other 22 were waiting for an independent assessor to be allocated. These had been kept under review to ensure the least restrictive measures were in place. The registered manager and nursing staff showed a good level of understanding of the process. Policies and procedures were in place guiding staff about the process of DoLS. There was a matrix to enable the registered manager and staff to monitor these to ensure where a further authorisation was required this could be applied for. Usually DoLS are authorised for no longer than 12 months.

Staff told us they had training as part of their induction and this had equipped them with the skills and knowledge to enable them to fulfil their roles in supporting people. The registered manager told us they had recently completed training in delivering the Care Certificate which is a new induction programme for care staff. This was introduced in April 2015 for all care providers. The registered manager told us in the provider information return (PIR) they were planning to implement this for all new and existing staff. For existing staff we were told this would enable the registered manager to identify any further training requirements on an individual basis. A new member of staff told us they were well supported during their induction and the training had equipped them for their role. They told us they had no hesitation in asking the staff team and the registered manager any questions if they were unsure.

Staff completed core training as part of their induction including safeguarding adults, health and safety, basic first aid, infection control, fire, food safety and moving and handling. These were periodically updated and a plan was in place to ensure that this was completed by all staff. Other training included dementia care, medicines and end of life care. In the PIR the registered manager told us they were reviewing the delivery of training. This was because in the past training was delivered by staff completing workbooks and it was recognised that some staff had different preferences in relation to learning styles. The registered manager was planning some further classroom based learning delivered by the clinical lead to enable group discussions and role play to aid learning for staff.

Good

Is the service caring?

Our findings

People told us they could have visitors whenever they wanted. Visitors confirmed they could visit regularly and speak with their relatives in the lounge, their bedrooms or the dining room and in private if they wanted to. Visitors told us they were offered refreshments when they visited and were made to feel welcome.

A visitor told us, "I have got to know the staff really well, they are all very pleasant, and I can ring at any time". Another visitor said, "I telephone the home to ask how my relative is doing, and in the past staff have not been helpful stating they have not seen her today, but this has improved, some staff are better than others when I telephone". The visitor told us, "I just need to know that she is alright or eaten well, as it provides me with assurances that I have done the right thing".

People and visitors told us they felt the staff were more caring than in the past and it is getting better. They told us a few staff had recently left and improvements had been seen in how the staff were caring towards their relative and the general morale in the home. One person told us, "It feels like the staff now want to be here, rather than it being just a job which pays".

People told us they could get up and go to bed when they wanted. Care records included information about people's personal routines including their preferences in relation to getting up, how they liked to spend their day and when they wanted to go to bed. This included how to maintain people's independence.

Daily records confirmed that where people could not communicate their choice, this was done in accordance with their care plan. Staff described to us how people were supported in an individual way. For example, some people liked to sleep with a light on, others liked two pillows and staff knew how people liked to take their tea including how many sugars and their food likes and dislikes.

Staff described people in a positive manner and they were knowledgeable about people's life histories and important family contacts. We spent some time in the lounge and dining area observing interactions between staff and people. Staff were respectful and spoke to people kindly and with consideration. Staff were unrushed and caring in their attitude towards people. Where people became upset, staff responded to the person offering reassurance which quickly calmed the person. However, there were long periods of time where there were no staff present in the lounge especially during the morning on the first day of the inspection. One person was sat in the dining area from 10am to lunchtime whilst staff interacted with the person it was only to ask a question for example what would you like for lunch or would you like a cup of tea. This was task orientated rather than making meaningful conversation. This person was not engaged with any activity during this time. The second day staff were more engaged with people. This may be because the staff were either regular staff or familiar agency staff.

We observed a member of staff asking a person if they were alright as they looked uncomfortable. The person told the member of staff they had a neck ache and they were immediately offered pain relief. The staff member explained and reassured the person, that it was ok for them to take pain relief if they were in pain. They returned later to check whether the person was feeling better showing an interest in the person's wellbeing.

We observed people being supported with lunch. The meal was relaxed and unrushed. Where people required assistance this was done sensitively and at the pace of the person. Staff were observed sitting alongside the person explaining what they were eating and offering encouragement. On the first day of the inspection we did observe two staff chatting with each rather than the person they were supporting. This showed a lack of respect for both people.

People and their relatives had an opportunity to attend meetings were their views were sought on the running of the home. The registered manager told us they were planning to organise these, every three months.

The registered manager had completed an action plan to improve how people were supported in respect of maintaining their dignity. There was a dignity champion who was monitoring staff in respect of these areas. Staff were signing up to a care agreement which described the ten areas on how they can improve their practice. This was to ensure people were treated with dignity, respect and developing an inclusive atmosphere. There was a notice board which gave staff information about maintaining people's dignity and showing respect as part of their day to day roles.

Good

Is the service responsive?

Our findings

People told us the staff were normally responsive to their requests for support. They told us staff usually checked on them quickly when they used their call bell. However, on our first day some people had to wait to be supported to use the toilet. This was because the staff had got distracted by the telephone or there was a delay in finding a second member of staff to support the person. One person told us, "Usually staff will come and explain if there is a delay but they did not today, I think they just forgot". This person was given an apology and advised it was alright to use the call bell again, if staff do not respond after the initial call. Some people told us they preferred to spend time in their bedrooms. One person said, "I have all I need here, my television, my paper and it is just how I like it. The girls check on me throughout the day and bring me drinks and my meals. I am ok here". They told us regular checks were completed at night with the night staff responding promptly to their call bell.

People had their needs assessed before they moved to the home by the registered manager or the clinical lead. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care.

The registered manager told us they were in the process of updating people's care plans on to a new planning system. This was still work in progress. The registered manager had written to relatives inviting them to be involved in the discussions along with their person living in the home. Some relatives and visitors we spoke with told us they had not been involved in this area as this was completed by another relative. One relative told us, "X (name of staff) is really good at both keeping me informed and asking how I think my wife would like to be supported". They told us they were no longer able to go out together but the staff will take her to the local shop or go for a walk which she still enjoys.

People had a care plan covering all areas of daily living. This included personal care, eating and drinking, sleep, hobbies and preferred daily routines. The care documentation included how the individual wanted to be supported. For example, when they wanted to get up, their likes and dislikes and important people in their life. The care plan included details of their representatives such as the main relative to contact in the event of an emergency. Care plans had been reviewed monthly detailing any updates and progress.

Relatives had been involved in sharing life histories to enable staff to get to know the person. This documentation was called 'This is Me Booklet'. This enabled staff to respond to people living with dementia who may not recall all their life histories and aided conversation with the person. However, this information had not been transferred to people's care plan in relation to socialising, hobbies and interests.

Information leaflets were available to staff about people's medical history and how it may impact on the person. A registered nurse told us this was important so the care staff had an increased knowledge on what to monitor in relation to a person's general wellbeing ensuring they were responsive to people's changing condition.

People's care files contained risk assessments in respect of mobility and other daily living activities. It was noted that these risk assessments were generalised in respect of the actions the staff should take. For example, they described the training staff should complete rather than the actions staff should take to reduce the risks for the person. By the second day the registered manager had updated many of the risk assessments to ensure they were specific to the person. This included the frequency of observations, who to contact if staff were concerned and any environmental factors staff need to take into account. As appropriate action had been taken by the registered manager we were satisfied this had been addressed.

People had a keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and spending time with them. A relative confirmed they knew who the keyworker was and told us the member of staff was approachable and kept them informed of any changes.

Activities included games afternoons, discussion groups to aid memory, gentle exercise, quizzes, baking, gardening and arts and crafts. There was an activity co-ordinator employed to support people with activities of their

Good

Is the service responsive?

choosing, either in group sessions or on a one to one basis. Staff told us the activity co-ordinator will support people with activities on a one to one basis in the morning and organise a group session in the afternoon.

Staff told us trips were organised for people to the local factory outlet shop, places of interest and trips to the local pub in the village. Staff told us they were planning a trip on a canal boat in September and a recent fete had been organised to raise funds for this event. We were also told external entertainers visited every Monday.

Links had been built with the local church with the vicar visiting every three weeks. Some people had in the past attended weekly coffee mornings at the local church however this had recently closed. The activity co-ordinator told us they were now building links with a local community café and people were supported to go there instead on a weekly basis. From talking with the registered manager and the activity co-ordinator it was evident they were supporting people to be part of the local community.

On the first day of the inspection there were no individual records being maintained of the activities people were involved in and whether it had been positive experience for the person. Some people's care plans stated that they should be engaged in one to one activities. There were no records to evidence that this was taking place. On the second day the activity coordinator had introduced a record for each person, detailing the activities they had taken part in, since the first day of the inspection. These were comprehensive and demonstrated that appropriate action had been completed.

Information was made available to people about the service. This included a statement of purpose, a brochure about Cotswold House Care Home and what it has to offer including information about how to raise a complaint. These were available in the main entrance of the service.

There was a complaints policy and procedure. It contained contact details for the Care Quality Commission, Gloucestershire County Council and the management team. The policy outlined how people could make a complaint with a timescale of when people could expect their complaint to be addressed. Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been 3 complaints since our last inspection and these had been investigated thoroughly. People confirmed they could speak with staff or the registered manager if they were concerned. A visitor told us they would have no hesitation in going to the office, if they had any concerns. They told us they were happy with the care being provided and presently had no concerns acknowledging the recent improvements in activities and staffing levels.

Good

Is the service well-led?

Our findings

Since our inspection in April 2014 there has been a change of management in the home. A new manager was appointed in December 2014. They were successfully registered with us in July 2015 as the registered manager. People and their visitors were complimentary about the registered manager and the changes that had taken place. Comments included, "It is much better now, staff seem to want to be here" and "I have no hesitation in going to the office if I have any concerns and I know they will sort it out".

A visitor told us there was one area the home could improve which was to ensure the wheelchairs were fit for purpose and available for use. Systems had recently been introduced to ensure the wheelchairs were regularly checked with records being maintained of any maintenance. In addition the registered manager told us two new wheelchairs had been purchased. These were delivered the day prior to the second day of our inspection. This showed the registered manager listened to people and responded appropriately.

People and their families had opportunities to share their views on the way the home was run. Annual surveys were completed to gain the views of people who use the service. These were collated and an action plan developed to address some of the areas of concern. Of the thirteen people who had responded two people had stated the laundry was poor. In response, clearer guidance had been introduced to the housekeeping staff on laundering and relatives reminded of the importance of naming of clothes. The majority of areas in relation to staff, care delivery, food and the environment, most people had responded it was either very good or good.

Since the last inspection the registered manager had relocated the office so that this was accessible to both visitors and people who used the service. The office was now located by the front door. During the inspection we saw staff, people and their visitors actively seeking out the registered manager and the provider. All staff we spoke with said that the registered manager, the provider and the clinical lead were approachable and supportive to them. Staff confirmed regular staff meetings took place. Minutes were kept detailing the discussions and any agreed actions.

A member of staff said, "I feel confident in raising any issues". Staff told us they had confidence to question the practice of other staff and would have no hesitation reporting poor practice to the registered manager.

There was a staff structure which gave clear lines of accountability and responsibility. The registered manager was supported by a clinical lead and a care co-ordinator. There was always a senior care worker on duty to guide the care staff and a registered nurse. All staff wore a name badge and uniform which was colour coded to the role. Staff had job descriptions that defined their roles and responsibilities. Staff echoed the comments received from people and visitors that there had been recent improvements made to the quality of the service. One member of staff said, "I used to dread coming to work but now it is so different, the people and the staff make it all worthwhile" another member of staff said, "I have worked here for quite a while and now I enjoy coming to work, staff morale is better and everyone seems to care" and another said, "If you've got a good manager, it's like a good captain of the ship. I felt an immediate bond with the manager when she said 'this is not a business, this is a home".

The registered manager and the clinical lead had recently completed an accredited course on supporting people with dementia with Gloucestershire County Council. The registered manager had devised an action plan which linked with the training they had completed to improve the service for people who were living with dementia. This included ensuring activities and the environment were suitable for people. The activity co-ordinator showed us how they were planning activities for those people living with dementia including accessing materials from the Alzheimer's Society. They had recently completed a course on 'making activities matter' and were passionate about supporting the registered manager in making the necessary improvements.

The registered manager told us they had recently signed up for the 'Social Care Commitment'. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services which has been initiated by the Department of Health. There are seven key areas or tasks that the provider has to assess to ensure they are meeting the Social Care Commitment. The Registered Manager had reviewed the service and identified areas for improvement which detailed the actions required and the timescales.

Good

Is the service well-led?

The Registered Manager told us they members of the Gloucestershire Care Home Association. They attended regular meetings which enabled them to keep up to date with any changes in legislation or requirements. In addition they told us they regularly looked at relevant web sites such as Skills for Care and the social care institute for excellence (SCIE). This enabled them to keep up to date with changing legislation and practice. The information was shared with staff through team meetings.

Systems were in place to review the quality of the service. These were completed by the provider, the registered manager or a named member of staff. They included health and safety checks, a falls audit, medicines, care planning, training, supervisions, appraisals and infection control.

Where there were any shortfalls action plans had been developed. The falls audit monitored whether staff had taken the appropriate action to ensure the safety of the person and relevant professionals were involved.

The registered manager completed checks on accidents and incident reports to ensure appropriate action had been taken to reduce any further risks to people. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incident reports were produced by staff and reviewed by the registered manager. This included looking at any themes.

From looking at the accident and incident reports we found the registered manager was reporting to us appropriately. A notification is information about important events which the provider is required to tell us about by law.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with cross infection because some bathrooms and equipment were not being effectively cleaned. Regulation 15 (1)