Colten Care (1993) Limited

Castle View

Inspection report

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22 November 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 20 and 22 November 2018 and was unannounced. □

People living at Castle View receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to accommodate 57 people and specialises in providing care, treatment and support for older people. The service was split over three floors which were all accessible by stairs or a lift. There were 55 people using the service at time of inspection.

There was a strong emphasis on eating and drinking well. Staff had a good knowledge of people's individual dietary needs. A 'night owl menu' was available to people for snacks and light meals during the evening and overnight. There was a smoothie menu to increase people's nutritional intake. There were systems in place to carefully monitor people's nutritional needs.

Care and support was provided by staff who had received an induction and continual learning that enabled them to carry out their role effectively including. Staff training was tailored to meet staff member's individual training styles and ensure they were able to meet people's needs. Nurses were provided with opportunities to maintain and develop their clinical skills. Staff felt supported by the management of the service and were confident in their work.

There were champions in dementia care, moving and handling, health and safety and end of life care to help improve outcomes for people.

Technology was used to support care delivery. The provider had introduced a tool which looked at patterns for falls, wounds, accidents/incidents, safeguarding alerts and infections. This information was used to help determine quickly whether any changes were required in the support people receive.

People were protected from avoidable harm as staff received training and understood how to recognise signs of abuse and who to report this to both internally and externally if abuse was suspected.

Staffing levels were adequate to provide safe care and recruitment checks had ensured they were suitable to work with vulnerable adults. Registered nurses had the necessary permissions to practice.

Risk assessments were individual and detailed which meant that staff understood safe practices which helped keep people safe.

Medicines were administered and managed safely by trained and competent staff. Medication stock checks

took place together with regular audits to ensure safety with medicines.

People knew their responsibilities about the prevention and control of infections within the service. Staff had received training and there was protective equipment readily available.

People had been involved in assessment of their care and support needs. They had their choices and wishes respected. The service worked well and in partnership with professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The registered manager actively sought to work in partnership with other organisations to improve outcomes for people using the service.

People, their relatives and professionals described the staff as kind and caring. People had their dignity and privacy respected and their independence promoted.

People had their care needs met by staff who were knowledgeable about their individual needs and how they communicated.

The service had a complaints procedure and people were aware of it. People knew how to make a complaint. The service actively encouraged feedback from people and this was used in making changes and improvements.

A variety of activities were available and people could decide what they wanted to do. The service actively encouraged people to be involved.

Relatives and professionals had confidence in the service. The home had an open, honest and positive culture that encouraged the involvement of everyone.

Leadership was visible within the home. Staff spoke positively about the management team and felt supported. The registered manager and clinical lead actively kept themselves updated.

There were effective quality assurance and auditing processes in place and they contributed to service improvements. Action plans were completed and those responsible kept things up to date.

The service understood their legal responsibilities for reporting and sharing information with other organisations.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff available to meet people's care and support needs. Staff had been recruited safely.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

Medicines were managed safely, securely stored, correctly recorded and only administered by staff that were trained and competent to give medicines.

People had their risks assessed and actions were in place to reduce the risk of avoidable harm

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Outstanding

The service was very effective.

Staff received comprehensive training and supervision and they were confident in their role. Training was tailored to meet individual staff members needs.

There was a strong emphasis on eating and drinking well. Hot food was available during the evening and overnight. Staff had a good knowledge of people's dietary needs. There were measures in place to carefully monitor people's nutritional needs.

People were supported in line with the Mental Capacity Act 2005 which meant their rights were upheld

The provider used real time technology to monitor any themes in areas such as falls, wounds, accidents or infections. This helped staff to respond quickly to determine whether any changes were required in the care and support people received.

The premises met people's needs and they were able to access different areas of the home freely.

The service worked well with health professionals and people had access to services when they needed them.

Is the service caring?

Good

The service was caring.

People were supported by staff that treated them with kindness and respect.

Staff had a good understanding of the people they cared for and supported them to make decisions about their care.

People were encouraged to be independent.

There was a relaxed and friendly atmosphere in the home.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who had a person-centred approach to deliver the care and support they required and understood their communication needs.

People were supported to access the community and take part in activities within the home.

A complaints procedure was in place and was effective, people knew how to complain.

People's end of life preferences had been discussed and plans were in place.

Is the service well-led?

Good

The service was well led.

The management team promoted inclusion and encouraged an open environment.

The home worked well in partnership with other agencies and professionals.

Quality assurance systems were in place which ensured the management had a good oversight of the service.

Positive feedback was received about the leadership of the home.

The home was continuously working to learn, develop and improve.	

Castle View

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 site visit took place on 20 November 2018 and was unannounced. The inspection was carried out by one inspector and a specialist nurse advisor on day one. It continued on 22 November 2018 with one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience related to older people and people living with dementia.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 11 people who used the service and three relatives. We spoke to the registered manager, clinical lead, clinical manager, training and development partner, companionship team leader, nine staff and two health and social care professionals.

We reviewed eight people's care files, four medicine administration records, policies, risk assessments, health and safety records, consent to care and quality audits. We looked at four staff files, the recruitment process, complaints, training and supervision records.

We walked around the building and observed care practice and interactions between care staff and people who live there. We used the Short Observational Framework for Inspection (SOFI) at meal times. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the registered manager to send us information after the visit. This included policies and the staff training record. They agreed to submit this by 23 November 2018 and did so via email. The registered manager also sent us a copy of a recent quality monitoring report carried out by local commissioners.

Good

Is the service safe?

Our findings

People felt they were safe living at Castle View. Staff were confident that people were safe and well cared for. Risk assessments, policies, audits, quality assurance and support systems were in place. People's comments included: "I do feel safe here", "I feel safe here, my things are secure nothing goes missing", "I do feel safe here, I was very giddy at home, this home is much better for me", I feel safe there is always so many people around". A relative told us, "My loved one is very safe here, as are their possessions".

People received their medicines safely. The service had safe arrangements for the ordering, storage and disposal of medicines. Staff responsible for the administration of medicines were all registered nurses and had their competency assessed by the clinical lead. Medicine Administration Records (MAR) had a photograph of the person, their medical conditions and allergies. Nurses cross checked people's medicines with their MAR to ensure the correct medicine was given to the correct person at the right time. MAR's were completed correctly and audited. Medicines that required stricter controls by law were stored correctly in a separate cupboard and a stock record book was completed accurately. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way. The home used body map diagrams to indicate where prescribed creams should be applied.

The service had enough staff to meet people's needs. The registered manager told us they would adjust the staffing levels as needed. Feedback from staff, people and relatives was considered by the registered manager when assessing staffing levels. The home had recently increased its waiting staff to support mealtimes. A person told us, "I do not feel rushed in any way". Another person said, "There are enough staff. I press my call bell and they come promptly". A staff member told us, "We have enough staff, we can give quality time". A relative told us, "There are enough staff, I can always find my loved one's nurse". Where people were unable to use call bells devices were used to alert staff when people moved. Call bell audits were undertaken and analysed and resulted in increases in staffing at certain times to support people at risk of falling.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as references, health screening and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people. There was a monthly check with the Nursing and Midwifery Council to ensure registered nurses remained eligible to practice.

Staff were clear on their responsibilities with regards to infection prevention and control and this contributed to keeping people safe. All areas of the home were tidy and visibly clean. The home employed housekeeping staff. A relative told us, "It's clean here, they redecorate and clean carpets". We observed staff changing gloves and aprons throughout the day. There were gloves and apron supplies in various places throughout the home. Staff received training in the prevention and control of infection and could tell us their responsibilities. The registered manager did regular hand washing observations and records showed staff

could demonstrate the correct technique. A person told us, "The home is kept very clean, they are always cleaning". A professional said, "Castle View always seems very clean, I have no concerns about hygiene there".

The home had received the highest Food Standards Agency rating of five which meant that conditions and practices relating to food hygiene were 'very good'.

Staff demonstrated knowledge of recognising the signs and symptoms of abuse and who they would report concerns to both internally and externally. Records showed all staff had received safeguarding training and updates. There was a poster in the staff room giving the telephone numbers and instructions on how to report abuse. A staff member said, "People may not engage with you, may be nervous or have bruises. I would tell the manager or the safeguarding team". The registered manager was clear of the home's responsibility to protect people and report concerns. A professional told us, "I've never had any safeguarding concerns about Castle View and the nurses all seem very competent".

Accident and incidents were all recorded by the registered manager and the clinical lead. This was then shared with the clinical manager through the home's live reporting system. This meant that all accidents and incidents could be analysed in a timely manner. Actions were taken and lessons were learned and shared amongst the staff through daily and monthly meetings. An example of this was where a person's health had deteriorated rapidly and they had fallen. The home had sought medical input promptly and medication was prescribed. This person's observations were increased for a short period and they recovered. This action helped to reduce the likelihood of reoccurrence of the fall. The clinical manager reviewed the records each day and contacted the home if they wanted to request further actions be carried out.

Risk assessments were in place for each person for all aspects of their care and support along with general risk assessments for the home. The risk assessments were reviewed regularly, or as things changed, and staff had access to them each day when delivering care. A senior nurse told us, "We keep people safe because we update their risk assessments and do audits". The home had created a new falls risk assessment which recorded the actions taken for a person following a fall. Examples of actions following the fall were, updating care plans and risk assessments, ordering of equipment and increases to staffing levels.

Environmental risk assessments were in place which assessed risks in the home such as heating, hot water and equipment. The home had a maintenance lead who supported health and safety within the home and carried out various visual and maintenance checks. The home used an external company who provided a full home health and safety audit each year. All electrical equipment had been tested to ensure its effective operation. The registered manager completed a daily visual check of the building. The home had a health and safety champion, this was a member of staff with an interest in health and safety. This member of staff had received additional training in health and safety and worked with other staff to ensure staff were working safely. People had personal emergency evacuation plans (PEEP) which told staff how to support people in the event of emergencies such as flooding or a fire. All staff had received fire safety training by an external fire safety company.

Outstanding ☆

Is the service effective?

Our findings

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

The home met the requirements of the MCA. Assessments had been carried out for people to determine their capacity to make certain decisions. When people had been assessed as lacking mental capacity the home had held best interest decision meetings which involved the person, family members and medical professionals. The service had documentation for assessment and planning for those who lacked capacity which demonstrated people's rights were protected. Staff had received MCA training and were able to tell us the key principles of the act. Staff records showed training had been completed. A staff member told us, "You cannot assume people do not have capacity. We support them [people] to make decisions and act in their best interests". We spoke with staff whose knowledge of MCA and safeguarding was in depth.

Consent to care was sought by the service from those that had capacity and this included consent for photographs. People's records showed signed consent for care or decisions made in people's best interest if required. A person told us, "The staff do seek my consent". Another person said, "The staff do ask my consent, they knock on my door before entering".

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The home did not have any authorised DoLS at the time of inspection. The registered manager and clinical lead understood the MCA and applications made under DoLS had been completed where necessary.

The home had an induction for all new staff to follow which included shadow shifts and practical competency checks in line with the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Many of the staff told us they held or were completing the Care Certificate and national health and social care diploma's which were supported by the home. Staff training was tailored to meet staff member's individual training styles and ensure they were able to meet people's needs. Some staff had been given an opportunity to apply for a nurse associate course at Solent University. The provider told us all staff have attended a dementia awareness training and that in addition to this the home has its own dementia champion who has a particular interest in this subject. They told us they support staff, people and relatives through their regular dementia friend's sessions. The registered manager told us they were keen to develop people.

Staff received training and support needed to carry out their role effectively, they told us they felt confident. Staff received training on subjects such as safeguarding, dementia, infection control and fire safety. The

home had many 'champions', these were staff with a special interest in a care related subject. The champion then kept up to date with best practice and had additional training this was then communicated to the rest of the staff team. The home had champions in a variety of subjects such as, health and safety, dignity and end of life care. We spoke with two staff who had received training to become 'ergo coaches', they supported staff and promoted independence of people by looking at movement. A staff member told us, "I have requested clinical training and it has been booked". Another staff member said, "We have lots of training".

Registered nurses were aware of their responsibilities to re-validate with their professional body, the Nursing and Midwifery Council (NMC). Nurse re-validation is a requirement of qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date. The registered manager and clinical lead were supporting their nurses to achieve this through reflective learning and development sessions arranged at the home and external training and events. Seven staff had received training in verification of expected death.

Staff told us they had regular supervision and appraisals. The home had a supervision process called 'All about us'. This helped the staff reflect on their practice. The process asked staff to detail what they have learned since the last meeting, the impact on them and people they care for, the actions they have taken. Staff felt these were positive experiences and that they were a two-way process. Records showed they were completed between the registered manager, clinical lead and staff. A staff member told us, "We get lots of praise. We have good feedback". Another staff member told us, "We feel appreciated and the nurse always thanks us after each shift. It makes it all worthwhile".

People's needs and choices were assessed and care and support was provided to achieve effective outcomes. People had individual care plans for each aspect of their needs, some examples were; personal care, moving and handling, communication, eating and drinking and pain management. Records showed people were involved in these plans and their choices were reflected. The provider told us they have introduced a real time management information tool which looks at patterns for falls, wounds, accidents/incidents, safeguarding alerts and infections. They told us as a result the home benefits from timely support of their clinical and quality managers as well as the opportunity to view instantly see if a new event is part of a trend or pattern for the individual resident concerned. This innovative and responsive system promotes the health and wellbeing of the residents by supporting the home to understand their individual needs and respond to them in a timely and evidence-based way. The provider told us improvements had been made to the television signal, shower room and flooring in response to people's feedback.

People were supported to eat and drink enough and gave positive feedback about the food. People were involved in the home's menu and were asked each day what they wanted to eat on the following day. We observed staff supporting people to eat and drink by giving various levels of support. Staff had a good understanding of people's needs regarding food intake and special diets. People had input and assessments by Speech and Language Therapists (SALT) and their instructions were being followed. The provider told us they had a nutritional needs tracker for each person, they said this enables them to see if people are losing weight. They said they take extensive action to manage the risk of malnutrition. The chef told us they were aware of all the special diets and requirements and told us about a person's needs in regards their recent weight loss. There was a whiteboard in the kitchen which was updated when people's needs changed. The chef said they can accommodate any requirements at all and told us, "We always try and say yes, this is their home". The chef had a good knowledge of people's needs. They showed us a folder which listed each person's nutritional needs they told us they could refer to this if needed. Changes in people's needs were updated in the folder. The chef told us they meet with each person within 24 hours of

admission to the home to discuss their preferences. There was a menu of smoothie's and milkshakes, some lighter options and those with higher calories to support weight gain or as a treat. A 'night owl menu' was available to people for snacks and light meals during the evening and overnight. One person told us, "The chocolate smoothie is my favourite". People and their relative's comments about the food included: "Before I came here I had lost a lot of weight, so they leave me a sandwich in my room should I feel hungry in between meals", "I do like the food here, they make me what I like", "The food is very good here, always a good choice of main course and desserts", "Tea, coffee and snacks are brought round mid-morning and afternoon".

Following our findings during our inspection May 2016 the home had made changes to the dining room experience to ensure it was not rushed. We observed the meal time to be a calm and relaxed social occasion with people having various discussions between themselves and with staff. People could choose what time and where to eat their meal. People were coming and going from the dining room over the lunchtime period. Food looked appetising and plentiful. The home employed waiting staff who attended to people's needs in the dining room this meant care staff were free to support people with their meals. There were positive interactions between waiting staff and people. A selection of drinks was available both alcoholic and non-alcoholic and these were offered to people throughout their meal. There were fresh flowers and condiments on the tables. Tea and coffee was served at the end of the meal.

People were supported to receive health care services when they needed. All records seen showed evidence of regular health care appointments and medical or specialist involvement. The registered manager and clinical lead said they worked well with medical professionals and were comfortable seeking their input when needed. A person told us, "The doctor comes to see me here if I need one at any time". A relative said, "They call the doctor out in a timely manner and they always call us". A professional told us, "Staff give the people their best attention. They always ask us for visits appropriately and promptly. They call us back if people are not improving". The home ensured effective communication with hospitals and used the 'Dorset Red Bag' scheme which is a local scheme which improves communication between care homes and hospitals when care is transferred. The service had access to an Admiral nurse, who are specialists in dementia. When a person was experiencing an increase in anxiety the home referred to the admiral nurse who completed an assessment and gave support to the person, family and staff. The provider told us the home was involved in a trial with GP, Consultant and Community Matron to improve communication between services, early recognition of conditions and escalation of treatment and has initiated a direct referral pathway to other professionals. The nurses in the home report that they use the service 'at least weekly' and found it very valuable.

The home was on three floors and there was access to three lifts. There were various lounges on each level. The home had a hairdressing salon and peoples own hairdressers visited and made use of the facilities. There was easy access to the garden where the provider told us events and activities took place. There were quiet lounges for people to hold private parties, wakes and visits from local churches. There was a café which the registered manager told us enables people to meet with family and friends. The provider told us the home has a memory garden where residents can sit.

Good

Is the service caring?

Our findings

People, their relatives and professionals thought staff were kind and caring. One person told us, "The staff are caring towards me, very supportive". Another person said, "Staff here are very nice and helpful". Relative comments included: "They are very kind, caring and patient. It's like they have all the time in the world", "Staff are efficient and extremely helpful". "They [staff] are marvellous".

People were treated with dignity and respect. We observed many respectful interactions. Staff were attentive to people when they asked for them. People told us staff treated them with dignity and respect and their comments included: "The staff are always very respectful towards me, they call me by my first name", "The staff protect my dignity, they are very careful like that", "The staff do treat me with respect, always". A relative said, "They always look after my loved one's dignity when caring for them". Staff members told us they knew how to show dignity and respect to people. A staff member said, "Dignity, it's important to me. It's the biggest value you have to follow as a health care assistant". Another staff member said they achieved this by "Using the persons preferred name, offer choices and give privacy". There were two dignity champions identified in the home to support people's dignity.

People's cultural and spiritual needs were respected. People's cultural beliefs were recorded in their files and they were supported to attend religious services which visited the home monthly. The home had recently held a service of remembrance to honour those lives lost during conflict. The activity planner and photo books showed most festivals were celebrated at the home and were well attended. One person said, "The thing that impressed me was holy communion, it's the busiest I have seen the lounge".

People told us they were happy with the care they received. Comments from people and their relatives included: "Staff are always around and nothing is too much trouble", "It has a nice homely feel to it". "They do their best". "It's so nice and not like a nursing home". "The staff know how my loved one likes things done, they are always well turned out when I visit". "They help my loved one with no fuss". Staff were proud to work at Castle View and told us, "It's a fantastic workplace". Another staff member told us, "I love it, staff are really friendly and the residents are fascinating".

There was a welcoming, fun yet relaxed atmosphere in the home. We observed care and companion staff spending time with people individually and in groups in the lounge and dining areas. People and staff were playing a word game in the lounge. The member of staff could attend to everyone in the room, answering questions, giving reassurance, offering snacks and this was supported by other staff who came and left throughout. A professional told us, "I think the care at Castle View is excellent".

People were encouraged to be independent, have their individuality respected and were encouraged to make decisions about their care. People and their relatives were as involved as they could be in their care. Staff had received training in equality and diversity and a staff member told us, "We support people to be whoever they want to be". Records showed input from the person, their family and professionals. People and their relatives told us: "They encourage my loved one to keep independent", "I needed so much help and they worked with me and I was involved all the way". "They encourage my loved one to be

independent".

The service had received many compliments about the care they gave. These included: 'You were all without exception, kind considerate, welcoming and supportive. You made such a difference'. 'I enjoyed my stay at Castle View, everyone was so kind to me'. 'Your friendliness, smiles and excellent care was exemplary and put our minds at peace knowing our loved one was in good hands'. 'Thank you everybody for looking after me so beautifully'.

People were supported to maintain contact with friends and family and visitors were welcomed into the home. WiFi was available and video conferencing was available. The provider and staff created a video where staff were pictured holding up cards stating why they were proud and what they enjoyed about doing their job. The video featured a couple of relatives who gave their views on the home. This video played in the reception area of the home. The provider told us this supported the staff to feel valued.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. There was a system for review in place and records showed this was monthly. However, the home had an ongoing care review form which had not been completed as stated. We spoke with the registered manager and the clinical lead who told us this would be discussed with the nursing team at the next meeting. The clinical manager told us they had created a new checklist for the ongoing care reviews for people and their families. This checklist would record all reviews relating to a person's care and would become part of their review process. Life histories contained information that was important to people. A relative told us, "I am involved in my loved one's care plan, it gets updated. We go through it together with my loved one and I explain it all to them". Plans were personalised and relevant to the person. This meant people were receiving the care that was important to them and met their individual needs. A professional told us, "They know their residents well. They have all of their information well organised and accessible to answer questions regarding their care".

People told us that there were a lot of activities inside and outside of the home. The home had a variety of activities for people to enjoy and had photo books of past events on display in the home's entrance. The home produced a monthly plan of activities. The home employed 'Colten companions', they were staff who supported people to enjoy activities within the home and access them outside. People and relatives' comments about the activities were: "They have a lot of activities within the home". "I like the activities here, I am very sociable". "There are lots of activities, we like armchair yoga and the musicians that visit. "We recently had a dog show, it was marvellous, it was super, what a lovely day". "I like the keep fit sessions". A professional told us, "There always seem to be lots of varied activities going on at the home including trips out and craft activities". The home had the use of a minibus for trips out each week. A person told us, "If you want to go out then you just put your name down, we have been for a pub lunch before".

The Colten companions arranged both group and individual one to one activity sessions for people. Colten companions were available seven days a week. The Colten companions prepared a monthly timetable following resident's meetings and feedback from people. Each person received a calendar for the coming months activities, on the reverse was a feedback form, we saw these had been completed by some people. On the first day of inspection the home was visited by a preschool class of children who sat in the lounge with people and listened to a story. The people in the lounge were enjoying the children with a person telling us, "They are wonderful". Another person said, "We love having the children, every time they come in they do something different". People were laughing as the children joined in with the story and then everyone joined in with a singsong. The registered manager told us that they were very keen to build on their links with the local school.

The home had a 'resident of the day' which happened once a month for each person. On this day the person was the focus. The person could give their 'wishes' to the staff, they chose what they did for that day, what they had to eat and it was an opportunity for the nurses to review their care plans. The home had photograph books in the main entrance showing people's wishes and chosen meals. People's wishes were as simple as having a coffee and a chat with a member of staff to an outing to a museum or out for dinner. People told us they enjoyed their 'day', some of the comments we received from people and their relatives

were: "I always choose my favourite meal", "They always try to meet the residents wishes, it's brilliant", "I like to have my nails done, it makes you feel like a human being".

The heads of each part of the home met each morning for the ten @ ten meeting. The meeting included; the chef, housekeeping, reception, Colten companions, nurses, clinical lead and registered manager. This was an opportunity to give an update on their area of the home. Individual people's needs were discussed, people's birthdays and the wishes of 'resident of the day'. The registered manager told us it was so important to get together each day and have this meeting across departments. It meant that the head of department could then communicate to the rest of their team any updates or important information regarding people's needs. An example of how the meeting improves care for people was, the housekeeping department reported that they had found food on the floor in the dining room. This meant that a person was not eating properly. Records had shown the person was losing weight, waiting staff thought the person was eating well but had discovered at this meeting that this was not the case. The registered manager and clinical lead could speak with the person and staff and made a few simple changes which meant the person was now enjoying their food.

People knew how to make a complaint and the service had a policy and procedure in place. Records showed that complaints were dealt with within agreed timescales and actions had been carried out to people's satisfaction. A person told us, "If I had a concern I would talk to a carer or a nurse". Another person told us, "I would talk to the manager but I don't have any problems". A relative told us, "If I needed to, I would talk to the registered manager [name], but I have never had to".

The service met the requirements of the Accessible Information Standard (AIS). This is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The service had considered ways to make sure people had access to the information they needed in a way they could understand, to comply with the AIS. Each person had a communication care plan. We observed staff supporting people to communicate by writing on a pad for the person to read, this was appreciated by the person as they thanked the member of staff. Each person had a communication care plan. Where a person wore glasses', or used a hearing aid the service had included a photograph of those so they could be identified should they misplace them. We observed staff supporting people to communicate by writing on a pad for the person to read, this was appreciated by the person as they thanked the member of staff

At the time of the inspection no one at the service was receiving end of life care. People's individual end of life wishes were recorded by the service in their care plan. Some people had made advanced care plans and these were reviewed monthly. The registered manager, clinical lead and clinical manager told us the provider had created an 'end of life strategy'. The strategy was a plan of the standards of care people should expect to receive at the end of their life. The strategy included continual learning by discussing the care given following the person's passing. This process included talking about what had gone well and what could be improved. Records showed this had been discussed and actions taken forward. The home wanted to look after the person and their families, including after their loved one had passed. The home held a 'celebration of life' event each year to remember those who had passed away. The registered manager said that families are always invited and people join in with the event.
The home had an end of life champion, this was a member of staff with an interest in end of life care. They told us they were passionate about care at the end of life, they said, "It's a privilege to be involved, they trust me to do the job". The champion had received additional training in this area of care and was able to support the other staff with end of life care. The clinical lead attended an end of life discussion group to talk and share best practice in end of life care. There were many compliments about the service regarding the end of life care and support provided by the home, these included: 'Thank you for the love and kindness

shown to our loved one by all the staff at Castle View. It was a comfort to know they were so well cared for. Thank you for the way in which we, their family were looked after during their final hours and after they had passed away'. The home had received accreditation for end of life care.

Good

Is the service well-led?

Our findings

There was a registered manager in post. 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.

The provider had a clear vision for developing the service which was supported by the registered manager and clinical lead. The provider had a set of values which were, friendly, kind, individual, reassuring and honest. A staff member told us, "We try and remember the values with everything we do".

The registered manager had created an open working culture and told us, "We have some fantastic staff". Staff, relatives and people's feedback on the management of the home was positive. Staff felt supported. The comments included: "They are good leaders, very approachable". "The registered manager [name] gives me reassurance". "The home is well managed". "The home runs smoothly".

The home sought people's feedback and involvement through meetings and minutes of those meetings were made available. The home had conducted various surveys with people and their relatives. The most recent survey results showed that satisfaction of the home was rated 'good or excellent' by 100% of people. The results were analysed and action plans created. The home displayed the results of their survey in the main entrance as 'You said, we're doing'. An example of this is a person said they do not have an opportunity to feedback to the manager, the home responded with, changes have been made to the 'resident of the day' experience to include a visit from the registered manager. The home asks people for feedback within the first 48 hours this is called 'first impressions'. The registered manager told us, "If you get things right from the start then problems are unlikely to develop". Staff meetings provided staff with an opportunity to suggest new ideas.

The service had made links with various community organisations such as local schools, churches, day centres and charitable organisations. People and staff had been involved in fundraising and held various events through the year more recently a dog show. The registered manager told us they choose a different charity each year, this year the home is raising money for hearing dogs to support those living with a hearing impairment.

Learning and development was important to the management of the service. The registered manager and clinical lead had attended regular registered manager network meetings, learning hubs, care home provider forums, clinical conferences and used online guidance and nursing publications to keep updated. The provider held a nursing conference which was attended by nurses from the home. The conference was arranged to share best practice and receive updates.

The registered manager understood the requirements of the duty of candour. That is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They confidently told us the circumstances in which they would make notifications and referrals to external

agencies and showed us recent records. The registered manager and clinical lead told us they were supported well by the provider.

Quality assurance systems were in place to monitor the standard of care provided at the service. Audits reviewed different aspects of care and actions were taken to make any improvements that had been identified. Systems were in place for learning and reflection. The registered manager completed a daily check of the building while delivering newspapers for people. The registered manager had a checklist which they completed and if there were any actions or concerns this would be discussed at the daily ten @ ten meeting. The registered manager and clinical lead had completed various audits such as food, daily care records, falls, accidents, incidents and health and safety. We saw accident reports and changes to care plans in response to this. This was recorded onto the live system which meant it could be monitored by the clinical and quality managers and was discussed during monthly clinical governance reviews.

The service had good working partnerships with health and social care professionals. The professionals we spoke with told us they had a good relationship with the managers and staff. A variety of professionals visited the home during our inspection, such as, specialist diabetes nurse and a speech and language therapist. These partnerships were evident in the feedback from people and the record of visits in their files.