Mr & Mrs K A Ackrill

Kelso Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 1 December 2017 and was unannounced.

Kelso Nursing Home is a 'care home'. People in care homes 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 care home accommodates 12 people in one detached building. There were 10 people living there at the time of our inspection. Bedrooms are situated on the first floor with two on the ground floor and there are four rooms which could accommodate two people. The first floor is accessed via a main staircase or a lift. People have access to a communal lounge and dining area and accessible rear garden. People had a variety of care and support needs related to their physical and mental health and most were unable to speak with us to tell us their views.

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.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

Staff had worked at the service for many years and this meant that they knew people extremely well. Interactions were kind and tactile and relatives told us that they had peace of mind that their loved ones were receiving safe, compassionate care.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care.

People were supported to make choices about all areas of their support and staff understood the principles of mental capacity. Where decisions were needed in people's best interests, these were in place.

People were supported to have enough to eat and drink and there were systems in place to ensure that any concerns around weight loss were monitored. People's preferences for meals were well known and choices were offered if people did not want the meal provided.

People preferred to spend time in their rooms, but there was access to more open areas to spend time with family or other's if people wanted to use these. Infection control measures were in place and monitored to ensure that people were living in a safe environment.

People and those important to them were involved in planning the support they would receive and also regularly asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People and those important to them were supported to make decisions about end of life care.

People were supported by staff who respected their individuality and protected their privacy. Staff understood how to advocate and support people to ensure that their views were heard and told us that they would ensure that people's religious or other beliefs were supported and protected. Staff had undertaken training in equality and diversity and understood how to use this learning in practice.

People were supported to have one to one time with staff in social activities which were meaningful to them. Visitors were welcomed at the home and kept up to date about how their loved ones were.

Staff were confident in their roles and supported by the registered manager who also worked on the floor. The registered manager was approachable and available to people, staff, relatives and professionals.

Quality assurance measures were used to highlight whether any changes to policy, processes or improvements in practice were required. We were given examples where feedback had been used to drive and sustain high quality at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who understood the risks they faced and how to manage these.

People were protected from the risks of abuse because staff understood their role and had confidence to report any concerns.

People were supported by staff who had been recruited with appropriate pre-employment, reference and identity checks.

People received their medicines as prescribed.

Infection control measures were in place and monitored to ensure that people were living in a safe environment.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about the people they were supporting and received relevant training for their role.

People who were able to consent to their care had done so and staff provided care in people's best interests when they could not consent.

People enjoyed a choice of food and were supported to eat and drink safely.

People were supported to receive joined up care and support from healthcare professionals where needed.

Is the service caring?

Good

The service was caring.

People received compassionate and kind care.

Staff knew how people liked to be supported and offered them appropriate choices.

People and their relatives were listened to and felt involved in making decisions about their care.

People were supported to maintain their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People were cared for with compassion at the end of their lives.

Is the service well-led?

Good

The service was well led.

People, relatives and staff had confidence in the registered manager and felt they were approachable and helpful.

Staff felt supported and were confident and clear about their roles and responsibilities within the service.

Quality assurance measures provided oversight and enabled the service to identify good practice and areas for further development.

Feedback was used to highlight areas of good practice or where development was needed. Information was used to plan actions and make improvements.

Kelso Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 December 2017 and was unannounced.

Before the inspection we reviewed information we held about the service. We reviewed information the provider had included in their 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 plan to make. In addition we looked at notifications which the service 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 also spoke with local commissioners to obtain their views about the service.

During the inspection we spoke with one person who used the service and four relatives. We also spoke with three members of staff and the registered manager. We spoke with one professional who had knowledge of the service.

We looked at a range of records during the inspection. These included four care records and three staff files. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments and staff training records.

Good

Is the service safe?

Our findings

Relatives told us that the service received by their loved ones was safe. One relative told us "I have peace of mind, I know (name) is safe." Another explained that they knew their loved one felt safe with staff because "(name) seeks their (staff) hand for reassurance which is a good sign". We observed a member of staff supervising a person who was anxious about walking. They offered verbal reassurance and encouragement and also gently rubbed the persons back as they walked to let them know they were behind them.

People were protected from the risks of abuse because staff understood the types of potential abuse and were confident to report. A staff member explained that they would be aware of "agitation if this was unusual, or changes in behaviour or demeanour". Because staff knew people well, they felt that they would be able to pick up on any subtle changes in how people presented as well as consider any physical signs such as bruising. The home had a safeguarding policy which provided contact numbers for external agencies including the local authority, Clinical Commissioning Group and CQC.

People were supported by staff who understood the risks they faced and their role in managing these. One person was at risk of developing pressure sores and had a risk assessment in place which was reviewed monthly. This gave details of pressure relieving equipment and topical creams which were used to prevent the person's skin from breaking down. The person was assisted to change position regularly and where an area of sore skin had developed, the risk assessment had been updated and wound charts completed to closely monitor and dress the wound. At the time of inspection no-one had any pressure sores and the registered manager spoke about the importance they placed on prevention of pressure sores as well as close monitoring if any pressure sores developed.

Staff had access to enough suitable equipment to assist people safely. This was maintained regularly and also audited to ensure that there were no safety concerns. For example, slings required to hoist people to move safely were monitored to check stitching was not loose or fraying.

There were enough staff available to meet the needs of people and the registered manager explained that they considered whether they were able to meet people's needs and had rejected some potential placements at the home if they felt that they would be unable to meet the persons needs safely with the staff they had available. We observed that staff had time to spend one to one with people and this promoted people's wellbeing. The service also employed cleaning and kitchen staff to ensure the service ran effectively.

A relative told us that when they used the call bell in the room of their loved one "they(staff) come immediately". We observed that when other call bells were used, these were answered without delay. Staff were consistent and people got to know them well. A relative explained that the stability of staff had been one of the reasons they had felt the home would provide safe care for their loved one and explained "staff have been here for 10-12 years…couldn't be bad".

Recruitment at the service was safe with appropriate pre-employment checks in place. A staff file included

references from previous employers, identification checks and application forms. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. There had not been any recruitment at the service in the past year and some staff had worked at the service for over 30 years. A staff member took the lead role in safe recruitment of staff and had a process in place to ensure that checks were made and documentation in place before staff started at the home. The registered manager told us that they had a full and stable staff team and placed a strong emphasis on the positive impact this had on the people living at the home and the safe level of care they provided.

Fire evacuation procedures were in place and each person had a personal emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks of the fire alarms, fire doors and fire safety equipment. The registered manager explained that they had service plans in place to cover amenities at the home which meant that any issues could be resolved quickly.

Accidents and incidents at the service were reported and used to identify patterns and trends and take actions where appropriate. Any accidents were audited monthly and considered any patterns to the times or circumstances around the incident. One person had fallen in their room and action had been taken following this to use a pressure sensory mat which could alert staff if the person tried to mobilise without assistance. Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Monitoring of incidents included the facility to identify any areas for development and lessons learned.

People received their medicines as prescribed. We observed people receiving their medicines and saw that these were administered safely and in ways which were appropriate for people. For example, one person required medicines to be in liquid form. Staff explained what the medicine was for and after measuring this into a pot, administered it in several spoonfuls as this was easier for the person to swallow. Some people had medicines which were prescribed 'as required'. We observed that people were asked whether they wanted this medicine and each 'as required' medicine had a form which provided staff with information about why the medicine was needed and how to observe whether a person required this if they were unable to verbally communicate this to staff.

The service had safe arrangements for the ordering, storage and disposal of medicines. Staff responsible for the administration of medicines had undertaken training and had their competency assessed. Medicines that required stricter controls by law were stored correctly in a separate cupboard and records kept in line with relevant legislation. We looked at the medicines administration records (MAR) for three people and saw that all medicines had been recorded accurately with no gaps in the MAR. Some people had prescribed creams which staff supported them to apply. Again there were body maps in place indicating where creams needed to be applied.

People were supported in an environment which was kept clean and safe with regular monitoring checks and cleaning. There were cleaning schedules in place to ensure that all areas of the home were kept hygienic and people were protected from the risk of infections. Availability of suitable personal protective equipment (PPE) such as gloves and aprons was monitored to ensure there were sufficient supplies and all staff had received training in infection control. The service had an infection control policy which had been reviewed in May 2017 and was in line with national best practice guidance. It included guidance around the use of PPE, handwashing and food hygiene. All staff had received food hygiene training and we saw appropriate use of PPE during our inspection. The registered manager held a lead role in infection control and carried out regular audits which monitored all areas of the home and ensured that any outbreaks of

infection were appropriately reported and managed. There had been no outbreaks of infection in the 12 months prior to our inspection.

Good

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 majority of people were able to make decisions and staff sought consent from people before providing them with support. Staff explained to people what they were doing and asked permission before giving personal care and respected peoples wishes if they refused this. Staff had received training in mental capacity and understood the principles of assuming capacity and enabling people to make decisions for themselves wherever possible.

Where people lacked capacity to make decisions about specific areas of their care and treatment, MCA and best interests were in place. Assessments of capacity were specific to particular decisions people needed to make and evidenced how people had been supported to try to make these decisions before considering MCA. Where one person had lacked capacity to make decisions about taking their medicines, they had a comprehensive MCA and best interests decision which considered the values and beliefs of the person and also the views of their relative which was in line with good practice guidance.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

No-one at the home required an application for consideration of DoLS at the time of inspection but the registered manager understood their roles and responsibilities to make applications to the local authority if this was necessary.

Staff understood how to offer people choices in ways which were meaningful to them. For example, one person was able to make choices but had limited verbal ability to communicate these with staff. We observed that staff asked them closed questions so that the person was able to verbally express their choice. A staff member explained how they visually offered another person a choice of what they wished to wear as this enabled the person to make a choice.

Before moving into the home, people had their needs comprehensively assessed and views of loved ones were also considered to ensure that the home would be able to effectively meet people's needs. The service had accepted a person into the home in the week prior to the inspection and we saw that they had been visited and assessed before plans had been made about the person moving. The pre-admission assessment included details about how the person communicated, what level of support they needed from staff and

considered whether the person had a preferred gender of staff to support them. Staff told us how people would be treated with respect and not discriminated against on grounds of religion, gender or race. The pre-assessments were used as basis to develop care plans for people and for the recent admission to the home, we saw that their care plan was in the process of being completed as staff got to know the person and were able to effectively plan a person centred approach to their support.

Staff had the appropriate qualifications, skills, knowledge and experience to provide effective support to people. Each shift had a skill mix which included a trained nurse who had responsibility for administering medicines, and two care staff. This was reflected at night when a trained nurse and one member of care staff provided support for people.

There had been no new staff at the service for over a year but we saw that there were induction processes in place which included competency checks and identifying strengths and areas for development for new staff. A staff member explained that they supported staff to develop in areas. where they had a prior interest or skill wherever possible. For example, if a staff expressed an interest in end of life care, then this would be encouraged and supported with training. Inductions also included shadowing of other staff to ensure that people were introduced and got to know new staff as well as supporting new staff to feel confident in their role.

Staff received training in some areas which the service considered essential and had opportunities for other learning in topics which were relevant to the people at the home. Essential training was completed in subjects including moving and assisting people, health and safety, fire safety and safeguarding. Staff had completed other training in end of life care and parkinsons disease.

Trained nursing staff received training in a variety of topics when these were available and also if development areas where identified through supervision. Areas of training had included male catheterisation, nasogastric feeds and oxygen therapy. One trained nurse had a lead role to support other trained nursing staff through their professional revalidation with the Nursing and Midwifery Council(NMC) and two trained staff had undertaken this at the time of inspection. This meant that trained nursing staff received appropriate support to keep their professional practice and maintain their professional registration.

Supervision was provided regularly for all staff and delivered through a combination of one to one and group supervisions. Topics which were relevant to people were covered and we saw that care planning and end of life care had been recent subjects discussed. There was a supervision structure in place and an annual plan to ensure that all staff received regular support. Staff also received an annual appraisal. One staff member explained that they had discussed any additional training, any further support they needed and discussed any issues as part of their recent appraisal.

The majority of people at the home required some type of modified diet to be able to eat safely. The chef was knowledgeable about each person and how they needed their food to be prepared. Where people had a soft diet, the chef explained that they ensured that foods were different colours to make them more attractive for people and always kept foods separate so people could identify the different tastes. No-one at the home was losing weight at the time of inspection but the chef told us that they were regularly updated by staff so that any concerns about changes to people was communicated and reflected in what foods they provided. The chef knew people's likes and dislikes and took this into consideration when planning meals at the home.

There was one hot meal option each day because the service was small, however the chef made alternative

options for people if they did not want the meal which was planned. We observed that the chef had a close relationship with people and after encouraging a person to try a pudding which the person had previously declined, the person agreed to try some pudding and managed to eat all of it. Where people needed assistance from staff, this was provided and the registered manager confirmed that staff who worked in the kitchen had appropriate food hygiene training.

The Food Standards Agency had awarded a top rating of five following an inspection in November 2016. This meant the service met standards of hygiene and safety.

People were supported with effective care by staff who worked in partnership with other agencies in a timely way. For example, one person had not been well the day before we visited. Staff had observed that the person did not seem well and communicated this to the trained nurse on duty. The nurse had seen the person, suspected a urine infection and contacted the GP. A short term medicine was prescribed and staff had gone out as soon as this was ready to collect it and ensure that the person was able to take this in a timely way.

People were supported to access a range of healthcare services including chiropody, Macmillan nurses, GP and social workers. A health professional spoke positively about the service and told us that they worked collaboratively to ensure people received input when needed. They also felt that the home were pro-active and often tried options and considered other solutions before involving other services. This meant that external resources were used appropriately as and when needed.

People were supported to access appropriate spaces in the home when they wished to do so. One person liked to spend time where they could watch the birds in the garden and we observed that they chatted to us about the birds when we visited. They also liked to spend time with two other people at the home and we observed that this was accommodated with an additional chair being made available in one room so the three people could spend time together. There were accessible spaces for people to eat together but the majority of people preferred to have their meals in their rooms. The registered manager explained that they had a portable ramp which meant that people could access the rear garden when they wished to do so.

Good

Is the service caring?

Our findings

Relatives and people who could speak with us told us that staff were kind and caring. One person said "the staff are really good, I can't fault them". A relative explained "staff are really gentle, considerate and talk to (name) nicely". Another relative told us the "care is very personal…they(staff) care about what they do". Staff interactions with people were familiar and friendly with tactile contact used to reassure and connect with people.

Staff understood how to communicate with people in ways which were meaningful and ensured that any barriers to effective communication were managed. For example, one person had limited sight and we observed that staff were respectful and ensured that they positioned themselves where the person could see them before they communicated with them. Another person required staff to be patient when communicating to enable them to express their wishes. We observed that staff waited and enabled the person to have the time they needed to verbally respond.

Staff knew people extremely well and took time to ensure that their likes, dislikes and preferences were understood and respected. Staff told us about people's histories and what was important to them and this was reflected in people's care plans. A staff member explained that one person loved jewellery and it had been important to them to wear this daily. They told us how they took time to support the person to make choices about what jewellery they wore because they knew this was important to them.

Staff protected people's privacy and were respectful in their interactions. A staff member explained how they maintained people's privacy when they were sharing a double room with another person and we saw that there were screens available which staff told us they used. Staff knocked on people's doors, introducing themselves before entering and spoke with people in a manner which was respectful. For example, when staff engaged with people, they crouched or knelt down if the person was sat so they were speaking with them and not over them.

People's religious and cultural needs were respected. One person received regular visits from a local church and staff explained how they were mindful about people's cultural and religious needs and would ensure that these were respected and that people were encouraged to maintain links with the community if they wished to do so. Staff had undertaken training in equality, diversity and inclusion and there was an equality policy which clearly set out that the home 'aims to celebrate differences between people and avoids treating people unequally…..as this can result in losing dignity, respect, self esteem and self worth". A staff member told us that the training had helped them to better understand people's religious beliefs and told us "we would ensure that people had their privacy, and support their visitors and relationships".

People were supported by staff to express their views and wishes. One person at the service did not like to be supported to move and preferred to spend time in their room. Some of the person's family expressed a wish for their loved one to spend time in the communal lounge at the home. Staff supported the person to try this but they were clear that this was not their wish and the staff worked with the family to advocate this choice on the person's behalf. No-one at the service had any involvement from external advocacy services at

the time of inspection but information about a local service was displayed in the information available for people.

Relatives told us that they were able to visit whenever they chose and that they were made to feel welcome. One explained they were "able to visit whenever we want to…..". Another explained that staff were respectful when they visited and enabled them to have time privately with their loved one. They said "they(staff) come in and check how (name) is, if its lunchtime, they ask us whether we want to assist (name) or whether we would like a staff member to assist". They explained that they were pleased that staff sought their opinion and offered them the choice about how to support their loved one while they were visiting. Relatives also explained that the home kept in contact with them and they were kept up to date with how their loved ones were. For example, one relative explained that the registered manager had contacted them just after their loved one moved in to the home to let them know how their first night had been and how they were settling. This gave the relative confidence and peace of mind that their loved one was being well supported.

Good

Is the service responsive?

Our findings

People received person centred support which was planned to meet their individual needs. Care records gave comprehensive information about people's previous lives and interests. They also identified worries that people had and ways of calming people if they became upset. For example, one person had identified that they worried about not being able to eat independently and were more anxious at night. Staff were aware of this and explained how they supported the person to eat in their room as this was the persons preference and they were a proud and private person who had not wished for others to see them being assisted in this way. The person had a call bell to ensure that they were able to alert the staff at night if they were anxious. A relative told us that a person used to enjoy biscuits with their tea but was no longer able to eat these because they needed a soft diet to eat safely. They explained how pleased they were when they visited to find that when their relative was brought a cup of tea, they were also given a biscuit which had been prepared in a way that they could still enjoy.

People's routines were well known and respected by the staff team. Several people liked to rest in the afternoon to provide relief if they were at risk of developing pressure areas or to relieve pain. One person liked to spend their mornings in the main lounge and spend some time with other residents on the first floor. They also liked to rest due to back pain and we observed that staff were able to anticipate the persons needs because they knew them so well. When the person walked into the corridor, staff offered them a choice and the person chose to go to bed for a rest. Staff had understood to offer this choice because they knew the persons preferred routine well.

We saw that there were regular reviews of people's needs and that support changed as a result of these reviews. For example, one person had been struggling to eat and the family had been concerned about this. Staff had identified that if the person held cutlery in one hand, this helped them to co-ordinate better and this helped the persons relative or staff to assist the person to eat more easily. Staff had identified that getting the person's slippers on was increasingly difficult because they had swelling in their legs and feet. Staff had been responsive to this change and contacted the family who sourced more appropriate choices for the person. Another relative explained that staff had identified that their loved one was becoming upset frequently. They discussed this with the person's relative and then referred them to the GP. A change was made to the persons' medicines which had helped them to be less upset.

People were supported with one to one time with staff in a range of social interactions which were planned around their likes and preferences. The home did not have an activities plan or separate staff. Because it was a small service the registered manager explained that all staff spent time each day with people in a range of ways which were personal to them. Activities records supported what the registered manager told us with staff spending time with people in a number of different ways. These included hand soaks and manicures, hand massages, listening to different types of music and watching films. Relatives told us that their loved ones enjoyed the one to one time with staff and preferred to spend time in this way. There were some external resources including reminiscence therapy and pet therapy who also visited the service regularly to engage with people.

People were supported to raise concerns or complaints if they needed to and relatives told us that they would be confident not only to complain, but that any complaints would be acted upon. A copy of the complaints policy was available for people in the main entrance to the home and included contact details for external agencies including local authorities and the local ombudsman. One relative told us "I'd be confident to speak to the manager with any complaints". There was also a complaints audit tool in place to ensure that any learning was used to drive improvements. The aim of the audit tool was 'to consider any lessons learned about policies and procedures and staff practice". This demonstrated that there were systems in place to learn from any feedback received by the service.

People were supported to receive comfortable, person centred end of life care at the home. Care plans included details about what was important to the person and involved relatives and those important to the person in planning their end of life support. The service advocated for people to ensure their support was individually planned. For example, one person had a large family who visited regularly. As the person become more unwell, they were tired and the home arranged a timetable of visits for family members to ensure that the person was not overwhelmed and was able to rest when they needed to.

Written compliments had been received from relatives, thanking the home for the end of life care their loved ones had received. One compliment received in October 2017 stated 'Thank you so much for taking such good care of (name) in their final days and making sure that they were comfortable and peaceful to the end…..thank you also for the unfailing kindness you all showed to the family. We will be forever grateful that you prepared and called us in time to say goodbye to (name)'. The home also spoke with families to gather feedback about the end of life care their loved ones had received in order to learn and further develop practice at the home. The registered manager explained that they had learned lessons from doing this which had helped them improve end of life care for people. One example was that a person had been visited regularly by an old friend. After the person died, the staff were unable to contact the friend because they had not taken their contact details. The registered manager explained that they learnt from this and now sought to ensure that people shared information about those important to them to ensure that the home could be responsive to the persons wishes about their end of life support and communicate with those important to them.

Good

Is the service well-led?

Our findings

The registered manager spoke with pride about their staff team and the quality of support they provided to people. Because they worked on the floor with staff, they were confident about the person centred culture and high standards of care staff because they observed this on a day to day basis. We observed that staff had a good working relationship with the manager, communicating frequently and discussing decisions and options for people's support. The registered manager brought in an additional staff member on the day of inspection and made us aware that this was because we were present and they wanted to ensure that had time to speak with us. This ensured that there was not negative impact on people because the additional staff member was able to provide support while we were speaking with other staff and the registered manager.

The statement of purpose for Kelso Nursing Home had a set of five values which underpinned their practice. These were identified as care, compassion, communication, courage and commitment. The aim of the service was stated as 'continues to strive to achieve the delivery of a service of the highest quality that aims to improve and sustain our client overall quality of life in a people orientated fashion. It also outlined that the home 'pride ourselves on our warm caring and homely atmosphere and maintain this ethos throughout the home'. Relatives told us that this ethos was evident when they visited and staff told us that the homely atmosphere was one of the reasons they enjoyed working at the home. We observed that staff promoted these values through their interactions with people.

Relatives and staff spoke highly about the registered manager and felt that they were available and approachable. One relative told us the "manager is very good…they are here and are very available. They stand in if they are short staffed". Another relative told us how the registered manager kept them updated about their loved one and had been told "I know I can call If I'm ever worried" which had reassured them. The registered manager also owned the home and had done so for over 30 years. They had a well established management style and had clear expectations about how they expected people to be supported by staff. We observed that staff shared these high standards and that leadership was transparent and led by example.

Communication between staff and the registered manager was effective and frequent. There were handover meetings three times daily and ongoing updates throughout the day we inspected. This meant that staff were always up to date with how people were and what they needed to do to provide effective support. The registered manager knew the strengths and interests of their staff and used this to delegate some roles so that they could maintain overall oversight. For example, one staff member had responsibility for overseeing training and competencies of staff and for recruitment when this was required. Another staff member had recently been delegated responsibility for monitoring creams that people were prescribed. They were working with the registered manager to ensure that they maintained an audit of these. The registered manager had delegated night staff to complete some documentation and explained that they shared some responsibilities and had faith in the competence and standards of their staff team.

The registered manager had links with other local managers and utilised this resource to discuss good

practice and any issues. They also had an external professional who completed regular audits and also provided the registered manager with updates about recent practice changes and new best practice guidance. They gave an example about learning from one recent audit which had identified the person centred details in people's care plans and asked how staff ensured that these happened in practice. The registered manager explained that staff knew people extremely well but they did not have a way of monitoring that people's care was provided in the way described. We observed this during our inspection but the registered manager was in the process of reflecting on this learning and ensuring that the details in people's care plans happened in practice.

The registered manager had clear understanding about their roles and responsibilities and these were shared by the staff team. They maintained a clear oversight of the service which was achieved through the use of audits and reflecting on information gathered and how it could be used to improve service delivery. Audits were completed in areas including infection control, people's weights and medicines. Each audit set out to identify any gaps or trends and consider any learning and potential improvements to practice. The registered manager explained that they were committed to providing high quality care and open to learning and improving practice where gaps were identified. They gave an example about care plan reviews and had introduced an evaluation form so that when they discussed people's care with relatives or those important to people and reviewed the support they were receiving, their input could be clearly recorded. They had also implemented care plans around mouth care for people as this was highlighted as an area which was not clearly documented.

The registered manager had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was displayed along with a copy of the last inspection report for people to view. Statutory notifications had been submitted to CQC as required and in line with legal requirements.

Staff told us that they felt valued by the registered manager and the positive ethos of the home was evidenced by the low staff turnover and lack of staff vacancies. One member of staff told us they enjoyed their role and said "all the staff are lovely…we know each other well and know how each other work". The registered manager explained that they were available out of hours for staff but had confidence that when they were not working, people were "in the best of hands" with their staff team. They explained that staff were responsive and flexible to people's changing needs and that if needed they would often come in for a shorter shift for a few hours. For example, when a new person moved into the home. An additional member of staff agreed to work a shorter shift to ensure that there were enough staff to spend time helping the person to settle in to the home.

Feedback was mainly sought informally from people, relatives and staff. The registered manager had some surveys but said that these had not been used for some time because feedback was sought on a day to day basis. The registered manager felt that is there were any issues, addressing them immediately was the best approach and this was echoed by relatives who told us that the registered manager was proactive about seeking feedback. One relative explained that the registered manager had discussed their relatives' appetite and listened when they suggested a food they knew their loved one enjoyed. We observed that this was available for the person in the home.

The home had received several compliments over the past year which highlighted the high standards of the support given and also provided positive feedback from relatives. Comments included 'all of the staff at Kelso treated (name) with great respect but also care and affection, meaning I had confidence they were in good hands. The owner/manager is very experienced and helped me by just listening and talking things through'. Another stated 'it was lovely to know that (name) was so happy and settled with you'.