Chengun Care Homes Ltd

St Augustines Court Care Home

Inspection report

105-113 The Wells Road
Nottingham
Nottinghamshire
NG3 3AP

Tel: 01159590473

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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 unannounced inspection took place on 10 January 2018. St Augustines Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Augustines Court Care Home is registered to accommodate up to 40 people in one adapted building. During our inspection, 27 people were using the service, including some people who were living with dementia.

The service did not have a registered manager at the time of our visit. The manager told us they were in the process of becoming registered and we received confirmation that they were registered shortly after our inspection. 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 supported by staff who understood their responsibility and acted appropriately to keep people safe. Risks to people's health and safety had been assessed, reviewed and mitigated to reduce the risk of harm as much as possible. People were supported by a sufficient amount of staff, received their medicines safely and lived in a clean and hygienic home.

People were supported by staff who received appropriate training and support. People were supported to eat and drink sufficient amounts and staff monitored and responded to changes in people's health. People lived in a building which had been designed and adapted to meet their needs. 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 home supported this practice.

People were supported by a friendly, respectful and compassionate staff team. Staff took action to relieve people's distress and provide comfort. The staff we spoke with were knowledgeable about the people they supported and ensured that people were involved in making decisions about their own care as much as possible. People could be assured that their privacy and dignity were respected by staff.

People received personalised care. An assessment of people's needs was carried out before they moved to

the home which considered the views and preferences of people and their relatives. People were engaged with by staff in appropriate activities and supported to maintain their interests. People were provided with opportunities to make a complaint about their care and these were responded to efficiently. Staff were knowledgeable about what support people required at the end of their life.

People's relatives were confident in the management of the home and felt they achieved their aim of providing friendly and professional support. People were supported by a staff team who felt supported and invested in the home. People's views regarding their satisfaction with their care and any areas for improvement were regularly sought and acted upon. Systems were in place to monitor the quality of the service provided 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 home was safe.

People were supported by staff who understood their responsibility and acted appropriately to keep people safe.

Risks to people's health and safety had been assessed, reviewed and mitigated to reduce the risk of harm as much as possible.

People were supported by a sufficient amount of staff.

People received their medicines safely and lived in a clean and hygienic home.

Is the service effective?

Good

The home was effective.

People were supported by staff who received appropriate training and support.

People were supported to eat and drink sufficient amounts and staff monitored and responded to changes in people's health.

People lived in a building which had been designed and adapted to meet their needs.

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 home supported this practice.

Is the service caring?

Good

The home was caring.

People were supported by a friendly, respectful and compassionate staff team.

Staff took action to relieve people's distress and provide comfort.

The staff we spoke with were knowledgeable about the people they supported and ensured that people were involved in making decisions about their own care as much as possible.

People could be assured that their privacy and dignity were respected by staff.

Is the service responsive?

Good

The home was responsive.

People received personalised care. An assessment of people's needs was carried out before they moved to the home which considered the views and preferences of people and their relatives.

People were engaged with by staff in appropriate activities and supported to maintain their interests.

People were provided with opportunities to make a complaint about their care and these were responded to efficiently.

Staff were knowledgeable about what support people required at the end of their life.

Is the service well-led?

Good

The home was well led.

People's relatives were confident in the management of the home and felt the management achieved their aim of providing friendly and professional support.

People were supported by a staff team who felt supported and invested in the home.

People's views regarding their satisfaction with their care and any areas for improvement were regularly sought and acted upon.

Systems were in place to monitor the quality of the service provided at the home.

St Augustines Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 January 2018 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a nurse 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 service.

We used 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. The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider.

The majority of people who lived at the home were living with dementia and provided limited views on the care they received. Therefore, during the inspection, we spoke with one person who lived at the service and six relatives either face to face or by telephone. We spoke with a nurse, a senior care assistant, a care assistant, a domestic, the housekeeping supervisor, the manager and a representative of the provider. Following our visit we also sought feedback from healthcare professionals who routinely visited the service and received feedback from one healthcare professional.

We looked at all or part of the care records of six people who used the service, medicines administration

records, staff training records and the recruitment records of three members of staff. We also looked at a range of records relating to the running of the service, such as audits and maintenance records.

We observed care and support in communal areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Our findings

People were supported by staff who understood how to protect them from avoidable harm and to keep them safe. People and their relatives felt the home was safe. One person's relative told us, "I feel my relation is safe here, all of the staff are fantastic, and I really do trust them all. I have always seen them be good to everyone." Another relative told us, "All the people who live here always seem to be under observation. I am sure [relation] is safe and there is always a carer with them."

The risk of people experiencing neglect, abuse or discrimination was reduced because processes were in place to protect them. People and relatives were provided with information about who to contact if they were concerned about abuse as this was displayed in the home. A safeguarding policy for staff was in place. Staff were required to read the policy as part of their induction when they commenced working at the home and records showed that staff had received training in safeguarding adults. The staff we spoke with described the signs of different types of abuse and the action they would take in response to any concerns about possible abuse.

The manager was fully aware of their duty to report safeguarding incidents to the local authority. Records we viewed confirmed that relevant information had been shared with the local authority when incidents had occurred. The local authority is responsible for investigating any allegations of abuse. Where recommendations which had been made to help staff keep people safe and avoid harm, these had been implemented. The manager also confirmed that people living at the home were treated equally and that staff received relevant training to ensure people were not subjected to discrimination.

Risks to people's health and safety were identified and regularly reviewed to ensure risks to people were minimised as much as possible. The records we viewed showed that risks had been assessed in relation to areas such as choking, nutritional risk, falls and skin integrity. Risk assessments were personalised and reflected specific risks to the person. For example, one person was at risk of leaving the service without the supervision they required to keep them safe. The risk assessment showed the measures required to keep the person safe and when we checked whether these measures had been implemented, we found they had been.

People's safety within the environment and when leaving the home had been considered and assessed. For example, a bedroom health and safety checklist had been completed for each person which considered the risk of harm from furniture, falls and fire. When equipment, such as bed rails were used, a risk assessment had been carried out to ensure they were safe and appropriate to use. Each person living at the service had

a personal emergency evacuation plan which detailed the support they would need to evacuate the service in the event of a fire. Records showed that regular safety checks had been carried out as required. For example in relation to fire safety, water temperature and equipment.

Many of the people who lived at the home were living with dementia and sometimes expressed their emotions through behaviour. People's relatives told us they were confident in how staff responded to the challenges as a result of people's behaviour. One relative told us, "My relative's behaviour is very well managed, they are reviewing [relation's] behaviour all of the time and constantly trying a different approach and if that doesn't work, they try a new way, another person and a different time of day."

We found that people were supported by staff who responded to their behaviour in a positive way. Whilst records contained clear information about the behaviour the person may display, there was limited information about what may cause this and how to respond. However, the staff we spoke with talked confidently and knowledgably about how they responded to people's behaviour in a way which was as least restrictive of their rights and freedom as possible. Our observations confirmed this. We observed the staff team to respond appropriately when a person displayed behaviour which could challenge. The staff team ensured that a member of staff received the support they needed following an incident whilst ensuring the person remained appropriately supported and engaged with.

People were supported by a sufficient amount of staff to keep them safe and meet their needs. All of the relatives we spoke with told us people were supported by enough staff. One person's relative said, "There are always lots of staff about and if my relative becomes unsettled and I think they need the toilet staff come straight away. I never have to wait for more than five minutes." Another person's relative said, "There are always lots of staff on duty."

During our inspection, we observed there were sufficient numbers of staff to provide support and respond to people's needs. The manager confirmed that several people who lived at the home had periods of one to one support from staff. We saw that this was provided to people during our inspection. The staff we spoke with told us there were sufficient staff rostered on duty and that if there was a short notice staff absence, they could normally obtain cover.

People could be assured that safe recruitment processes were followed. Before staff had started working at the service, a check had been carried out through the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We also saw that proof of identity and appropriate references had been sought prior to staff commencing work. This meant that the provider had taken appropriate steps to ensure people were protected from staff who may not be safe to support them.

People received the support they needed to take their medicines as prescribed by their doctor. People's relatives were complimentary of the support their relation received to take their medicines. One person's relative said, "I'm sometimes here when my relative takes medication and they (staff) always seem to come on time. The staff sit with [relation] and make sure [relation] takes it." Another relative told us, "I am always here at teatime and my relations medication always comes on time. They (staff) are very observant of [health condition] and give tablets to help."

We observed staff administering people's medicines and saw they stayed with people until they had taken their medicines. However, good practice was not always observed in relation to the safe storage of medicines. We saw that the medicine trolley was closed but unlocked in a communal area of the home and

that the keys had been left in the cupboards in the medicines room. Although the risk of harm to people was mitigated by either staff presence or a locked medicines room, this did present a small risk of unauthorised access to medicines.

Medicine records contained a photograph of the person to aid identification, a record of any allergies and the person's preferences for taking their medicines. Other information was recorded to aid the safe administration of medicines and to ensure their effectiveness, such as guidance for medicines to be given 'as required.' Staff told us they completed medicines administration training and competency assessments prior to administering medicines. Regular checks were carried out to check that medicines were being managed appropriately.

People told us they felt the service was clean and our observations during our inspection confirmed this to be the case. We saw that staff adhered to infection prevention and control procedures such as using personal protective clothing and equipment (known as PPE). Staff told us that PPE was readily available and we also found that bathrooms contained soap and hand towels in addition to visible instructions about hand washing. The home appeared visibly clean. We spoke with domestic staff who told us they had adequate time allocated for cleaning and laundry duties and were aware of the action they should take in the event of an outbreak of infection. Records showed that daily cleaning schedules were completed.

People were supported by staff who understood the need to report accidents or incidents to the management team. One person's relative told us about an incident whereby their relation had sustained an injury and confirmed, "I was told as soon as it happened and how things had been reviewed. I was involved in a discussion about what could be done differently to prevent it from happening again."

The manager told us that staff completed accident and incident forms which they reviewed to ensure that these had been completed correctly, that risk assessments had been updated and referrals made to external professionals or agencies as required. We checked whether recommendations which had been made following an incident at the home had been implemented and found they had been. This meant that the service responded appropriately to accidents and incidents and implemented changes or recommendations to help prevent a reoccurrence.

Good

Our findings

Before people started using the service, an assessment of their needs was carried out. People's relatives confirmed this to be the case, with one relative stating, "When my relative was admitted I sat with the staff and told them everything. I felt they really assessed [relative] and began to look at ways to help them." Records suggested that best practice guidance was used to ensure that people's needs were assessed and provided for. For example, a local NHS screening tool was used to assess nutritional risk and guidance for staff on specific health conditions was also documented in people's care plans.

People's relatives told us they were supported by staff that knew how to care for and support them. One person's relative commented, "I have never observed any poor care or had any concerns," whilst another said, "The staff know what they are doing. A new carer recently started and I hear the staff training them all the time, explaining things. I think that is extremely good."

Staff received training relevant to their role and records we viewed showed the majority of staff had completed training which the provider has identified as being mandatory. Staff described the training they had received in relation to area such as wound management, continence and moving and handling. Staff described the training as "handy" and "really useful" and stated they were able to request training if they identified a need and this was provided. However, further training was required to ensure that staff could meet people's nursing needs. We spoke to the manager and provider who were aware of the need for additional training for nurses and we received confirmation of training which had been arranged for nurses following our inspection.

Staff told us they received regular supervision and an annual appraisal to discuss their performance and any development needs they had. The manager showed us a copy of their supervision planner which showed that staff received supervision every two months.

People were supported to eat and drink enough and their individual preferences were catered for. One person's relative said, "The food is good. My relations food preferences have totally changed. The staff have addressed this and know what [relation] likes. At times [relation needed] lots of encouragement and lots of different options were tried until they found something my relation wanted to eat. They also offered small portions regularly, which I though was good."

We observed part of the lunch time meal at the home. We saw that people were offered a choice of drink and a choice of meals and that when a person did not want to eat the meal provided, staff offered a range of

alternatives. People were offered additional helpings and support and encouragement to help them eat. When people required physical assistance to eat this was provided in an engaging, encouraging and patient way.

The chef was provided with information about people's food preferences and dietary requirements and regularly sought feedback from people using the service on the food provided. This ensured that people were supported to eat the food they enjoyed. Risks to people in relation to their nutrition were assessed and records showed that people's weight was monitored. We spoke with the registered manager about one person who had lost a significant amount of weight as it was not clear what action had been taken in respect of this. The registered manager informed us that a dietician had provided advice which was being followed; however, this had not been clearly recorded.

People were supported to maintain their health and access external health support. People's relatives were confident that external medical support would be sought from the GP if their relation became unwell and that they were kept updated of any changes to their relations health. One person's relative commented, "The doctor visits on a regular basis and if the staff were concerned they would discuss with me and call the doctor." Records showed that people had access to a range of external health professionals which staff had contacted when changes had occurred. For example, care records showed input from a GP, dietician, dentist, optician, dementia outreach team and speech and language therapist.

People's care records contained information about how people should be supported with specific health conditions, although these had not always been updated to reflect changes or the recommendations of health professionals. This made it difficult to obtain a current indication of their health need or a chronological history. For example, a person had suffered a broken wrist and later had a fall and broken their other wrist. However, some of the contacts with external health professionals were not recorded in the care record. Despite this recording issue, the staff we spoke with were knowledgeable about people's health needs and how they supported people to maintain good health.

One healthcare professional who visited the home told us that although staff sometimes required prompts to update care records, they witnessed therapeutic interactions and staff responded positively to feedback and engaged well with external agencies.

Systems were in place to ensure that information about people's health and care needs accompanied people in the event they were admitted to hospital. The provider told us in their Provider Information Return (PIR) that each person living at the home had a transfer document in place which provided up to date information. In addition the home participated in the red bag initiative adopted by local commissioners which was designed to help services meet national best practice guidance. A red bag is used to transfer paperwork, medicines and personal belongings and stays with the person throughout a hospital admission and is returned home with them.
The premises that people lived in met their needs. The home was well lit and had been adapted to suit the needs of people with dementia. For example, grab rails were in place along corridors which were free from trip hazards. People had access to suitable bathing equipment in spacious bathrooms. People's bedroom doors contained personalised information that people had chosen to display or which reflected their interests. The corridors contained plenty of sensory items and the provider told us of their plans to make improvements to the secure garden area so that people would benefit more from the outside space. This was in addition to an area of the home which had been refurbished to look like a pub. The staff told us that people used this area to have a weekly disco. One person's relative told us they appreciated the effort that had been made to adapt the home to the needs of the people living there. They told us, "Even the corridor is interesting which is good as my relative spends a lot of time walking."

People's relatives told us that staff supported their relation as much as possible to their own decisions. One person's relative said, "My relation cannot tell the staff what they want, but they (Staff) look at his body language to try and understand." Another person's relative told us, "My relation cannot really make choices, but the staff know [relations] background in detail, which is very complex, but they use this and listen to very carefully to gauge what [relation] means." Our observations supported what people told us, with people being offered choices and provided with explanations by staff to aid their understanding.

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 staff we spoke with showed an understanding of the principles of the MCA. They were able to describe how they would support people to make their own decisions as much as possible by using visual prompts and observing people's facial expressions or body language in relation to choices offered. People's care plans contained details of people's capacity to make decisions and where people had been assessed as lacking the capacity to make certain specific decisions; an appropriate best interest decision had been made and recorded.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that a number of applications had been made to the local authority if people were identified as potentially being deprived of their liberty and some of these had been authorised. The staff we spoke with were aware of which people had a DoL authorisation and described how the person should be supported in line with the authorisation.

Good

Our findings

People's relatives described the positive impact that staff support had on their relations wellbeing. One person's relative said, "The staff are caring, all of them, from the owner to everyone. I cannot criticise anyone as they look after everyone so well. "Another relative told us, "The staff are kind to my relation. If [relation] starts to become agitated they are just gentle with [relation], setting appropriate boundaries and being respectful."

We saw numerous examples of staff talking to people with warmth and respect. Staff showed genuine interest in people's welfare, stopping to ask how they were and taking practical and compassionate action to relieve people's distress or discomfort. For example, we observed a member of staff talking with a person whilst they encouraged them to have a cup of tea and some biscuits. The staff member showed a genuine interest in the person and when the person mentioned they had some pain, the staff member said they would ask the nurse for some pain relief on behalf of the person. On another occasion, a staff member asked a person if they were feeling okay. The person said their hand was hurting and the staff member rubbed it for them. The person smiled and said, "Oh that's better."

All of the relatives we spoke with were complimentary of the way staff spoke with people. They said, "The staff are really nice to my relation and seem to be asking all of the time if [relation] is okay. They encourage [relation] and thank [relation] which is good." We observed several instances of staff providing explanations of the support they wished to provide, asking people's permission, providing encouragement and offering their thanks. The respectful interaction of staff elicited positive reactions from people and contributed to a calm, respectful and warm atmosphere at the home.

The staff we spoke with knew the people they were supporting well. For example, two of the staff we spoke with consistently described the support they provided to a person who could be resistive to personal care interventions. They described the person's need for reassurance and explanations and the comfort that holding their hand provided the person. Staff knew people's personal histories, what was important to them and the support they required to maintain their interests. Staff told us they had time to spend with people to get to know their needs and preferences and that care plans provided additional guidance about people's history and backgrounds.

People had access to independent advocacy. Although the manager was not fully aware of the different types of statutory advocacy available to people, such as an Independent Mental Capacity Advocate (IMCA), information about advocacy was available at the home. The provider informed us that representatives from

an advocacy organisation had previously visited the home and met with people to ascertain if they had any worries or concerns. This service was currently provided by a relative of the home. Some of the people living at the home had independent advocates appointed as a result of their DoLS authorisation who visited regularly. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People were supported by staff who ensured they maintained people's dignity. One person's relative told us, "My relative is always clean and looks lovely. They (Staff) match his clothes and on Christmas day I had brought [relation] some new things to wear and [relation] was wearing them." Another relative said, "My relation is always dressed appropriately with things that go together and in [relations] clothing. The staff try at different times with care interventions, they just never give up. It's not just that people are well cared for as the staff are always looking for ways to enhance people's lives."

The staff we spoke with described the strategies they used to ensure that people's privacy and dignity were maintained. These included knocking on people's doors before entering, promoting choice; ensuring people received birthday cards and were able to maintain contact with their relatives.

We saw that staff spoke to people respectfully, used their preferred name and ensured people were clean and happy. For example, people were given choices throughout the day of where they spent their time and were offered clothes protectors during mealtimes in order to preserve their dignity. Staff were aware of which people wished to receive support from female care workers and we saw that people's preferences were respected.

Good

Our findings

Before people moved to the home an assessment was carried out to ensure people could receive the support they needed. People, or often an appropriate relative were consulted about how they wished for their relation to be cared for. The provider told us in their PIR that, "Care plans record preferences and choices; families and significant people are involved from the start."

The relatives we spoke with felt fully involved in planning and reviewing their relations care. One person's relative confirmed, "When my relative first came in they (staff) spoke with me as part of the assessment, but this is ongoing. They (Staff) talk to me all of the time and sort things out for my relative." Records showed that people's relatives were routinely involved or invited to be involved in reviews of their relations care. The relatives we spoke with gave examples about being informed about incidents which had occurred at the service and involved in decisions about their relations care.

People's care plans contained an individual profile in the form of a one page summary of what was important to the person, their interests and personality. People's care plans also contained information about people's backgrounds and life story. Each person had care plans which provided guidance and information to staff about their care and support needs in relation to different areas of care, such as skin integrity, nutrition and mobility. These generally contained personalised information about the person's needs and their preferences in relation to their care.

Although people's care plans has been reviewed on a monthly basis, they had not always been updated when changes had occurred. This meant they did not always reflect the person's current level of need. For example, one person's end of life care plan stated they wished to be resuscitated but they had subsequently decided they did not wish to be resuscitated and had a do not attempt resuscitation order in place. Two other people had recently returned from hospital with changes in their care needs and although staff were aware, their care plans had not been updated. The manager provided information following our visit which confirmed that these people's care plans had been updated to reflect changes.

Many of the people who lived at the home were living with dementia. The manager told us that staff were provided with training in equality and diversity and that all people were treated equally, according to their preferences and needs. The manager was not fully aware of the Accessible Information Standard (AIS); however they were implementing its principles. For example, the manager and staff described how they used visual aids to identify people's choices and preferences or provide explanations. The manager told us that one person who lived at the service spoke English as a second language and sometimes spoke in their

first language. The registered manager told us the person sometimes needed to have information translated and either a staff member who spoke the same language or the person's friend would provide this assistance.

People were provided with stimulation, activities and supported to maintain their interests. The home employed an activities co-ordinator and a programme of activities was in place. On the day of our inspection we saw that staff engaged with people and encouraged interaction and participation. For example, we saw a member of staff engaging people in a game of bat and ball, another member of staff engaging in a conversation with a person over a book with photographs and a third member of staff using touch and hand massage to engage with a person. The home had a cinema room which we saw being used throughout the day and were told by staff and relatives that on other occasions, the 'pub' and garden were used by people.

The relatives we spoke with were complimentary of the activities provided at the home. One person's relative said, "My relation cannot join in the big activities, but I know there is a lot going on. We do have a disco and a dance on a Friday and my relative likes to listen to the music." Another person's relative told us, "the activities are very individualised, for example; my relative likes church music and certain musicals and they provide for that."

People's care plans included information about people's interests and whether they liked to join in with communal activities. One person's care plan stated that they required the support of staff to accompany them to buy a newspaper from the local shop. Staff confirmed that the person was supported to do this when they were well and wished to do so.

People's relatives told us they felt confident raising any concerns or complaints and that these would be responded to appropriately. One person's relative told us, "I know to go to the manager with anything big, but little things are always sorted by the senior carer." Another person's relative told us that when they raised an issue with staff it was responded to appropriately.

The provider told us in their provider information return (PIR) that they encouraged feedback and comment on people's experiences of the service. Information was prominently displayed about how to make a complaint, what could be expected in response, and who the complainant should contact if they were unhappy with the response. Records showed that one concern had been raised with the service by an external healthcare professional and that the manager had investigated and responded to the concerns raised.

People or their relatives were involved in discussions about end of life care. One person's relative told us, "I have been asked about this by the staff and the GP and I want my relation to stay here as [relation] knows the staff and they know [relation]." Another person's relative confirmed, "My relation has been in what we thought was an end of life situation a couple of times. The staff were lovely and there are good procedures in place. All of my relative's end of life care is in place and it is documented that my relative will stay here and that it is in [relations] best interests."

The manager told us that people had end of life care plans in place. We found this to be the case and found they contained basic information. We saw that some people had a Do Not Attempt Resuscitation (DNAR) in place and if appropriate, an advance care plan which had been provided by the person's GP. Although the care plans did not provide detailed or personalised information, such as details about pain management, food and fluid and personal care, the staff we spoke with told us they had received training in how to care for people at the end of their life and told us about the things they would consider in line with the person's

wishes. We saw that the contact details of an external end of life team were available in the service.

Good

Our findings

People's relatives were confident in the management of the home which resulted in positive outcomes for both them and their relations. One person told us, "This is a good home and my relative is very contented," whilst another relative commented, "I moved my relation from another home and once [relation] arrived I began to realise that this is how it is supposed to be. I feel my relation is safe because the place is transparent and open."

St Augustines Court Care Home aimed to provide 'professional care' with a 'personal touch.' The provider told us in their PIR that "clear expectations are set up by the Director and staff are aware of what is expected of them. We have a good team of staff with experience and dedication for the residents." The relatives we spoke with described the service as both friendly and professional. One person's relative commented "The owner has very high standards and ensures they are kept." Another relative told us, "It is a friendly home and a 'tight ship.' I think the staff are treated well, but in turn they are expected to do their job very well. The manager leads by example and is very visible; she absolutely knows what's going on."

People were supported by staff who were enthusiastic and committed to providing good care to people. The staff we spoke with told us they received constructive feedback on their performance and felt involved in the running of the service. Staff gave us examples of positive changes which had been made by the provider and the manager. One staff member told us, "I enjoy it (working at the service). There has been positive changes. Staffing has improved. There are more activities. More supervisions. I feel involved in the running of the home. We have a staff representative you can go to with any problems, or straight to the manager. Improvements are made." Another member of staff told us, "I love it (working at the service). They (management team) are always asking if we have any suggestions (to improve the running of the home). The manager is willing to help. It's really good. I feel supported."

The service had an open and transparent culture. The staff we spoke with told us they felt comfortable to report any incidents or accidents which occurred and that any learning or recommendations from incidents were shared with them. One person described receiving regular feedback from both the provider and the manager and told us this was done in a constructive and helpful way. The staff member told us, "I learn from that." The staff felt comfortable raising any issues of concern and were familiar with the service's whistleblowing procedure. Whistle blowing is a term used to describe the reporting of concerns about the care being provided by a person who works at the service. The staff felt confident to raise concerns and were confident these would be dealt with.

Although the manager was not registered at the time of our inspection, they became registered shortly after our visit. The manager was clear about their responsibilities. For example, providers are required to notify us of certain significant events which occur in a service, such as serious injuries or allegations of abuse. We checked our records and found that we had been notified of such events as required. The manager told us they were supported in their role by the provider who visited the service most days. They told us that the provider responds positively to any requests for resources or support. We observed both the manager and the provider to be involved in the daily running of the home, visible and engaged with people and staff.

The manager told us they regularly attended manager forums to learn and share best practice, for example in relation to caring for people with dementia and ensuring people are safe from abuse. They told us that close links were maintained with external agencies such as the dementia outreach team and falls team. A relative confirmed this to be the case and told us, "The home has such a good relationship with the Community Dementia Support Worker which is really good and very reassuring."

People's relatives felt engaged with the running of the service. Regular meetings were chaired by a relative's representative and the relatives we spoke with were confident this process was an effective way to be heard and involved. One person's relative commented, "We have a family group that meets every month with the manager where we can discuss anything. The meeting is always very positive, and we can raise anything we want to." Another relative told us that an issue was raised at the meeting and responded to. They told us, "The manager listened, knew this was an issue and I don't know what she has done, but it no longer happens."

In addition to regular meetings, a survey had been provided to people's relatives to enable them to provide feedback about the care their relation received at the home. Information was on display in a communal area informing people of the action which had been taken in response to any areas of improvement which had been identified. For example, as a result of feedback received from the survey, more senior care assistants had been appointed to improve staff deployment.

The provider told us in their PIR that, "Audits are performed regularly and actions taken on any issues found". Records showed that regular audits were completed in relation to different areas of service provision such as care plans, medicines, falls and pressure ulcers. The audits showed high levels of compliance and therefore did not generally contain action plans. We discussed with the registered manager that an audit in relation to pressure ulcers did not show that an analysis had been carried out to show whether the pressure ulcer was preventable and whether the guidance in care plans was being followed. The registered manager told us they would include this analysis as part of the audit in future.