All Hallows Healthcare Trust

All Hallows 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

All Hallows Nursing Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service provides nursing care. All Hallows Nursing Home accommodates up to 50 adults, the majority being older people, in one adapted building.

There were 34 people living in the service when we inspected on 9 April 2018. This was an unannounced comprehensive inspection.

There was a registered manager in place. 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.

At our last comprehensive inspection of 27 October 2016 this service was rated requires improvement. The key questions for safe, effective, responsive and well-led were rated as requires improvement and caring rated as good. There were breaches of Regulation relating to care planning and governance. At this inspection, improvements had been made and the service was now rated good.

You can read the reports from our last inspections, by selecting the 'all reports' link for All Hallows Nursing Home on our website at www.cqc.org.uk.

There were systems in place to provide people with a safe service. Staff were trained and understood how to safeguard people from abuse. Risks to people were managed well and staff were provided with guidance about how to mitigate risks. There were systems in place to provide adequate staffing levels to people who used the service. Staff recruitment processes were robust. Medicines were managed safely. There were infection control processes in place which reduced the risks of cross contamination in the service. Where incidents had occurred, the service had systems in place to learn from these and use the learning to drive improvement in the service.

Staff were trained and supported to meet people's needs effectively. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment. Staff worked with other professionals involved in people's care to provide people with an effective and consistent service. People's nutritional needs were assessed and met. 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 environment was appropriate for people using the service.

People were treated with care and compassion by the staff. People's privacy and independence was

promoted and respected. People were listened to and their views about how they wished to be cared for were respected.

People's care was assessed, planned for and met. Care records guided staff in how people's preferences and needs were met. Social activities were in the process of being improved. People's choices were documented about how they wanted to be cared for at the end of their life. Compliments received by the service demonstrated that caring and compassionate care was delivered at the end of people's lives. There was a complaints procedure in place and people's complaints were addressed and used to improve the service.

The service had systems in place to monitor and improve the service provided to people. There were ongoing improvements being made in the Trust intended to further improve the service provided to people.

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 systems in place to minimise risks to people and to keep them safe from abuse.

The staffing levels were assessed to provide people with the care and support they needed. The systems for the safe recruitment of staff were robust.

People were provided with their medicines when they needed them and in a safe manner.

The service had infection control policies and procedures which were designed to reduce risks to people.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet the needs of the people who used the service.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

The environment was suitable for the people who used the service.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed, planned for and met. People's end of life decisions were documented and their choices were respected. People were provided with the opportunity to participate in meaningful activities. There were ongoing improvements being made in the activities provision.

There was a system in place to manage people's complaints.

Is the service well-led?

Good

The service was well-led.

The service's quality assurance systems supported the provider and registered manager to identify shortfalls, and address and learn from them. There were ongoing improvements being made in the Trust to further improve the service.

The service provided an open culture. People were asked for their views about the service and these were used to improve the service.

All Hallows 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 unannounced comprehensive inspection took place on 9 April 2018 and was undertaken by 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.

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. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. Prior to our inspection we contacted local authority for feedback about the service. We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law.

We spoke with 10 people who used the service and seven relatives. We observed the interaction between people who used the service and the staff throughout our inspection.

We looked at records in relation to five people's care. We spoke with the registered manager and seven members of staff, including the human resources manager, nursing, care, activities and catering staff. We also spoke with a visiting health professional. We looked at records relating to the management of the service, training, and systems for monitoring the quality of the service. We also looked at three volunteer recruitment files, we had completed an inspection on another of the provider's services in March 2018 and visited the human resource office where we reviewed their recruitment processes.

Good

Is the service safe?

Our findings

At our last inspection of 27 October 2016, the key question of safe was rated requires improvement. This was because improvements were needed in how the service managed medicines and risks associated with bed rails. We recommended that the service explored current guidance relating to the safe use of bed rails. At this inspection, we found improvements had been made and the rating for safe was now good.

People told us that they were safe living in the service. One person said, "When they [staff] have to move me, say using the hoist, there's always a team. I feel totally safe when they move me."

Staff had received safeguarding training and understood their responsibilities in keeping people safe from abuse. Where a safeguarding concern or incident had happened, the service had taken action to reduce the risks of future incidents and used them to drive improvement. This included disciplinary action and further training for staff.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks associated with mobility, pressure ulcers, bed rails and falls. Where people were at risk of developing pressure ulcers systems were in place to reduce these, this included seeking support from health professionals and the use of pressure relief equipment. One person told us, "[Nurse] just come in to check, bed sores, anything like that. I've had a lot of problems over the years, so that [nurse] can tell the doctor. They take a photograph, they could open a photo gallery with the photos of me." We reviewed records where people required support to move their position to reduce the risks of pressure ulcers developing. When people remained in bed these were completed in line with the recommended timescales in their care plans. However, for one person's records during the day there were no records of repositioning in place. The registered manager told us this was because the person got up and spent their time in the communal areas. They agreed that these would be completed to show where the person had been, such as sitting in the lounge. Where people were at risk of falls actions were taken to reduce future risks, for example by making referrals to health professionals and risk assessments which guided staff on how risks were reduced including referrals to health professionals to obtain guidance.

Risks to people injuring themselves or others were limited because equipment, including hoists, the passenger lifts, and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. Portable electrical equipment had been checked to ensure they were safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. Fire safety checks were undertaken and there were personal evacuation plans in place for each person to ensure that staff were aware of the support that people need should the service need evacuating. Windows had restrictors in place which prevented them from being opened wide enough for people to fall out of. However, there were balcony rooms, which opened out onto a balcony that overlooked the garden. There were no risk assessments in place to reduce the risks of people falling from the balcony. The registered manager told us that none of the people who used these bedrooms were mobile but they would ensure that each time a person moved into one of these bedrooms a risk assessment would be completed.

People told us that they felt that there were enough staff in the service to support them. One person said, "They [staff] don't leave you on your own very long, somebody pops in, and nothing seems to be too much trouble."

People told us that when they called for assistance this was attended to promptly by staff. One person said, "It doesn't take long [response the call bell], just a couple of minutes if that. At meal times it takes a little longer, but normally if they are busy somebody else will come [staff from another floor / part of the home] and pop down and see what you need." Another person commented, "Yes, it's always answered." Another person said, "They respond to an emergency immediately." One person's relative told us that if the staff were to be delayed in attending to the person's needs when they had used the call bell, "They will reassure [family member] and come back." We observed that call bells were present and located within people's reach. Everyone told us they used their call bell and that staff promoted its use.

We saw that staff responded to people requests for assistance, including call bells promptly. The registered manager told us how the service was staffed to meet people's needs. This was confirmed in our observations and records. The registered manager told us that they used a system to calculate the required numbers of staff to meet people's dependency needs. If people's needs increased the staffing was adjusted.

On 15 March 2018 we inspected another one of the provider's locations where we met with a member of the human resource team who explained the provider's processes for the safe recruitment of staff. Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. At this inspection, we reviewed the records of volunteers who worked in the service. These records demonstrated that checks were made which were the same as required by other staff. One person told us how they participated in the interviewing of new staff, "I'm going to interview a new carer and they [registered manager] has asked if I can go along."

People told us that they were satisfied with the arrangements for their medicines administration. One person said, "The meds [medicines] are done at various times, no problem at all. You can set your clock by them." Another person commented, "It's all given regularly [medicines]." One person's relative told us about how the staff supported their family member with their pain relief medicines, which took into account their choice and ability and the need for the medicines.

Records showed that staff who were responsible for administering medicines had received training and competency checks. Staff who were responsible for giving people their medicines did this politely and checked the medicines administration records (MAR) before providing people with their medicines and signed them when they had seen people taking them. MAR were appropriately completed which identified staff had signed to show that people had been given their medicines at the right time. Photographs of people were included in the MAR folder with the date of their photograph. This assisted staff to, as well as the name of the person, identify that they were providing medicines to the correct person. People's records included information about their prescribed medicines and the support they required to take their medicines.

Where people were prescribed medicines to be taken as required (PRN). Records included protocols which guided staff when these PRN medicines were to be administered. Where people were prescribed topical medicines, such as creams, there were body charts in place to guide staff where on the person's body these were to be administered.

Medicines were kept safely in the service and there were safe systems in place for the ordering and disposal

of medicines. Regular audits were undertaken which supported the registered manager in identifying discrepancies and taking swift action to make improvements. This included further training for staff.

People told us that the service was regularly cleaned. One person said, "No problem at all, they clean once a day, in the morning. They mop the floor every day, usually in the bathroom for about an hour." One person's relative commented, "All rooms have been changed [vinyl floor covering], I didn't like the carpet. They [domestic staff] come in every day. I do wipe things down, there's only very light dust, and that's about me [being over protective]."

There were disposable gloves and aprons that staff could use, such as when supporting people with their personal care needs, to reduce the risks of cross contamination. These were stored throughout the service to allow access. We saw staff collecting these when preparing to support people with their person care to reduce the risks of cross infection. The communal toilets and bathrooms were bright and clean. There were lidded bins in place for the disposal of paper towels and clinical waste. There were no unpleasant smells present, either in the communal areas or in people's private bedrooms that we entered, with their permission, and this remained so throughout the day. The registered manager told us that they had a visit from infection control professionals in October 2017. They had received feedback and took action to reduce the risks to people. This included removing hand rails where not needed and ensuring that photographs and decorations in the service were wipeable to reduce risks. Staff had received training in infection control and food hygiene.

Good

Is the service effective?

Our findings

At our last inspection of 27 October 2016, effective was rated requires improvement. This was because improvements were needed in how the service recorded how they supported people who lacked capacity to make their own decisions and support provided to people with their nutritional and hydration needs. We recommended that the service explored current guidance relating to supporting people with specialist nutritional needs. At this inspection, we found improvements had been made and effective was now rated good.

People's care needs were assessed, planned for and delivered holistically. This included their physical, mental and social needs. The service was working with social care professionals to improve the care plans. Discussions with the registered manager and records showed that the service worked with other professionals involved in people's care to ensure they received a consistent and effective service. This included the commissioners for services and health care professionals. We spoke with a visiting health professional who told us that they regularly visited people in the service. They attended the service twice a week and said, "The nurses are well trained and recognise issues."

People told us that they felt that their health needs were met and they were supported to see health professionals if needed. One person said, "I asked [deputy manager] to put me on the list for the optician, the dentist has been very good. [Dentist] was absolutely brilliant, they come, regular check-ups every six months. We have got a chiropodist who comes in, and the podiatry people come. It's all very well managed, anything that needs doing they do it." Two people's relatives told us how the staff had been quick to call in the doctor when their family member was ill. One said "[Family member] couldn't breathe properly, and they didn't manage the toilet. They were all brilliant and the doctor came very quickly." Records showed that where there had been concerns about a person's health, they were referred to health professionals and any advice and treatment was recorded.

Where people moved between services, for example if they required hospital admission, care records included important information about the person which would be transferred to hospital with them, including if they wished to be resuscitated. One person told us, "The hospital visit was organised, they got me ready. On the whole they're very satisfactory." Another person said, "When I'm referred for a hospital appointment they have it all in hand, the [staff] will come in and start preparing me, and I'll be waiting in reception when the transport arrives."

People told us that they were provided with choices of food. One person said, "There's always three choices at teatime, Saturday and Sunday it's a buffet, sandwiches, sausage rolls, cheese sticks, quiche, cold food selection." Another person told us, "I'm 85% happy with the care, the food is cold, it arrived cold." A staff member told us how they had returned the plate of food to the kitchen to have it re-heated saying, "[Person] likes it hot." However, one person who required a softer diet said, "Mine [meals] are nearly the same every day, very mashed. It tastes the same every day."

One person's relative told us how they and their family members sat down together every two weeks to

choose what to order from the menu. They said, "They have lovely food but [family member] just couldn't eat it, so matron [registered manager] said just pick what you want. They listen to you, they said if you'd like to choose, they like something light, they'll do whatever they want." Another relative commented, "The [staff] give [family member] breakfast, sometimes they'll be awake for dinner. If [family member] fancies anything we just go down and get it." A member of staff arrived with the person's supper. They explained to the person why they were there and what they had brought. Another person's relative said, "The [staff] in the kitchen are very good, they check that [person] likes what they've chosen."

People told us as well as the meals in the service they could have snacks. One person said, "They've always got fruit on the trolley, yoghurts, cakes, biscuits. They'll rattle them off, the different cakes, in fact there's so much choice."

We observed three people in the dining room at lunchtime. This was clearly anticipated as only one table had been laid for service. The three people present got on well together, and all told us they were enjoying their meal which was hot and looked appetising. One person was observed to benefit from a plate guard attached to their dinner plate to support them to eat their meal independently. Other people had chosen to eat their meals in other parts of the service, such as in the communal lounge and their bedrooms. We saw that staff assisted them, where required, and at the person's own pace.

People told us that they got plenty to drink to reduce the risks of dehydration. One person said, "I have loads and loads of juice." Another person commented, "I drink as much as I can." One person's relative told us, "It's well monitored, their [family member's] fluid intake." One person who required a diabetic diet said, "They haven't barred anything, only sugary drinks." There were cold water dispensers and plastic cups located in small kitchenettes on both floors for use by people, staff and visitors. We observed the presence of covered jugs containing water in people's bedrooms, and in all cases a beaker was positioned within the person's reach.

People's records included information about how their dietary needs had been assessed and how their specific needs were met. If there were risks identified relating to eating and drinking there were risk assessments in place to show how the risks were reduced. This included people who were at risk of choking or malnutrition. Where required, other professionals were contacted for guidance and support to meet people's needs, such as a dietician or the speech and language therapy (SALT) team.

People told us that the staff had the skills to meet their needs. One person said, "The regular staff do a good job, they're helpful and informative. They are really lovely that work here." Another person commented, "I get the impression they have been trained to a good standard, oh yes they know what they're doing." One person's relative said, "The dementia side of caring comes through quite strong, their understanding."

There were systems in place to ensure that staff were provided with training and support and the opportunity to achieve qualifications relevant to their role. Staff told us that they were provided with the training that they needed to do their job. This included training in safeguarding, medicines, moving and handling, fire safety, first aid, and dementia. We also saw training certificates where nursing staff had received training in people's specific needs including continence and eating equipment used by people. The registered manager told us how they were speaking with a community health professional to deliver training to staff on Parkinson's disease.

New staff were provided with an induction course, which included training such as safeguarding and moving and handling. Where new staff had not completed a recognised qualification in health and social care, new staff were completed to complete the Care Certificate. This is a recognised set of standards that staff should

be working to. One person told us about how staff were supported, "They are supervised, we've got one nurse, I'd say [they are] very close to being qualified, matron [registered manager] decides when [they] can be on their own, they can't give injections on their own, they have to get someone to supervise them."

Staff told us that they were supported in their role. Records showed that staff were provided with one to one supervision meetings. These provided staff with a forum to discuss the ways that they worked, receive feedback on their work practice and used to identify ways to improve the service provided to people, including identifying any training needs they had.

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.

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.

The registered manager understood when applications should be made and the requirements relating to MCA and DoLS. Staff had received training in the MCA and DoLS. We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals and where they wanted to spend their time in the service. People told us that the staff asked for their consent before they received any care. One person said, "They [staff] even ask if it's okay to give me my medication." Care records included information about if people had capacity to make decisions and documents had been signed by people to consent to their care identified in their care plan. The records included best interest DoLS assessments, which stated if people required a DoLS and any best interest decisions.

People were complimentary about the environment and how it met their needs and choices. One person said, "They come in and move anything for me, move my equipment around for me. Matron [registered manager] said is there anything we can do to change that [tall storage unit], it was blocking out the light, it's much better now." One person said, "I'm using their Wi-Fi, it works very well." Another person told us, "The maintenance staff here is excellent, [they are] quite good with computers will come in, sort out a couple of problems for me." This showed that the service provided technology to people to use to, for example, keep in contact with their relatives.

There were systems in place to monitor the environment and where required, redecoration was undertaken. Records showed that safety checks were undertaken as required, including electrical and gas safety. People's bedrooms included items of their personal memorabilia which reflected their choices and individuality. One person told us about the large photographs and canvases on the wall, high up above the foot of the person's bed to enable them to be seen. "The maintenance [staff] put them there," which was the person's choice. Bedrooms varied in size but were largely of good proportions with good natural light. People's bedrooms benefited from anti-slip vinyl floor covering. The environment had communal areas that people could use, including lounges and dining area. There were areas in the service where people could see their visitors in private.

The facilities was designed and adapted for use by people with limited mobility and users of wheelchairs.

For example, bathrooms had wide doors, there was equipment to raise the height of the toilet seat and grab rails. Handrails were present on both sides of each of the two stairwells and two lifts were provided, one at each end of the main corridors leading to people's bedrooms. Good contrast existed between walls and floors and the ambient light was adequate throughout. The registered manager told us how there was an ongoing programme of redecoration. Walls were being painted in a way which contrasted with each other to support people living with dementia. People and relatives had been consulted about the changes in the décor.

There were signs present providing directions to room numbers along corridors on both floors. Bathrooms, toilets and facilities such as laundry room were labelled and people's names and bedroom numbers were present on the entrance doors to people's private rooms. The signage however was indistinct and people using the service, and their visitors would benefit from larger visual signs positioned with disability awareness in mind. We spoke with the registered manager about this and they said that they would look into making these improvements.

There were gardens which people could use. One person had their bed positioned so they could look out to the garden. They told us, "They [staff] get me up for a little while, but I can't sit for more than an hour." Another person said, "I went down to the garden last week, we were planting sunflower seeds. I hope to go outside again soon."

Good

Is the service caring?

Our findings

At our last inspection of 27 October 2016, caring was rated good. At this inspection the service had sustained the good rating for caring.

People spoken with said that the staff were caring and treated them with respect. One person said, "It's very comfortable, and they're very caring." Another person told us, "First class, I can't fault them at all, they're here to do what you want them to, that's their attitude, they're keen to help." One person's relative commented, "Excellent, they look after [family member] really well. They are friends as well as carers. They have a laugh with you, singing songs and joining in." Another relative said, "The carers really do care, and the nurses. They just seem to care about [family member's] feelings and comfort." Another relative told us, "One carer treats [family member] as their own relative. They will stroke [family member's] cheek, rouse them gently from sleep."

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff talked about and with people in a caring and respectful way. We saw examples of caring and compassionate care which helped to make people feel as though they mattered. A member of staff entered a person's bedroom and said, "How are you doing [name of person]? I've just come on shift so I thought I'd say hello." Another staff member offered to take a person to the afternoon entertainment, when the person was not yet ready the staff member said, "You give me a call anytime when you're ready my lovely and I'll come back for you." We saw a staff member pick flowers from the garden and take them to a person in their bedroom, this person was cared for in bed. We heard a staff member talking with a group of people about their grandchildren. The staff listed the people's grandchildren's names and complemented each saying things such as, "[Grandchild] is beautiful." This made people laugh and they chatted about their family. Staff spoke with people in a caring and calm manner. They positioned themselves at people's eye level when speaking with them and gave them time to share their views.

People's records identified how people's privacy was to be respected. We saw that staff knocked on bedroom and bathroom doors before entering. We observed a member of staff who knocked and waited outside a person's bedroom when we were present. They were polite with the person, when we left they closed the door to ensure the person's privacy whilst they were supporting them. One person's relative said, "They always respect [family member], cover them up."

People's records identified the areas of their care that they could attend to independently and how this should be respected. We saw that staff encouraged people's independence, such as when they were eating and mobilised.

People told us that they made choices about their daily lives and the staff acted in accordance with their wishes. One person said, "In fact I've done it only this week, I said to the nurse that I was finding that if I had a cooked breakfast at 8.30am, once they've done my personal hygiene, that lunch was too early for me. They've now changed my lunch, made it an hour later, and that helps me to eat my meals." One person's relative told us, "They are very good [asking about care preferences]."

People told us that they contributed to the planning of their care, including in the drawing up of their care plans and their care reviews. One person said, "Twice a year, and I have to sign it [care plan] after they've done the review. It's normally one of the nurses, they let me know what's going on, what they have recorded. [Relatives] have been to a couple of meetings, they do contact [relative] when a review is on and invite them." One person's relative commented, "We've just had a review, and that's when we got [how their family member makes choices about their food], it was [deputy manager] that came up to do that." Another relative said, "They talk to us about their [family member's] review."

People's views, and those of their representatives where appropriate, were listened to and their views were taken into account when their care was planned and reviewed. This included their choices and usual routines, such as how they preferred their personal care to be delivered and their preferred form of address.

There was a chapel on site which was promoted as a multi-denominational facility. People were invited to use this facility for their personal spiritual needs. In addition one person told us, "The lady from the church comes in to see me once a week."

People told us that they could have visitors when they wanted them. Records included information about the relationships that people maintained which were important to them. One person commented, "I keep in touch with relatives with my [electronic device]." The service had Wi-Fi installed to support this. One person's relative said, "We stayed one night, every hour they were checking on us, offering us drinks and food."

Good

Is the service responsive?

Our findings

At our last inspection of 27 October 2016, responsive was rated requires improvement. This was because improvements were needed in how people's needs were assessed, planned for and met. There was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and responsive was now rated good.

People told us that they felt that they were cared for and their needs were met. One person said, "They clean my dentures and things." Another person commented, "They look after my mind and body, this is my home now and I've got to live here." Another person said, "They attend to all of my needs, yes they do everything, and all to my satisfaction, absolutely." Another person told us about how they preferred their personal care needs met, "I put my dressing gown on, they pick me up on a trolley [wheelchair] and take me round to the bathroom before breakfast."

Staff were responsive to people's needs. One person's relative told us, "[Family member] spilt tomato soup, they [staff] came straight away, put a clean nightie on." Another person's relative said, "They stopped the hoisting when they knew [family member] was too uncomfortable and became anxious and breathless when they were hoisting and moving them. We had to sign a letter stating that we agreed to this."

People's care records detailed how their specific care needs were assessed, planned for and met. They provided staff with clear guidance on how people's needs and preferences were to be met. Daily records identified the care people had been provided with to meet their needs and preferences. In addition they identified how the person had presented, such as, "Good mood." This enabled staff to identify if there were any changes to people's wellbeing.

There had recently been the appointment of an activity staff member who was working on improving the activities provision to people. This included larger group and one to one activities. They showed us research they had done in relation to assisting people with their interests which improved their wellbeing. They had plans in place for future activities. People and relatives told us about the activities staff and how they were finding out about their interests to plan activities that were meaningful. One person said, "[Activities staff] has been here a long time as a carer, [they have] been in a couple of times, will talk to you about anything." Another person commented, "We've got a new [activities staff], we've had [them] about two weeks now." One person's relative said, "[Activities staff] was talking to [family member] asking about their interests. We have had one of the [staff] in, asked you [to their family member] what music you like." A compact disc and player had been provided by the service in response to what the person had said, for them to enjoy in their bedroom. Another relative told us, "[Activities staff] is absolutely wonderful, talks to [family member] about their background and interests. You can see, as soon as [family member] hears [activities staff's] voice, they relate to [activities staff]."

The activities staff told us about how they had introduced activities for people living with dementia. They said, "I've done hand massage, and they [people] have reciprocated. I try and talk to them about that time [the time that people were living in]. I would like to put things in their rooms, memory boxes, photographs,

pictures of places they used to go."

As well as the activities staff, changes in the service included an overlap of the morning and afternoon/evening care staff which gave staff time to spend with people on a one to one basis. This was confirmed by staff and a relative who were spoken with.

People told us that there were social events that they could participate in, both in a group and one to one basis. One person said, "We get a regular newsletter, events that are going to happen." Another person told us about the displayed photographs of them planting seeds in pots in the garden, "[Activities staff] put them there for me to look at, and my [relative] can see them too." Another person said, "They took me in the wheelchair to the shops in town last Friday, it was nice to get some fresh air." Another person said, "They have been and helped me with my [tablet computer], and [staff member] came in on Sunday, spent half an hour with me, using it."

There was an activities programme in place which included visiting entertainers, a pat dog scheme where people could see and stroke dogs, arts and crafts and gardening. The activities staff was supported by a group of volunteers who did activities with people such as reading to them. We saw people participating in activities during our inspection. We observed the afternoon activity which were visiting entertainers performing in the chapel. People were using coloured nets to hold and wave in the air to the music. It was evident that everyone was enjoying the music and several people were observed to be actively joining in. One person had gone into the lounge and requested to have the Commonwealth Games on so they could watch. Some people spent some time with the volunteers.

We spoke with one person who remained in their bed and was unable to respond to our questions verbally. They were however able to make facial gestures which we concluded to be positive in response relating to if they were happy using the service. The person's bed was positioned to enable the person to benefit from a good view of the garden and they held a tactile colourful object in their hand. Another person told us about the support they received whilst they remained in bed, "Oh yes, the [staff] when they come to see you they're always chatting. They do come and see me when they're not doing jobs. The hairdresser does my hair in bed, the next caller I've got is the chiropodist. I've not had them before but they have put my name down." One person's relative told us how the service had miniature donkeys in the service and they had tried to get them in the lift to visit their family member who was being cared for in bed and liked animals. This was not successful so the staff took photographs of the animals and provided them to the person.

People told us that they knew how to make a complaint and that they were confident that their concerns and complaints would be addressed. One person said, "I'd get one of the carers to get hold of [deputy manager], they will be back to me quite quickly to tell me it's sorted." One person's relative told us, "I'd go straight to [registered manager] or [deputy manager]. They always let you know they're open at any time." Another person's relative commented, "We would talk to the [staff], ask to speak to the nurse, and it's always been resolved at this stage". Another relative told us when they had raised a concern, "Matron [registered manager] said don't worry, we can sort it out. The door is always open."

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. Records showed that people's complaints and concerns were investigated and responded to in line with the provider's complaints procedure.

People's records included their decisions about the care they wanted to receive at the end of their life. For example, if they wanted to be resuscitated, where they wanted to be cared for, specific choices relating to their care at the end of their life and any arrangements they had made for their funerals. One person told us,

"We did discuss end of life, I wanted them to attempt resuscitation, my [relatives have] been involved too."

Cards and letters had been received by the service from people's relatives thanking them for the care provided. One of these stated, "[Family member] was so happy in [their] final years and days and this was made possible by all of you." Another stated, "You were all so kind and caring to [family member] in [their] last days, it was much appreciated by us all. Thank you for supporting us as a family too in those final days." Another commented, "Your care and compassion have made [family member's] last few years as comfortable as they could have been."

Good

Is the service well-led?

Our findings

At our last inspection of 27 October 2016, well-led was rated requires improvement. This was because improvements were needed in the provider's systems for monitoring the service. There was a breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and well-led was now rated good.

On 15 March 2018 we inspected another one of the provider's locations where we met with the Trust's chief executive. They told us how they ensured all of the provider's services continued to improve. To support this there had been a restructure in the provider's senior management. There was regular communication between locations to share good practice, suggestions for improvement and using learning from all locations to drive improvement. There was a structured system in decision making which included senior management and the management teams from each location. We saw the minutes from the core management meetings which confirmed what we had been told.

There was a system to continually improve the culture across the organisation, including the introduction of values workshops from January 2018. Each member of the organisation was to attend. These were to ensure a caring and compassionate organisation. They were also sharing learning via newsletters which were provided to staff working in the Trust with their pay slips. Changes had been made in the provider's terms and conditions for its staff, staff were kept updated in meetings and information provided. Since July 2017 there was a clinical educator in place who was a registered nurse, they were working on the provider's mandatory training, development and induction. From April 2018 improvements were being made in the appraisal system, based on the values workshop to improve on quality and efficiency. All of the improvements made were seen as a way of improving the service provided to people.

People and relatives told us how they had been kept updated and consulted about the improvements being made in the service. One person's relative said, "I attended the meeting at Ditchingham, I asked at the meeting and received a response from the person, told me who was in charge, open and honest. It was a good meeting, he [chief executive] was a lovely chap." Another relative told us, "They invited us to attend a meeting, the new director, I came out feeling really excited that they wanted to bring this [the service] into the 21st century and make it work. The staff were encouraged to go, relatives and volunteers. We were able to ask questions, they interviewed everybody. I do know that staff have an hours overlap now, so that came out of it. I know this director wants to improve people's morale. I was quite encouraged by all of that."

The service's Provider Information Return (PIR) detailed what the service did well and the improvements that were intended in the next 12 months. This included what we had been told by the chief executive and improvements being made in the culture of the service. One staff member told us about the changes in the service, "Once the staff get used to being more activity orientated, rather than task orientated, and the culture. It's changing, we had people here who became very isolated, and when there's a lot of change on the go it takes a long while to filter through…I think we're on the right track now." Another staff member told us that they could see improvements. Another staff member told us about the positive culture in the service.

We had received information of concern in July 2017 which stated that because the registered manager and deputy manager were related, this made it awkward to raise concerns. During our inspection we spoke with the registered manager and the human resource manager who told us that if concerns were received which related to the registered manager and deputy manager, these were managed by the human resource manager, which reduced the risk of a conflict of interest. We also received a concern in September 2017 which told us that all staff did not speak or read English. We wrote to the registered manager who provided us with information about how prospective staff member's language skills were assessed during recruitment and ongoing language skills were provided by the organisation, where required. This was confirmed by records we reviewed during our inspection. One person told us, "The carers are wonderful, 80% of the carers here are [from another country] and they're all amazing. They work here because they like what they do."

The provider and registered manager had systems in place to monitor and assess the service provided to people. These included audits in care records, infection control and medicines. Where shortfalls were identified actions were taken to address them, such as providing training for staff. Falls and incidents were analysed for trends and these were used to identify if any improvements were needed. However, we noted in the incidents records for issues that had arose with medicines, the same staff member had been found to be requiring improvement. They had been provided with re-training twice, the records did not identify that the same staff member was responsible for incidents. We discussed this with the registered manager about how this could be identified as a pattern. They assured us this would be included in future analysis and actions to be taken. Incident reports identified that staff were spoken with, however, they did not demonstrate that the person's wellbeing had been checked. The registered manager said that they would do this in the future.

People and relatives were involved in developing the service and were provided with the opportunity to share their views. This included quality assurance questionnaires. There were satisfaction questionnaires in people's records which had been completed by them and by their relatives. One person's relative told us, "We had a meeting here, the other day, asking our views. [Staff member] asked us to write down what we thought could be done better, and things in general, keeping the standard up. How did we think they could improve." Minutes of resident and relative's forum meetings were reviewed. People had voted that these were to be held six monthly. They discussed ideas for areas such as the menu and activities. A person commented on the open culture in the service. They said, "I got as letter saying CQC [Care Quality Commission] was due, it said to be honest and answer the questions and to say what we thought."

Large notice boards were present in the main corridor leading from the reception area, and positioned at both seated and standing level with some information duplicated. These contained a variety of essential and useful information for both people using the service and their visitors. The registered manager told us that the lower notice board was provided because a person had said that they could not read the information because it was too high.

People we spoke with were complimentary about the approach of the registered manager and provider. One person commented, "Yes, matron [registered manager] comes regularly, comes in for a chat. She's on first name terms with everybody." One person's relative said, "In general everything works pretty well. I know them well, the matron [registered manager] and the deputy matron [deputy manager], and they keep me informed as well. I'm very happy with that." Another relative commented, "The manager always comes in, speaks to [family member], and to us, she shares an interest."

Staff understood their roles and responsibilities in providing good quality and safe care to people. Staff told us that they could go to the registered manager and other members of the senior team if they needed any advice or support. Staff meetings were held where they discussed the service and any changes in people's needs.