

Colten Care Limited

St Catherine's View

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

About the service: St Catherine's View provides nursing and personal care for up to 56 people who have dementia. The home is located in a residential area, approximately one mile from the centre of Winchester.

People's experience of using this service:

Leaders and management ensured a positive culture of person centred care, based on best practice and continuous learning. The management provided good leadership and were actively working to drive improvement. Feedback from people, staff and relatives confirmed the management were respected and led by example. Staff and people were supported and encouraged to share ideas about how the service could be improved and had been pro-active in supporting changes. Staff spoke enthusiastically about the positive teamwork and support they received. Fully embedded and effective systems were in place to promote lessons learned and to implement change, resulting in positive outcomes for people.

Staff were responsive to people's needs and consistently went the extra mile to ensure people's wishes and aspirations were known, understood and met. This had led to people being active and valued members of the community, continuing the 'working' life and having an important role in family life.

Staff felt their achievements were recognised and that they felt valued. Staff had a clear understanding of their roles and responsibilities. We observed staff were confident in performing their jobs and when speaking with people, other staff and the registered manager.

People and their families told us they felt the service was safe. Staff had received safeguarding training and had their competency in this subject checked. They were aware of the types of abuse that could happen to people, what signs to look out for and their responsibilities for reporting any concerns.

The registered manager had a good understanding of their responsibilities to notify the CQC of important events that happened within the service. People and their families had been given information so that they knew what to expect from the service.

People who required assistance with their medicines were supported by appropriately skilled and qualified staff. They had received training and competency checks and had a good understanding of the risks associated with the medicine people were taking.

Staff received appropriate induction into their role and learning opportunities were made available. They told us they received regular supervision and had a yearly appraisal. Staffing levels met the needs of the people using the service. Staff had been recruited safely.

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

People, their families and other professionals had been involved in an assessment before the service provided any support. The assessment had been used to create care and support plans that addressed people's individual identified needs. Staff demonstrated a good understanding of the actions they needed to take to support people. People had good access to healthcare services.

A complaints procedure was in place and people told us they were confident, and concerns would be dealt with appropriately by management.

Rating at last inspection: We previously inspected the service on 12 and 14 October 2016 and rated the service good.

Why we inspected: This was a planned inspection based on the previous rating.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 remains safe.

Details are in our safe findings below.

Is the service effective?

Good ●

The service remains effective.

Details are in our effective findings below.

Is the service caring?

Good ●

The service remains caring.

Details are in our caring findings below.

Is the service responsive?

Good ●

The service remains responsive.

Details are in our responsive findings below.

Is the service well-led?

Good ●

The service remains well-led.

Details are in our well-Led findings below.

St Catherine's View

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection team consisted of two inspectors, a nurse advisor 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.

Service and service type

St Catherine's View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We used information the provider sent us in the Provider Information Return (PIR). Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We looked at information we held about the service including notifications they had made to us about important events. We sought feedback from partner agencies and professionals.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and eight relatives about their experience of the care provided. We spoke with eleven members of staff including the operations manager, the registered manager, a senior carer, the clinical lead and the chef. We 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.

We reviewed a range of records. This included six people's care records and 10 people's medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, clinical and care audits and feedback questionnaires.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same.

This meant people were safe and protected from avoidable harm.

Feedback from people, their relatives and healthcare professionals was positive.

Comments included, "This is a safe place for me to live, I am really spoilt here", "This Home is nice and clean, my room is clean and my sheets are changed", "Staff are mainly available when he needs them, sometimes they are very pressured", "His medication is brought on time, he can be difficult but they make sure he takes it" and "I do think Mum is in a safe place, any problems are dealt with quickly, she is prone to falling and is closely watched".

Systems and processes to safeguard people from the risk of abuse

- The service had taken appropriate steps to protect people from the risk of abuse. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to.

Assessing risk, safety monitoring and management

- Records mostly reflected that risks were assessed, and plans developed to mitigate these. However, there were occasions when the records needed to be improved upon. For example, one the first day of our inspection we found that one person living with a blood clotting condition had not clear care plan in place to guide staff about the risks associated with this. Experienced care staff were aware of this risk and how to monitor for this. Following our inspection, a care plan specifically in relation to this condition was provided to us.
- Other identified risks were clearly assessed and appropriate plans to reduce these risks for people. These were developed based on individual needs and provided a good level of guidance for staff. This included a variety of areas such as skin integrity, continence, malnutrition as well as more specific risks for individuals.
- Staff had good knowledge of the people they supported. They were aware of risks associated with their care, how to monitor for these and the action to take to reduce these risks, meaning that the risk to people was minimised.
- Equipment such as hoists, call bells and fire safety equipment were serviced and checked regularly.
- There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations such as staff emergencies, heat-waves, flood, fire or loss of services. This also included information about evacuating the premises, alternative accommodation and important telephone numbers. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each

person would need to evacuate the premises in an emergency.

Staffing and recruitment

- Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions. Checks to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.
- There were enough skilled staff deployed to support people and meet their needs. During the day we observed staff providing care and one-to-one support at different times. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staffing levels had been determined by assessing people's level of dependency and staffing hours had been allocated according to the individual needs of people. Staffing levels were kept under review and adjusted based on people's changing needs. Staff told us there were enough of them to meet people's needs. Staff provided care in a timely manner to people throughout our inspection. Staff responded to call bells quickly. People said call bells were answered promptly and staff responded quickly when they rang for help. People who were unable to use this system were checked by staff at regular intervals to ensure their safety but also monitor their needs.

Using medicines safely

- People could be confident that medicines were managed safely and administered by competent staff who had access to appropriate guidance and information.
- Medicines were stored securely. The temperature of the medicine's storage was checked daily to ensure medicines were stored at the correct temperature. Medicines that required extra control by law, were stored securely and regularly checked.
- Medicines had pharmacy labels and were in date. They were kept in suitable quantities without large excesses. Bottles and creams were dated when they were opened to ensure they were not used past their expiration time.
- Accurate records were maintained of medicines received into the service, administered and disposed of. Medicine administration records (MAR) were completed as required.
- Where medicines were prescribed to be administered on an 'as required' basis, clear protocols to guide staff about the use of this were in place. Staff ensured medicines were reviewed with people's GP's on a regular basis. The clinical lead monitored the usage of medicines for mental health conditions and behaviours to ensure this was effective and still required. This process had led to positive outcomes for some people living in the home. For example, one person's medicines were reduced and were now able to be transferred to a specialist wheelchair, converse with staff, engage in communal areas with other people and have a more meaningful relationship with their spouse.
- Staff told us they received training in medicines administration and that their competence was assessed on an annual basis, in line with national guidance.
- We looked at two people's records in relation to antipsychotic medication. Staff discussed the balance between ensuring that medication is used appropriately to manage symptoms but not overused as a way of addressing some symptoms of behavioural and psychological symptoms of dementia. The care plans suggested alternatives for managing some behavioural elements, for example a resident was risk assessed

as a high risk of falls but becomes distressed when sitting down for periods of time. There were plans in place to support the resident to keep active safely. Reviews suggested that there was a reduction in their distress and the number of falls.

Preventing and controlling infection

- Systems and processes were in place to ensure the service managed the control and prevention of infection well.
- Staff received infection control training.
- Staff had access to and used appropriate personal protective equipment.
- The home was clean, tidy and free from bad odours.

Learning lessons when things go wrong

- When something goes wrong the service responds appropriately and uses any incidents as a learning opportunity.
- All incidents and accidents were monitored and reviewed regularly by the registered manager, clinical lead and provider to identify any patterns or trends. They were analysed for any necessary action and learning was discussed with staff.
- For example, following an incident that occurred which resulted in a person being admitted to hospital the service undertook and completed a review of all nutritional support in the home. The service held a multidisciplinary meeting with key individuals from the provider to look at the way the home prepared, delivered and provided all meals in the home. As a result of this incident and meeting a number of actions were taken to ensure the risk of an incident such as this reoccurring for this person and for any other person living in the home was minimised.
- Following an incident whereby a person left the home unsupported and put themselves at risk, the service undertook a 'Significant Event Analysis' to identify the cause of the incident. Management meetings took place and multiple actions were implemented to reduce the risk of this reoccurring. This included partnership working with the Fire and Rescue service, to ensure measures implemented did not pose other risks.
- The clinical lead told us how they had identified from an analysis of infections a concern which led to observation of staff practice and a change in the way personal care was delivered. The outcome of this being that the level of infections in the home had significantly reduced.
- Staff confirmed that learning from incidents and accidents was shared with them.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this. Feedback from people, their relatives and healthcare professionals was positive. Comments included, "The food is good here, there is a good choice", "Snacks and drinks come round all the time and mid-morning and afternoon", "I use the visiting doctor if I need one", "The Staff noticed a problem with Mum's teeth and took her at once to a Dentist to sort the problem out", "The Staff are well trained, capable and compassionate in their dealings with Mum", "Mum loved the food but now she finds it difficult to eat so they make her things she can manage" and "Mum needs support with her feeding and the staff are always there for her" and "He does enjoy his food here, he shouldn't eat his favourite Chinese foods but they sometimes disguise his meals to look like a Chinese meal".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they wished to receive.
- Staff delivered care and support in line with best practice guidelines; for example, they used nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition and planned care to reduce any risks for people.

Staff support, induction, training, skills and experience

- To reduce staff turnover the provider had seconded a member of the team to a new role for the home called 'Induction Partner'. The purpose of this role was to mentor and support new staff to the home; providing a bespoke induction experience with the aim of improving retention and successful completion of the care certificate. The induction partner was provided with training in mentoring, coaching and was a central point of contact for all new starters at the home, overseeing their first few months in post. Since the introduction of this role staff turnover had reduced by 12% in 12 months.
- Staff were supported in their role and had been through the provider's own induction programme. This involved attending training sessions and shadowing other staff. The induction programme embraced the 15 standards that are set out in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.
- There was an on-going programme of development to make sure that all staff were up to date with required training subjects. Examples of these included health and safety, fire awareness, moving and handling, emergency first aid, infection control, safeguarding, and food hygiene. More specific subject areas of training had been provided to staff. For example, dementia awareness and diabetes and where an additional need was identified following incidents this was also delivered to staff. This meant that staff had the training and specialist skills and knowledge that they needed to support people effectively.

- A member of staff said, "We have tier one dementia training for all staff and tier two dementia training for groups of staff is planned with a following competency workbook and an individual supervision a month later to see how the training has improved or changed their practice".
- The provider employed additional roles at more senior levels to support the training needs of all staff and the clinical skills of the nursing teams across the homes and to provides nurses with additional professional development opportunities.
- There was a consistent approach to supervision and appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Staff received regular one to one supervision, annual appraisal and on-going support from the registered manager. This provided staff with the opportunity to discuss their responsibilities and the care of people living at the home. Records of supervisions detailed discussions and there were plans in place to schedule appointments for the supervision meetings. Staff had annual appraisals of their work performance and a formal opportunity to review their training and development needs.
- Competency assessments had been carried out in relation to moving and handling, personal care, risk management, medicines administration and infection control.

Supporting people to eat and drink enough to maintain a balanced diet

- People were protected from risks of poor nutrition, dehydration and swallowing problems. Where people required their food to be prepared differently because of medical need or problems with swallowing this was catered for.
- People's nutritional status was monitored, and action taken where a person was losing weight.
- Staff were knowledgeable about people's differing dietary requirements. Kitchen staff told us they were kept informed of people's needs, likes and dislikes. They attended risk meetings where any issues of concern for people were discussed. The chef visited people no later than 24 hours after they were admitted to the service to establish their individual preference and this information was reviewed six monthly to ensuring the kitchen staff had up to date information about people's likes and dislikes. They used this information to ensure people received meals that would provide them with good nutrition and that they would find appetising.
- People's care plans highlighted people's food preferences.
- Menus were personalised to people's needs and preferences and people received a balanced diet.
- Throughout the inspection, we observed that people were offered drinks and snacks regularly.
- Where people were supported to eat, this was done in a relaxed and encouraging manner.
- A Malnutrition Universal Screening Tool (MUST) and Waterlow scores were regularly reviewed. Any person who had weight loss was monitored with a food and fluid which was put in place for a period of three days to review intake. Several were in place; however, one residents' weight had been incorrectly entered and therefore clinical lead had not been alerted.
- In addition, dining experience audits took place to ensure this was a positive experience for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Robust needs assessments were in place. Pre-assessments were conducted, and further reviews were repeated every 12 weeks to establish the level of required care for each person.
- Regular meetings took place to discuss care, including 10 at 10 (handover meeting) , where new information was shared, and staff have the opportunity to raise any issues/concerns.
- Where people required support from external healthcare professionals this was organised, and staff followed guidance provided.
- Records confirmed regular access to GP's, district nurses and other professionals.
- Transfer records were available for when people required admission to hospital.

- There was clear evidence in people's care records of liaison with multi professionals, including Speech and Language Therapy (SALT), GP, Mental Health Services, Chiropody, dentist and opticians.

Adapting service, design, decoration to meet people's needs

- Technology such as call bell reporting systems, ramble guards and sensor had been implemented to ensure people received a safe and effective service. Equipment used to support people with their mobility needs, including hoists, had been serviced to ensure they were safe to use and fit for purpose. Staff had received training in moving and handling, including using equipment to assist people to mobilise. One staff member told us it was important to know how to move people safely and they felt confident that they and their colleagues were fully competent with this.
- To support people to communicate with family members who did not live nearby, the service offered the use of Skype.
- The service supported people who were living with dementia effectively. The layout, design and decoration of the building assisted people to navigate through the home as independently as possible.
- The home had used best practice guidance to ensure it was suitable for people who were living with dementia. Different coloured doors that looked like 'front doors' were in place. Signs were at an appropriate height and clear, using both text and pictures. Lighting and windows had been considered to maximise vision and a comfortable, homely environment. Large windows in communal lounges increased natural light during the day with curtains that were drawn in the early evening to reducing issues with sleeping that people with dementia may face. Themed rooms had been created to ensure there are areas of interest for all. A relative said, "The colours, the signs on the doors, the pictures of old celebrities all helps people to remember things and it gives them something to talk about".
- We were told the provider ensured the environment was kept under constant review to ensure it meet people's needs.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- Staff were observed seeking consent from people before providing any care.
- Consent forms were in place and signed by people where they had capacity to make these decisions.
- Mental capacity assessments had been carried out where required and best interests' decisions made, involving people's relevant representatives.
- We did note that for one person the records could be confusing as MCA determining a person lacked capacity were placed behind a signed consent form for the same decisions. Whilst this reflected people's ability to make decisions for themselves was kept under review, the records being held together could cause confusion.
- Applications for DoLS had been submitted to the supervisory body responsible for assessing and approving these. At the time of our visit two people had conditions associated with their DoLS which were being met.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question remained Good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

- Feedback from people and their relatives was positive. Comments included, "They do know how I like things done and they do it that way for me". "The Staff do treat me with respect always". "I am encouraged to be independent", "Mum is very well looked after, they are very caring here". "I was involved in Mum's care plan; the home gave me lots of information and help". "They call me by my first name and knock on my door to come in". "They are careful about protecting our dignity always", "His consent was sought and he was treated in a caring way", "Mum is treated with the greatest respect there".

Ensuring people are well treated and supported; respecting equality and diversity

- The Equalities Act 2010 is designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. There was evidence that people's preferences and choices regarding some of these characteristics had been explored with people and had been documented in their care plans. For example, gender and sexual orientation. We saw no evidence that anyone who used the service was discriminated against and no one told us anything to contradict this.

Supporting people to express their views and be involved in making decisions about their care

- Supporting people to express their views and be involved in making decisions about their care: Staff supported people to make decisions about their care, for example, when they wanted to get up, what they wanted to wear, how they wanted to spend their time.
- Staff understood peoples' communication needs and the registered manager assured us that information would be provided in a format that people needed to help them understand information.
- Resident committee meetings also took place which enabled people to be involved in discussions about wider aspects of the service. A minimum of 6 monthly reviews of care were conducted and included both the person and their relatives where appropriate. Relatives told us, "When my Husband first came here I was involved in a Care Plan for him, this gets updated" and "I was very involved in Mum's Care Plan from the start of her stay there."
- People said they felt listened to and confident to talk to any staff about any concerns they might have.
- Everyone was encouraged to engage in their care planning and in the running of the home.

Respecting and promoting people's privacy, dignity and independence

- Staff were observed to engage very positively with residents and visitors. they demonstrated good knowledge of the residents, their likes and dislikes. Information in care records relating to resident's life

stories are used to ensure staff take a holistic view of the person.

- An example of this within a care plan was an ex nurse, who supports the waitress and waiting team with setting up the dining experience which provides a meaningful activity of daily living. Staff report that this has a positive effect on the individual's wellbeing.
- People's independence was supported and promoted as much as possible. One person who was at high risk of falls, could become distressed if asked to rest or engage in a seated activity. Behaviours included pushing furniture around as part of their presentation and as a way of alleviating their distress. Risks were managed in a very positive way as the person was safely supported by staff to do this. This has resulted in a reduction in distress, a reduction in antipsychotic medication and also in the falls. The person retained their dignity, freedom of movement and independence.
- Where required people were provided with adapted crockery and cutlery to enable them to remain as independent as possible with meals.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained good. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Feedback from people and their relatives was positive. Comments included, "I do like the activities and join in most of them", "If I had a problem I would speak to the Manager", "If there were any problems I would talk to a Nurse or the Manager, none so far though", "I like the activities and enjoy dancing and games". "He likes music so any activity involving that he likes to be there. The staff have taken him out in their minibus and he enjoys that", "I am involved in Mum's care Plan and it is updated regularly" and "Mum likes activities like music and animal visits, she still goes out on Minibus trips".

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff activity encouraged and supported people to follow and maintain their interests as well as supporting them to take part in activities that were socially and culturally relevant and appropriate to them. They had gone the extra mile to find out about people's past, as well as engaging the local community to meet people's needs and make their wishes happen.
- A 'Resident of the Day' system was operated in the service which included a member of the companionship team spending time with people to determine what activities they had enjoyed, what they would like to do, if there were activities they hadn't enjoyed and if there was any trip destination or wishes they had. As appropriate, family and friends were also included in these discussions. The companionship team held 'activities committee meetings' where they spoke with all the people in the home to give them another opportunity to say what activities they would like to take part in or try something new. Monthly a plan of activities was created to include the activities people had enjoyed as well as other suggestions made.
- One person's wish was supported to come true by the service. This person had seen some motor bikes on display whilst visiting a local museum. They had enjoyed motorbikes prior to moving into the home and while out had made the comment that they would love to be able to go out and ride a motorbike. The companionship team worked with the local community and organised a fleet of motorbikes to visit St. Catherine's View and the person joined them on a trike motorbike ride around Winchester city waving and smiling at passers-by.
- Another person who had always been a big supporter of Southampton Football Club but who had never been to the most recent stadium was supported by the companionship team to watch a match at the stadium which they thoroughly enjoyed.
- A third person who loved motor sport was supported to visit Thruxton; this was recorded by a cameraman who filmed the trip so the person and their family could remember and enjoy the trip for the months/years to come.
- Arrangements for social activities to engage people, support them to live as full a life as possible and

ensure they felt valued were creative and innovative. One person's daughter was getting married but the person was unable to attend the wedding. Staff at the service arranged to hold a wedding at the home, where the person was then able to walk their daughter down the aisle.

- Arrangements to support people to continue to undertake a role similar to that of their previous employment took place and was creative. For example, one person used to be a Vicar. It was their wish to get involved in the services held in the home on a Sunday. The Companionship team supported the person to become involved by helping organise the readings, hymns and prayers, as well as supporting the person to deliver this for other people in the home.
- Another person was supported by the companionship team who contacted the current Mayor to arrange a visit for a tour of their residence.
- The provider worked in partnership with various educational services and community projects to promote integrational interaction and learning. Children from local nurseries, schools and dance groups had visited the care home to perform dance sessions and Christmas carols. Staff were organising a chat and tea session run by community volunteers at Badger Farm Community Centre.
- The environment had been arranged and themed to encourage engagement in activities. People took part in the 'Colten Village Produce Show' which took place to engage people with gardening. A world travel room with a huge atlas on the wall was available, a boutique country style tea room was also in place. We were told this room helped to promote both a social experience as well as nutritional and fluid intake with a tea/coffee machine and sweet treats/snacks always on offer.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- There was clear evidence of person-centred care within people's care records. Care plans were individualised, and regular reviews provided a summary of the effectiveness of the care or whether things have changed.
- People received personalised care and support specific to their needs and preferences.
- Staff were knowledgeable about people's preferences and could explain how they supported people in line with this information.
- Staff involved people and their relatives where appropriate in the support. They gathered information from a variety of sources to ensure that the care plans implemented were based on the individuals needs and preferences.
- Care plans and our observations demonstrated that people's choices were respected. For example, one person's care records identified it was important for one person to wear makeup and perfume. We observed that this was supported.
- Staff responded to people's needs to ensure good outcomes. Following a review of the use of medicines for one person, staff made a referral to the Older Persons Mental Health Team which resulted in a more appropriate choice of medication to support the person mental well-being. This resulted in a reduction in distressed behaviours and increased intimacy with their spouse, enhancing their quality of life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were recognised, and action taken to support these. The provider ensured people with hearing or visual impairments had access to either audio or enhanced visual formats of information relating to the service.
- An example provided to us included, one person who due to their condition, regressed to only understanding their first language and became unable to speak. The staff supported this person by

developing cue cards, learning key phrases and enabling the person to use facial expressions in response to these key phrases.

Improving care quality in response to complaints or concerns

- The provider kept a complaints record. People and relatives told us they knew how and who to raise a concern or complaint with. The complaints procedure gave people timescales for action and who in the organisation to contact. People told us that if they were unhappy they would not hesitate in speaking with the registered manager or staff. They told us they were listened to and that they felt confident in raising any concerns with the staff. Complaints had been appropriately investigated by the registered manager. Relatives and staff were familiar with the provider's complaints procedure and they all said they would speak to the registered manager directly. A relative said, "I have never had to complain, this home is brilliant in every way".

End of life care and support

- One person was receiving end of life care at the time of our inspection. Their family confirmed that staff had discussions with the person and them about end of life care needs and wishes. Staff demonstrated a good understanding of these and were ensuring appropriate physical and emotional support was provided. However, no plan of care had been developed. We discussed this with a nurse and a quality manager who agreed end of life care planning needed to be undertaken at a time when the person is able to contribute to this. On the second day of our inspection the registered manager provided us with a care plan that reflected the person's needs.
- The provider had established an End of Life steering group and the clinical lead was involved in this. Leaflets and additional training were being developed for staff. The service was also working closely with a local hospice to build on knowledge and skills in end of life care delivery.
- Following a death staff reflected on the experience of the person, their loved ones and the staff who were involved in the end of life care of the person. An 'After Death Analysis' was completed which aimed to provide an opportunity for the team to identify and commend best practice in end of life care as well as supports them to highlight actions needed where necessary.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant the service was consistently managed and well-led. Leaders, and the culture they created, promoted high-quality, person-centred care.

Feedback from people, their relatives and healthcare professionals were positive. Comments included, "This is a happy place to live, I like it here very much", "The Atmosphere is very good here, everyone gets on well together", "Staff, Manager and residents make this a nice place to live, the atmosphere is quite jolly sometimes", "The Staff do keep me informed about my Husbands condition", "They do invite me to Residents Meetings held every few months", "We are kept informed of any events taking place", "This Service is well managed and runs well, Staffing levels seem better now", "This Home is well run, professional caring I call it" and "The home does ask our opinions and they hold Residents Meetings".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The day to day culture of the home was that of high-quality care, delivered by staff who cherished people and cared about their wellbeing. The management team and staff demonstrated dedication and understanding in their roles. They told us they were proud of what they did and worked together to achieve positive outcomes for people. People and relatives without exemption expressed a positive view about the ethos and values of the management and staff team's dedication in providing excellent person-centred care. One visitor said, "The atmosphere here is just wonderful, I can't fault it at all". Another person said, "The Staff do seem happy in their work here, they create a very nice atmosphere. This Home is well run, professional, caring I call it".
- The management team had strong oversight of the service. When we asked questions about the service they replied promptly with in-depth responses. This demonstrated a thorough knowledge and understanding of the services. The provider and the management team led by example. They showed they had a strong commitment in continuing to review their systems and processes, based on best practice and to continually improve. For example, directors undertook annual 'walkrounds' and the most recent had led to further improvements to the environment for people living with dementia.
- The provider held an annual conference, inviting external speakers which enabled those attending to learn about national agenda's and innovations in practice and education. This also enabled the provider to recognise and celebrate success of their teams, encouraging openness and promoting a person-centred culture.
- The culture was open, and everyone's input was listened to and valued. Staff had confidence to whistle blow, if they felt other staff had exhibited poor practice or were not working in line with the services value base.

- Staff attended regular handovers in the morning, afternoon and evening when there was a change in staff teams. Handovers were detailed. Information was provided verbally by sharing up-to-date detail about people's physical, emotional and medical needs and any changes. It was clear that staff knew people, their lifestyles and their medical needs very well.
- The provider had invested in an 'Employer Assist Programme' for staff. Recognising that the job and life can be very stressful, and staff may need additional support with health and well-being. This meant that staff had a 24-hour confidential helpline to access external guidance and support if required.
- A clear staffing structure was in place and everyone knew and understood their roles and responsibilities. The provider supported staff in senior care roles to gain the skills needed to support more junior staff. Individual staff members had lead roles in the service and used the knowledge gained to cascade to other staff and ensure best practice was delivered. In addition, the provider employed a team of 'Admiral Nurses'. The role aimed to support people, relatives and the community affected by dementia throughout their journey from diagnosis through to end of life and bereavement support for families. The role provided training and support, practice advice, relative support and audit.

Continuous learning and improving care; Working in partnership with others;

- The provider's leadership team ensured a strong emphasis was placed on continuous learning and improvement. Governance arrangements were thoroughly embedded and effective. There was a strong framework in place to ensure that themes and trends were clearly identified, and corrective actions taken proactively when required.
- Regular senior leadership meetings took place to discuss the service, reviewing risks, policies and procedures, complaints and human resources. We saw detailed minutes and actions from these meetings, highlighting who was responsible for the action and the completion date.
- Action plans detailed how to improve the service which contained innovative service developments they were in the process of developing further. This included looking at the use of new technologies, setting up staff steering groups, community engagement and further developing work with local schools, increasing meaningful activities for people to increase happiness and well-being. This meant that the management team continuously strived to improve and enhance people's care, support and experiences.
- The service worked in partnership with other organisations to ensure best practice and ongoing learning. The Clinical Lead from the home attended a networking/learning event with Winchester Hospice to develop their knowledge and to encourage partnership working.
- Links with local universities had been established and some staff were undertaking mentor programmes to be able to support student nurses through their training. The provider was working with a university to gain accreditation for a registered nurse preceptorship programme.
- The provider also supported student nurses through offering placements at the home. The provider aimed for this opportunity to open up the prospect of working in residential based nursing care following qualification whilst improving perceptions of the sector. Feedback to the provider received from one student nurse supported this. They said, "I felt SCV delivered a great learning opportunity and I would definitely recommend future students to work at this placement with a wonderful team of people to help support them through their learning experience".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

- Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People and staff were involved in every aspect of developing the service and were at the heart of all decisions made, from staff recruitment to the décor and layout of the home.
- People, relatives, staff and external professionals were given opportunities to feedback about their experiences of the service. We found that survey responses were overwhelmingly positive, with the majority of responses being excellent. Staff told us, "The manager is just first class, we have all worked together so well and I wouldn't want to work anywhere else", "This is the best company I have ever worked for" and "We are like a family, we have plenty of support, lots of training and there is a huge amount of knowledge in the home"
- Staff were encouraged to voice their opinions using staff surveys and there was an 'open door' management approach. Staff came to the office unannounced and the registered manager ensured they were available to listen to any staff concerns.
- Without exception staff told us they felt valued and supported by the management team and enjoyed working as part of a dedicated team. There was a strong, positive culture of continuous learning and development. The registered manager had introduced reflective learning sessions. For example, once a month staff came together to reflect if they have supported someone with end of life care, identifying what went well and what could have been better to improve on staff practice.
- The registered manager had made strong links with the community, through coffee mornings and published success stories from the service through regular press releases and online social media sites to advertise. This ensured that information was shared more widely across the local community.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had a Protected Characteristics Group Supervision form which looked at case studies and encouraged proactive discussion about meeting the needs of the individuals. The Equality and Diversity Policy and training materials had been updated to include sexuality in the older person. One person's mental wellbeing care plan detailed the support they required to engage safely in their relationship. The relationship was supported by the staff.
- Staff were provided with training in equality, diversity and human rights. One member of staff said, "We treat everyone fairly and we don't judge".
- Following feedback, the provider actively worked to make changes based on this. For example, the development of a two-tiered approach to Mental Capacity and Dementia training was a direct result of consultation and feedback from all staff, including home managers.