Sunrise Operations Winchester Limited

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Inspection report

Sunrise of Winchester
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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

Overall summary

This inspection took place on the 2 and 3 December 2015 and was unannounced.

Sunrise of Winchester provides nursing and personal care for up to 103 people, including people living with dementia.

The home consists of two communities. The reminiscence community is for people living with dementia and is based on the second floor of the building. This community has secure access. The assisted living community is based on the ground and first floor of the building. People living in both communities were supported with nursing needs. At the time of our inspection there were 32 people living in the reminiscence community and 60 people on assisted living. The home provides accommodation in ensuite

Summary of findings

rooms and suites that include bathrooms, bedrooms, kitchens and living areas. There was a large garden and a secure outside terrace on the second floor. People had access to a range of facilities such as; community dining areas, a private dining room, library, activity and entertainment areas, TV parlour and a 24 hour bistro for self service drinks and snacks.

The service was overseen by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Sunrise of Winchester. Staff completed training in safeguarding people from abuse and knew how to act on any concerns. The registered manager took action to ensure people were protected from harm to themselves or others.

People were supported to manage risks to their safety. Risk assessments guided staff on how to support people safely and these were followed in practice. People's risk assessments were regularly reviewed to ensure they were updated with any changed needs. People experienced safe care and treatment.

People told us there were enough staff to meet their needs safely. The provider assessed their staffing levels against people's care and treatment needs to ensure enough staff were deployed to meet these. Action had been taken to address a shortfall in nursing staff and staffing needs were kept under daily review. Staff had the time to meet people's needs at their pace and to enjoy social interactions with people.

Staff were recruited safely and all the required checks were carried out to ensure people were protected from the employment of unsuitable staff.

People's medicines were managed safely. Staff administering medicines were trained and assessed as competent to do so. People were supported to achieve a reduction in the use of anti-biotic and anti-psychotic medicines where other interventions could achieve a positive result. This included increasing fluids to prevent a urinary infection and responding to people's behavioural needs without the use of medicines to control their anxieties.

People were supported by staff who completed training to meet the needs of the people they supported. Staff were assessed as competent to carry out their role at induction through completion of the Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care that care workers are nationally expected to achieve.

Staff told us they were adequately supported in their role and records showed staff had regular supervision and appraisal. Staff had access to professional qualification training to enable their professional development. People were supported by staff who were trained and assessed as competent in their role.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate DoLS applications had been made on behalf of people following the completion of proceedures under the MCA.

Staff understood the principles of the MCA and people's consent was sought prior to care and treatment being provided. People rights under the MCA were upheld.

People were supported with their nutrition and hydration needs where risks had been identified. Where people required assistance with eating and drinking this was provided. People told us and we observed the food was good quality and people were offered plenty of choice to meet their dietary needs and preferences.

People were supported to meet their health needs by nursing staff on site and treatment provided by other healthcare professionals. People told us they achieved good health outcomes and were well cared for when they were ill.

People experienced kind and compassionate care from staff who knew and understood their needs and preferences. People's care plans included information that detailed their personal histories, likes and dislikes and this enabled staff to provide appropriate support. People told us they enjoyed positive relationships with staff.

Staff supported people to make decisions about their care and treatment and gave people choices. People who

Summary of findings

lacked the capacity to make decisions and express choices were supported by family and representatives to inform the way their care was delivered. People had access to an independent advocate to represent their feelings and wishes when they faced important decisions they may not be able to make alone.

People received dignified care and their right to privacy was respected. People's relatives valued the sensitive approach taken by staff at the home when their loved one died.

People received person-centred care. People's care plans included information about their preferences and how staff should support people in the way they preferred. People's care and treatment was regularly reviewed with them or those lawfully able to represent them and adapted to meet their changed needs.

People received nursing care to meet their assessed needs.

People living with dementia were cared for in a calm and unhurried manner. The reminiscence community environment was adapted to meet the needs of people living with dementia and resources were available to meet their needs. For example; when people retreated to past memories they had access to items that helped them recreate their experience.

People's activity and social needs were met through a wide ranging programme that included group and individual activities. People told us about the activities they enjoyed and this included learning new skills and interests.

A complaints system was in place and information on how to complain was available to people, their families and visitors. People's concerns were promptly addressed and complaints were acted on.

There was a positive, open and inclusive culture within the home. Staff spoke positively about their work and felt well supported by their managers. A recognition scheme was operated by the provider and the registered manager to acknowledge when staff made positive contributions to the quality of care people experienced.

Staff completed training in the provider's values and evidenced the application of these in their work with people. For example; staff were seen to be joyful in their interactions with people and treated them and each other with respect.

The registered manager and her management team worked closely with each other and kept service needs, concerns and risks under daily review. Regular staff meetings were held to ensure all staff were informed of concerns, required improvements and the opportunity to contribute to service development. This supported staff to understand their role and accountabilities.

People, their relatives and representatives were given opportunities to feedback on the quality of the service they received. This included formal processes such as a satisfaction questionnaire as well as informal opportunities such as drinks with the managers. Feedback was acted on to improve the service.

A quality assurance system was in place to audit, review and monitor service delivery. Information from this system was used to drive continuous improvements and ensure people received safe and appropriate care. A clinical governance meeting was held weekly to review people's nursing care. The meeting included activities and catering staff to ensure people's needs were considered in a holistic and person centred way.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse because staff knew how to identify and act on safeguarding concerns. Action was taken to protect people from harm when required.

People experienced safe care. Risk assessments were in place to guide staff on how to support people safely. Where people used equipment to manage risks, this was assessed for its safe use.

There was a sufficient number of staff to care for people safely and meet their needs.

People's medicines were managed safely and staff were trained and assessed as competent to administer people's medicines.

Is the service effective?

Good

The service was effective.

Staff received appropriate training, supervision and appraisal to ensure they were adequately supported and competent to meet people's needs.

Staff sought people's consent prior to providing care and treatment. People's rights under the MCA 2005 were upheld in decision making where people lacked the mental capacity to agree to their care and treatment.

People were only deprived of their liberty where an application had been made to the local authority for authorisation. This meant the correct legal processes were being followed.

People were supported with their nutrition and hydration needs to minimise and address risks from malnutrition and de-hydration. People were provided with a good quality and choice of food to meet their dietary needs and preferences.

People were supported to achieve good health outcomes by nursing staff on site and other healthcare professionals as required.

Is the service caring?

Good

The service was caring.

People experienced kind and compassionate care and enjoyed positive relationships with staff.

People were involved in making decisions about their care. People who lacked the capacity to make decisions were supported by family, friends or an independent advocate. This ensured their feelings and wishes were supported as far as possible.

People received dignified care and their right to privacy was respected.

Is the service responsive?

Good

The service was responsive.

People received person-centred care in line with their assessed needs and preferences. People's care was regularly reviewed and updated with their changed needs.

Summary of findings

People received nursing care to meet their assessed needs.

People living with dementia were cared for in a calm and responsive manner within an environment adapted to meet their needs.

A complaints system was in place and complaints and concerns were acted on.

Is the service well-led?

Good

The service was well led.

There was a positive, open and inclusive culture within the home. Positive contributions to the quality of care people experienced were recognised by the provider and the registered manager. Staff were positive about their experience of working in the home.

Staff understood and demonstrated the provider's values in their work with people. These included; passion, joy in service, stewardship, respect and trust.

The registered manager and their management team demonstrated good leadership and management. They achieved this through effective communication and teamwork with each other and with the staff they managed.

There was a strong quality focus and robust quality assurance processes were in use. These resulted in improvements to the quality of care people received.

Sunrise Operations Winchester Limited

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 December 2015 and was unannounced.

The inspection team consisted of three inspectors, two specialist advisors 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. The specialist advisors were registered nurses with specialist experience of dementia and care auditing.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 25 people living at Sunrise of Winchester and two people's relatives to gain their views of people's care. We spoke with the registered manager, deputy manager, two community co-ordinators and interviewed 20 staff including, nursing, care, training, activities, maintenance, business and catering staff during our inspection. We also spoke with a visiting occupational therapist. During our visit 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 11 people's care plans and the care records of 19 people who were receiving nursing care. We observed care being given at lunchtime and throughout the inspection in communal areas. We reviewed the medicines administration records (MARs) for 20 people and we observed a medicines round. We looked at five staff recruitment and supervision records and reviewed staff training records for all staff. We reviewed policies, procedures and records relating to the management of the service, including staffing rosters from 28 September 2015 – 29 November 2015. We joined two staff handovers and two daily heads of department meetings.

We last inspected this service on 8th July 2013 where no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. A person said "The staff are so good, it makes you feel confident in them, and safe." Staff had completed training in safeguarding people from abuse and told us about how they would recognise and respond to allegations or concerns. For example; a staff member said "Abuse can be physical, sexual, psychological, institutional, financial or neglect. I would notice bruises on their body or if a person was behaving differently to normal. If I had concerns I would raise them with the manager". A safeguarding policy and procedures, including the local authority multi-agency safeguarding procedures, were accessible to staff for guidance.

Through our discussions with the registered manager and our review of people's care plans it was evident that when people were vulnerable to abuse, action was taken to protect people from harm to themselves or others. For example; when people had behaviours that challenged, management plans were put in place to ensure people's safety. The registered manager liaised with the local authority's safeguarding team if they had concerns about a person's safety or if they wanted any advice on how to keep people safe. Staff were confident that the registered manager and heads of departments would act on any concerns. People were supported by staff who understood the indicators of abuse and acted on concerns.

Risks to people's health and welfare had been assessed and plans put in place to instruct staff how to keep people safe. People's care plans evidenced risk assessments were consistently completed for identified risks, such as; falls, medicines, choking risk, nutrition and hydration and skin integrity. Equipment required to support people's needs had been assessed for associated risks. This included; wheelchair use, grab rail use and chair riser use.

Where risks were identified action was taken to reduce the risk. For example; where people were at risk of falls an assessment was completed which addressed risk factors in relation to falls. This included; footwear, medicines, infections and environmental risks. Falls were monitored and reviewed monthly to ensure appropriate action was taken. Records showed people had been supported to reduce the risk of falls through actions such as; referral to the specialist falls clinic, having their feet measured and footwear changed, equipment to assist people to mobilise safely and monitor their movements where required. Risk assessments took into account the person's choices for example; to remain as independently mobile as they were able to. People were supported to manage risks to their health and welfare.

Weekly fire system tests and monthly fire evacuation drills were carried out. People were not involved in fire evacuation drills, however each person had an individual evacuation plan which detailed the support they required in the event of a fire. This information was kept in people's care plans and in an emergency grab bag at reception. Checks and servicing of equipment were regularly completed to ensure the safety of equipment and utilities in the home. For example; water temperature testing, window restrictor checks and wheelchair checks. A business continuity plan was in place to ensure people were cared for safely in the event of an incident or emergency.

A system was in place to assess how many nursing and care staff hours were required to meet people's needs. Details from people's monthly and six monthly care plan reviews were fed into the system to generate a figure of how many care hours each person required. The system included additional hours to allow for staff sickness or annual leave. Staffing hours and recruitment needs were kept under daily review by the registered manager and heads of department to ensure the identified staffing levels were maintained. We noted a staffing shortfall in the October and November staffing rotas where there were not always two nurses available over night as required. The registered manager confirmed there had been no impact on people from the shortfall in nursing staff and resident numbers had been lower at that time. The registered manager told us they had recruited a nurse who was due to start work later in the month, following recruitment checks to ensure there was sufficient staffing deployed to meet people's assessed needs.

People and staff told us there were enough staff available to meet people's needs. During our inspection we noted that staff were patient and unrushed. Staff spent time with people enjoying social interactions as well as supporting people with their personal care needs. People were supported by enough staff to safely meet their needs.

Staff recruitment files contained evidence of all the required checks to ensure staff were safely recruited. This included; criminal records check, a full employment

Good

Is the service safe?

history, satisfactory references from previous employers and photographic proof of identification. Checks were completed for nursing staff regarding their registration status with the Nursing and Midwifery Council (NMC). This was to ensure they had no restrictions or cautions on their registration to practice. Records showed regular checks were completed to evidence their registration remained up to date.

Recruitment was underway for care staff vacancies in the home and agency staff were used to cover these vacancies. The registered manager told us they used the same agency staff whenever possible to provide consistency of care for people. The registered manager assured themselves of the suitability of agency staff by obtaining written confirmation of employment checks and details of their training and experience. Records confirmed these checks were completed. This meant people were protected from the employment of unsuitable staff.

Nurses and senior care staff administered people's medicines. These staff had completed safe medicine administration training and had their competency assessed before they were allowed to support people with their medicines. Competency assessments were repeated annually or as required. An audit system was in place to check medication procedures were followed. Medicines were safely stored in a locked trolley within a locked room. There was a robust system for checking that medication had been given as prescribed and was signed for. This included; stock balance checks and recording gap checks on people's MARs Arrangements were in place to receive and dispose of medicines safely. People's medicines were managed safely.

Information was kept with people's Medicines Administration Record (MAR) on their needs and preferences in relation to their medicines. For example; preferred times and preferred drink or snack to take their medicines with. We observed a medicines round and saw people's medicines were administered safely and appropriately in line with their preferences.

We noted the low usage of anti-psychotic and sedative medicines for people living with dementia. These medicines can be used to control people's behaviour. Staff on the reminiscience unit worked proactively with people to support them to manage behaviours that challenge by responding to their needs without using medicines. A reduction in the use of antibiotics had also been achieved. The deputy manager told us this was due to increasing fluids for people showing positive for a urinary tract infection and re-testing before antibiotics were prescribed. The use of both types of medicines were monitored as part of the provider's quality indicators audit. This meant people were supported to manage their behaviours and health without the inappropriate use of medicines.

Good

Is the service effective?

Our findings

Staff working in all departments for example; nursing, care, activities, housekeeping and concierge completed an induction specific to their role. This included a competency assessment and shadow shifts to ensure all staff could demonstrate their ability to carry out the role effectively. New care staff were completing the Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care that care workers are nationally expected to achieve. New staff were also allocated a 'buddy' to support them through to the completion of their Care Certificate. Staff we spoke with told us they were well supported throughout their induction and help and advice was available from managers and other staff as required. People were supported by staff who were assessed as competent in their role.

Staff were required to complete mandatory training as determined by the provider. This included safeguarding, moving and handling, infection control, health and safety, dementia awareness, the Mental Capacity Act 2005, equality and diversity and the provider's values. The provider's learning and development manager visited the home on a regular basis to support learning in the home and ensure completion rates were on target. Additional training to meet people's individual needs was available. For example; the reminiscence community leader was specifically trained and had delivered training to all of her team in supporting people to manage behaviours that challenge and minimise distress. People were supported by staff who completed training to meet their needs.

Nurses were supported to maintain their registration through professional development training. Records confirmed clinical training sessions had been planned across 2016. Topics included pressure area prevention, wound care, stoma care, blood glucose monitoring, venepuncture, vital signs, catheterisation and end of life care.

Staff we spoke with told us they were supported by senior staff and managers in their role. Staff confirmed managers were readily available for support and guidance. Records showed that formal processes such as supervision and annual appraisals were regularly completed. Staff had access to continuing and professional development, and the provider worked with external agencies to deliver professional qualifications in health and social care. People were supported by staff who received training, professional development and support in their role.

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.

Appropriate applications had been made for DoLS. Where an authorised DoLS application had not yet been received, a letter was held on file from the local authority to acknowledge receipt of the application. Records showed a process had been followed prior to the DoLS application being made that included a mental capacity assessment and best interest decision to determine whether a DoLS application was appropriate. Decisions were made with people's legally appointed decision makers such as those with a Power of Attorney for people's health and welfare.

Staff training in the MCA and DoLS was underway at the time of our inspection. Staff we spoke with understood the principles of the MCA and sought people's consent prior to providing care and treatment. For example; we observed staff asking people if they wanted to take their medicines and for their permission to assist them with their care and support needs. People's care plans included their written consent to the care and treatment planned. Where people lacked the mental capacity to consent to specific decisions, a mental capacity assessment and best interest decision was recorded. For example; where bed rails were used or for sharing information and taking photographs. This meant people's rights under the MCA 2005 were upheld and their consent was lawfully provided.

Good

Is the service effective?

Records showed an Independent Mental Capacity Advocate (IMCA) had been appointed to help a person who lacked capacity to make an important decision about their care and treatment. An IMCA is a person appointed to support and represent the person's wishes and feelings in the decision-making process. They make sure that the Mental Capacity Act 2005 is being followed and people are involved in decision making as far as they are able. People's decisions and preferences were identified in their care plans and where people lacked the mental capacity to consent people who knew them well had been involved in agreeing their care and treatment in their best interest. People were supported to make decisions about their care and treatment

People were complimentary about the food provided in the home. We observed lunch time in both communities. Lunch was a relaxed and social experience. People were able to choose where and who to sit with. Staff assisting people were cheerful and helpful. They greeted people by name and enjoyed some chat and humour with people. residents. The majority of people came to the dining rooms for lunch. Where people were not comfortable with a large group experience alternative settings were arranged. For example one couple in reminiscence enjoyed their meals at a table by the terrace, creating a quiet and intimate setting away from the main dining room to meet their personal preferences.

People who required some assistance were mostly provided with this in a dignified and appropriate way. For example; people who appeared distracted were gently reminded or assisted to continue eating by a carer. We noted one newer team member needed further guidance on supporting people in a dignified way and this was addressed during our inspection.

In the assisted living dining room there was a choice of food for each of the three courses served and people were able to ask for an alternative if they preferred. On reminiscence staff were aware of people's preferences and were seen to offer choices. People's individual dietary needs were catered for such as; gluten free or low sodium diets.

Risks to people from poor nutrition and hydration were individually assessed using a recognised malnutrition tool. People's weights were regularly recorded and monitored monthly as part of the quality indicator audit carried out by the deputy manager. Records showed people were supported to maintain and re-gain weight. Where people continued to experience risks associated with their food intake action was taken to investigate and address this as far as possible. Strategies in place to support people with their nutrition and hydration needs were; daily food and fluid monitoring, fortified diets and referral to dietician and GP as necessary. A dietician was available for support and guidance. The registered manager said "Following our nutrition audit, we introduced smoothies using milk, cream and flavouring, they are very popular and we've had a great weight gain in reminiscence."

People had easy access to drinks, with a full cup or glass within easy reach, and were encouraged by staff to take fluids several times a day. A person said "Staff are always going on about drinking plenty!".

People were supported to maintain their health by nursing staff on site and access to specialist health and social care practitioners as needed. The service worked with; GPs, tissue viability nurses, speech and language therapists (SALT) and palliative and diabetic nurses to ensure people's health needs were met appropriately. Staff implemented their guidance. For example, where people were at risk of choking, this was assessed by a SALT. If people then required thickened fluids or a soft diet this was provided as assessed. Records confirmed people had attended appointments with the GP, dentist, optician, chiropodist, mental health professionals and physiotherapist as required. A person said "I was ill with an infection on admission and they (staff) looked after me so well, it was marvellous". People had access to healthcare services and were supported to maintain good health.

Good

Is the service caring?

Our findings

We observed many kind, patient and affectionate interactions between staff and residents. We noted that staff listened to people and took the time to understand what people needed and wanted. There was a cheerful and positive atmosphere throughout the home and people appeared comfortable and relaxed with staff. People were complimentary about the attitude of staff. Comments included; "Staff are marvellous – they work so hard". "This is a nice place to live the staff always know what they are doing and are most kind. I have a memory problem, and they are so understanding". "Yes, we're really well looked after, its top rate you can't have better, I like hot chocolate and if I wake in the night I press my button and someone comes with a hot chocolate". People experienced kind and compassionate care.

Staff were able to tell us about people's preferences and likes and dislikes. This included what people preferred to eat, how they liked to spend their time and their interests. People's activity profiles included information about their previous employment and life history and this enabled staff to share in their interests. People's rooms had a memory box by their door which contained photographs and items of interest to the person. A person used this information to explain to us about their history and we experienced how this helped people to share information and express elements of their identity. For example; about their career, their marriage and their family life.

When a person died staff gathered in the reception area to pay their respects as they were taken from the home. The registered manager told us this was an important ritual in the home for staff and people's relatives. A person's relative said "When daddy died the nurse called me, everything was made beautiful, we were given time with him, and when the undertakers came the staff quietly lined up to show their respects, he left the same way he came in, with dignity. They even arranged for a carer to come to the funeral to support mum and bring her home afterwards, some of the carers came on their days off". People's privacy and dignity was respected by staff.

A person who at times spoke in the language of their birth was able to speak with a staff member who also spoke this language. This person communicated their needs at times by making noises which the staff had come to understand. As a result of effective communication the person had reduced incidents of behaviour that challenges. The reminiscence leader told us "They have settled in like a dream". People's relatives told us they were enagaged in people's care planning to help inform staff of people's needs and important information where they were unable to give this themselves. People were supported by staff who knew their preferences and personal histories.

Staff told us about how they supported people to express their views and make decisions about their care and treatment. For example; a staff member said "We respect individuals choice, give encouragement and ask what they want, we observe body language if they are unable to communicate verbally". We observed staff giving people choices and seeking their consent before supporting them with care and activities.

People told us they were treated respectfully by staff. Our observations confirmed that staff respected people's privacy and dignity. Staff used people's preferred names and spoke with them in a kind and patient manner. If people required support with personal care tasks this was done discreetly, behind closed doors to ensure their dignity was maintained. People had access to private rooms to meet with their families and friends such as a private dining room. We saw that people were eating privately when they requested this.

Good

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs and preferences. For example a person said "They (staff) don't stop you from doing anything. If you need anything like a massage or your nails and feet done it's there. If you need to go to hospital you have a car and staff to go with you. You can't have better". People's care plans were person-centred and reflected their individual preferences and abilities. People's had an Individual Service Plan (ISP) which detailed what people preferred to be called, their background and preferred method of communication, including how they made themselves understood and their ability to understand others. The ISP also included tips for staff on how to support the person to meet their needs such as; 'inform me of activities' and 'I like to spend time in the bistro and with other residents'. Or 'I sometimes get fixated on my past life please listen to me and reassure me'. Information to ensure staff were aware of people's likes, dislikes and the care required to support them safely was detailed. For example; the size of portion a person preferred to eat and their nutritional risks. How a person communicated and how staff should respond to help them manage behaviours that challenge.

The provider operated a system of assessment, review and evaluation to ensure care plans remained relevant and were updated as required. This included a monthly care plan review involving the person wherever possible. Where people lacked the capacity to participate in their care plan the team shared information based on their observations and experience of the person to update care plans where required. Relatives or representatives were invited to attend six monthly reviews and were kept informed of changes either face to face or through e-mail and telephone calls. Relatives we spoke with confirmed they were involved in reviews and that changes to their relatives care were made as a result. People's needs were regularly assessed, reviewed and evaluated to ensure they received appropriate care and treatment.

People's needs in relation to their health care were assessed and recorded in their care plans. Nurses were responsible for overseeing people's healthcare needs. Care staff completed daily records and monitoring information to evidence care had been carried out as required. For example; people with risks associated with pressure ulcers and poor nutrition had monitoring plans in place to detail when their position was changed or what they ate and drank. People's individual healthcare needs were clearly documented and discussed at handover. We observed care was delivered as required. People were supported to make improvements to their health. For example; people had been supported to improve their mobility, weight and general health since their admission to the home. People received healthcare to meet their assessed needs

We observed the atmosphere within the reminiscence community was calm. Staff responded to people living with dementia with care and compassion, there was no sense of people being rushed or hurried to meet task driven deadlines. The community included a 'bridal station' and a 'baby station'. These areas contained clothing and accessories that created links to the past for people such as, wedding dresses, a baby cot and dolls. People living with dementia may retreat to past memories and these resources allowed them to recreate past activities. The reminiscence community was spacious with access to an outdoor terrace. Bathrooms and toilets were clearly labelled to assist with way finding. Rooms were easily identified with individual's personal memorabilia in memory boxes as well as clear name signage. There was a sensory room which was used to relax people when they were agitated or distressed. People living with dementia had access to resources and were cared for in an environment responsive to their needs.

Activities were available for people every day and they were able to choose whether to join in. Activity profiles were developed for each person in assisted living, and profiles for people in reminiscence were underway. The profile detailed people's histories related to their education, employment and family life. They included people's religious beliefs, hobbies and interests and what made people happy, sad or anxious. This was used to identify people's interests and activity needs.

People's social and activity needs were met either through group activities or one to one if preferred. During our inspection we observed people engaged in games and social chat with staff, an art class and Christmas carols sung along with a local school choir. The day prior to our inspection people told us they had enjoyed a visit from a donkey. There was a bistro area where people and their visitors could help themselves to drinks and snacks 24

Good

Is the service responsive?

hours a day. Other facilities available included; a parlour with cable television so people could watch sports if they chose, a card room and a library. We observed people enjoying the use of these facilities.

People were involved in activities in the home for example; the home had a garden that included a nature walk and bird feeders, and people were involved in gardening and 'doing pots'. People told us about visits from local drama students, who put on plays or excerpts of plays, and involved people in readings, or asked them to use their imaginations and improvise. The Christmas trees had just arrived and people were getting involved in making and sorting out decorations, as the trees were to be decorated by residents over the next few days. People spoke positively about the activities on offer and a person said "My sons couldn't believe I could do art – but when they saw my paintings, one went quiet, and the other one said 'Mum has a new skill!' – and I do!" People were supported to follow their interests and participate in activities when they chose to.

The provider had a complaints policy and procedure and this was displayed in the home. People and their relatives told us they felt confident to speak with the registered manager or staff if they had any concerns and these were addressed. For example; a relative said "I was bothered at one point about mum's hearing aids consistently not working when I visited, as soon as I raised the issue it was addressed and we have not had any further problems". Complaints were recorded and monitored through the provider's quality assurance system. We reviewed the record of complaints and saw that action had been taken to address these in line with policy and procedures. A system was in place for people to raise their complaints and concerns and these were acted on.

Good

Is the service well-led?

Our findings

There was a positive, open and inclusive culture within the home. Staff consistently told us that managers were open, accessible and responsive. Staff spoke positively about the experience of working in the home and comments included; "It's not like going to work", "I feel part of a team and there is lots going on, I feel lost if I have a day off I miss the place", "I feel privileged to come to work".

The provider's core values included; passion, joy in service, stewardship, respect and trust. The provider operated a recognition scheme to acknowledge particular contributions from staff in demonstrating these values. The registered manager had won a 'Joy in service award' and told us this was in recognition of their attitude. They described this as "Whatever is thrown at me I treat as a challenge and I absolutely love my job, it's an attitude to your work. I think the most important thing is the carers – without happy and satisfied staff we are not going to achieve what we want for residents".

The registered manager gave small gifts to staff whenever they "Saw something good from staff'. People, staff and others were also able to nominate staff for 'heart and soul awards' and these were presented at a monthly team forum. The registered manager gave us an example of how they had recently acknowledged a team member's contribution which led to a more effective system of care for people. This was to do with how staff were allocated. The registered manager said "We now have a team on the ground floor and a team on the first floor with a nurse on each floor. We have tried it for a month and staff are loving it – we have been complimented by family and people about this". The registered manager added "I'm open to anybody's ideas, if they can find a better more effective way to do it then we will". Staff were actively involved in developing the service.

The registered manager told us they were supported by the provider to deliver high quality care. For example; the provider employed specialist staff to support the delivery of care in their services. This included; a national training officer, dementia manager and senior care and training support nurse and nutritionist. The registered manager sought advice and support from these specialist staff to help inform and improve the care people received. Regional management meetings enabled the registered manager to share information including best practice with their regional manager and colleagues in other services.

The registered manager, deputy manager and community co-ordinators supported staff to be clear about their role and responsibilities. Records showed this was achieved through staff supervision, team meetings and by taking action to address staff performance when improvements were required. For example; records showed concerns about staff performance were investigated and addressed to ensure people were supported safely and appropriately.

Staff completed a 'fundamentals programme' as part of their induction which included understanding the provider's mission, principles and core values. We observed staff demonstrating the provider's values, for example; staff were joyful in their interactions with people and treated people with respect. We saw community co-ordinators demonstrated positive leadership to their teams through leading by example and promoting person-centred care at handover and in their interactions with staff. During our inspection a community co-ordinator received a letter from a team member to thank her for 'her caring, passionate and understanding leadership'. People were supported by staff who demonstrated the provider's values in their work.

The registered manager and their management team worked closely together to make improvements and keep their progress under review. We observed throughout the inspection the registered manager, deputy manager and community co-ordinators communicated effectively, and worked as a team. A daily meeting was held with all heads of department called 'the daily huddle'. We attended two of these meetings. Meetings included an update on people's needs, recruitment, staffing levels and staffing needs, health and safety arrangements such as first aiders on shift and key actions for the day. We noted the registered manager also used these meetings to celebrate success and give positive feedback. For example; acknowledging the interviews that had been organised for recruitment and that a nurse had achieved their first aid award. The management team worked co-operatively to agree plans and tasks for the day and through this process shared an understanding of service challenges, concerns and risks.

Information from heads of department meetings was cascaded to staff at handovers and monthly team meetings. Records of team meetings showed they were

Good

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used to discuss staff responsibilities and highlight practice concerns and required improvements. It was evident that staff contributed to meetings and were asked for their ideas for improvements. For example; staff were asked to think about how the meal time experience for people could be improved. Staff were supported by managers to be aware of and accountable for their responsibilities.

An annual resident satisfaction survey was sent out to people and their relatives or representatives from the provider. Records showed the 2014 survey results had been collated and analysed by the registered manager. A report on the feedback received and action taken was then circulated to people. The registered manager felt the response rate was disappointing as only 16 surveys were completed out of 87 sent out. Action had been taken to address the improvements requested such as; improved medicines training for staff and an improved activities programme. Other opportunities for people and their representatives to give feedback were; care plan reviews, monthly residents council meetings, lunch and drinks with the registered and deputy managers and an open door policy. People and their relatives told us they could talk to staff and managers as required and felt they were listened to. People were asked for their feedback on the service and it was acted on to make improvements to the service.

There was a quality assurance system in use. This included a monthly Quality Indicators (QI) audit completed by the deputy manager who told us how this helped her to keep a "Quality focus". This audit reviewed people's needs and care in relation to; skin pressure damage, nutrition risk and unplanned weight loss, infections, accidents, use of restraints such as bed rails, hospital admissions, complaints and use of anti-psychotic medicines. Completed audits were reviewed by the provider's quality team to monitor and support the staff to respond to issues or trends. This meant risks to people were assessed, monitored and addressed to ensure people received safe and appropriate care.

Other audits included a monthly medication audit and a more detailed audit based on a different element of care each month, for example; nutrition. Records showed action was taken to make improvements based on the findings. For example; improved recording of people's weights and use of smoothies to encourage weight gain had resulted in the required result, An improved weight gain.

Information was included to explain the findings and actions taken in response to risks where identified. The deputy manager explained how the audit helped them to identify areas for improvements. For example; the October 2015 audit noted there were nine people receiving antibiotic treatment for a urinary tract infection (UTI). In November 2015 this had reduced to four people. The deputy manager told us about the actions they had taken to support this reduction. These included; further training for staff on the reasons for encouraging and recording fluid intake, and re-testing for a UTI once a higher input of fluids had been achieved. The QI results were discussed at all meetings to ensure staff and managers were aware of actions required and these were acted on. Information was used to drive continuous improvement to the service people experienced.