AJ & Co.(Devon) Ltd

Merafield View Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 May 2017 and was unannounced on the first day. Merafield View Nursing Home (Merafield) provides care for people who may require nursing care and for people who are living with dementia. Merafield provides care and accommodation for up to 40 people. On the day of the inspection 38 people lived in the home.

A registered manager was employed 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.

There was a very positive culture within the service. The registered manager had clear values about how they wished the service to be provided and these values were shared by the whole staff team. Staff talked about 'personalised care' and 'respecting people's choices' and had a clear aim about improving people's lives and enabling opportunities where possible.

There was a management structure in the service which provided clear lines of responsibility and accountability. The registered manager was highly valued and well respected by people, relatives, staff and local professionals.. They were supported by an extremely knowledgeable, caring team of nurses and support staff who had designated management responsibilities. All areas of the home were exceptionally well managed including housekeeping and the kitchen. People told us they knew who to speak to in the office and any changes or concerns were dealt with swiftly and efficiently.

Staff were exceptionally thoughtful and kind. Their care and love for people at Merafield made them feel they mattered and staff and relatives gave many examples of going the extra mile to make someone feel special. Feedback we received about staff was superb.

End of life care was excellent. People's last days were dignified, pain free and relatives were fully involved and supported at all stages.

Feedback received by the service and staff was exceptional. Outcomes of audits and incidents were used to aid learning and drive improvement across the service. Robust action plans drove further improvement. Training and networking by staff across the city improved the care and outcomes for people. The manager and staff monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People and their relatives told us the management team were excellent, visible and included them in discussions about their care and the running of the service.

The service had strong links with organisations in the local community including the local hospital, acute hospital and the local authority. The registered manager was well respected across these organisations and the service was involved in pilots with Plymouth University to trail technology within nursing homes and a pilot project to reduce falls.

People loved the homecooked food and lovely smells which came from the kitchen. Mealtimes were a positive experience, which people looked forward to. Meals were of sufficient quality and quantity and there were always alternatives on offer for people to choose from. People were involved in planning the menus and their feedback on the food was sought. Allergies and preferences were known. People at risk of poor hydration or nutrition were monitored closely and cared for well. This could move down as its from a good rated domain.

People told us they felt safe using the service. There were risk assessments in place to help reduce any risks related to people's care and support needs. Staff had received training in how to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected.

People were kept safe by suitable staffing levels. Relatives told us there were enough staff on duty and we observed unhurried interactions between people and staff. This meant that people's needs were met in a timely manner. Recruitment practices were safe and robust to ensure staff with the right attitude and strong values and integrity were recruited. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people. Improving safety of residents was a goal for the home and the registered manager analysed and learned from incidents and accidents to improve people's care.

Staff received a thorough induction and essential training to ensure they were skilled in their roles. Competency was monitored and staff were supported through a regular system of informal and formal supervision. Additional training in health and social care qualifications and enhanced clinical skills was undertaken to meet people's needs. Staff all told us they felt supported and valued and loved their jobs.

People had their healthcare needs met. Robust handover processes ensured important information was shared quickly with staff. Prompt referrals were made to external professionals when required. People were supported to see a range of health and social care professionals including social workers, chiropodists, physiotherapists and doctors. Feedback we received from professionals indicated good working partnerships had been developed and were valued.
The registered manager and staff had attended training on the Mental Capacity Act 2005 (MCA).

Staff were knowledgeable about the Mental Capacity Act and how this applied to their role. Where people lacked the capacity to make decisions for themselves, processes ensured that their rights were protected. Where people's liberty was restricted in their best interests, the correct legal procedures had been followed. Independent Mental Capacity Advocates had been involved where there was disagreement about what might be in a person's best interest; these processes ensure people's rights are protected. Those who had capacity were involved in their care at all stages.

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

People benefitted from robust recruitment process and sufficient numbers of staff to meet their needs safely.

People were protected by staff who could identify abuse and who would act to protect people.

People had risk assessments in place to mitigate risks associated with living at the service.

The service smelled fresh and looked clean because staff followed safe infection control procedures.

Is the service effective?

Good

The service was effective.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

People were cared for by competent staff. Staff were well supported through training and supervision systems.

People's human and legal rights were respected. Staff had a good understanding of the Mental Capacity Act 2005 (MCA)and sought consent whenever possible.

People received a healthy, blanced diet and had their dietary needs met.

Is the service caring?

Outstanding

The service was exceptionally caring.

People and relatives were looked after by staff who treated them with kindness and respect. People and visitors spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People felt in control of their care. People were listened to and there was a strong emphasis on the person's personal identity. Staff helped people find different ways to be involved and

express their views on their care.

People said staff protected their dignity and they were treated with respect at all times.

People received compassionate, dignified end of life care. People's last wishes were known and staff made every effort to ensure they were met.

Is the service responsive?

Good

The service was responsive.

Care records were written to reflect people's individual needs and were regularly reviewed and updated.

People received personalised care and support, which was responsive to their changing needs.

People were involved in the planning of their care and their views and wishes were listened to and acted on.

People knew how to make a complaint and raise any concerns. The service took these issues seriously and acted on them in a timely and appropriate manner.

Is the service well-led?

Good

The service was well led.

There was a positive culture in the service. The management team provided strong leadership and led by example. There was a strong commitment to providing high quality care.

The provider and registered manager had clear visions and values about how they wished the service to be provided and these values were understood and embedded within the staff team.

People's feedback about the service was sought and their views were valued and acted upon.

Staff were motivated and inspired to develop and provide quality care.

Quality assurance systems drove improvement and raised standards of care.

Merafield View Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on the 10 and 11 May 2017. The first day of the inspection was unannounced.

The inspection was carried out by one inspector, a specialist 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 lives with dementia.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which 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 also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tells us about by law.

During the inspection we spoke with 13 people and five relatives.

To help us assess how people's needs were met, we reviewed ten care records in detail. This included assessments, risk assessments and essential care information kept in people's rooms. We also spoke with seven staff including the registered manager, the activities coordinator and two registered nurses.

We reviewed four staff personnel records, medicine administration records, training records and other records held within the service to show how the registered manager reviewed the quality of the service. This included a range of audits, quality assurance surveys, minutes of meetings and policies and procedures. We attended a multi-disciplinary review meeting and discussed people's care with visiting professionals

including two social workers, an occupational therapist, two pharmacists and a paramedic.

Prior to the inspection we received feedback from the local authority quality team. Following the inspection we sought the views of 14 professionals. These included commissioners, social workers, pharmacists, nurses and the local hospice who worked closely with the service.

Good

Is the service safe?

Our findings

People told us they felt safe and relatives confirmed their loved ones were protected from harm. Comments included, "Yes, I feel safe, staff are good and I have a call bell"; "So reassured by how they look after her and keep her safe"; "She's been in bed five years and not one bed sore!"; "Everyone here knows it is shared care, if there is someone more in need, the nurses prioritise and spend more time with them"; "They keep me quite at ease, that makes me feel relaxed and safe"; "The staff always pop in to see if I'm ok and say hello"; "The staff always make sure I have my call bell nearby"; "The staff are always popping in during the day and the night to check I'm ok" and "Mum doesn't leave her room much, but the staff are always coming round to make sure she's ok".

People were protected by staff who knew how to recognise signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Training records showed that staff completed safeguarding training regularly and staff accurately talked us through the action they would take if they identified potential abuse had taken place. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately by the service. Staff told us safeguarding issues and possible signs of abuse were discussed regularly within the team to ensure all staff understood the potential different forms of harm and abuse. Staff explained what they might look out for including changes in people's mood such as anxiety and bruises. This was especially important when people lacked capacity to inform staff themselves. Policies and notices related to safeguarding and the local contact telephone numbers were visible within the service. We reviewed the safeguarding alerts which had been made within the service, the registered manager kept a safeguarding audit tool and any learning was embedded promptly to avoid a reoccurrence. For example following a spitting incident, a new policy had been developed to guide staff in supporting people who might spit. The PIR advised, "Our staff receive training so they can recognise potential abuse and have the confidence and skills to know how to act in such cases."

People were protected by robust processes in place to manage an emergency situation such as a fire. People had personal evacuation plans in place (PEEPS). These plans helped to ensure people's individual needs were known to staff and to emergency services, so they could be supported and evacuated from the building in the correct way. Staff had participated in fire training and there were weekly fire drills. The fire alarm was linked to the local fire station to enable a prompt response in the event of an emergency.

Regular health and safety checks had been undertaken within the home including the servicing of equipment such as the hoists and lifts. Most routine maintenance was carried out by the maintenance man, staff recorded broken items / faults promptly and these were quickly repaired. Regular checks were undertaken on the windows and restrictors were in place to ensure these remained fit for purpose. Staff were alert to trip hazards as they walked around the home and in people's rooms; this helped to ensure the environment safe. We spoke to the registered manager about the water temperature which was not regulated and very hot. They advised people would not use these bathrooms however; we were concerned they were accessible to visiting adults and children. Ensuring these taps were safe had already been identified as a risk by the registered manager and was included in the service action plan with a date for it to be completed by.

People were supported to take everyday risks to enhance their independence and enable them to feel in control where possible. For example, those people who liked to wash independently but needed some staff support to reach areas such as their backs and feet were supported. Staff were thoughtful regarding people who liked to be mobile but were at risk of falling. On the day of the inspection one person who liked to move around the home but was at risk of falling was moving rooms to reduce the likelihood of falls.

Falls and other incidents were analysed for trends and themes. The registered manager was trying a new system to identify if there were particular areas of the home where falls were more likely. The results of this would enhance people's safety. Staff told us they made sure people had the equipment they needed around them such as their call bells and mobility aids to encourage their use. Staff knew people well and those who might try to walk unaided. Pressure mats and mattresses were in place for these people so staff could respond promptly to minimise the risk of falls but maintain independence. Staff told us they checked rooms to ensure they were uncluttered and made sure people had appropriate footwear to reduce the likelihood of falls. Staff were aware of those people whose mobility had changed over time and had updated people's risk assessments and care plans accordingly. The service was participating in a local pilot project at the time of the inspection with a group of health professionals to further look at reducing the likelihood of falls. A falls pack had also been developed for staff with the facts about falls, best practice guidance in this area, risk factors and management. It had been identified through research that robust falls management could reduce falls by 15-30%.

Risk assessments highlighted individual risks related to people's diet, skin care and mobility. Those who were at risk of developing sore skin had special equipment in place to reduce the likelihood of their skin breaking down, for example pressure relieving cushions to sit on and special mattresses. Personal care plans highlighted checking people's skin vigilantly; using prescribed skin creams when needed and helping people maintain their mobility. Repositioning checks were in place and carried out frequently. During the first day of the inspection we fed back to the registered manager we had found several mattresses we checked were not set accurately according to people's weight. All mattresses were checked immediately. The service carried out a monthly check and during the inspection this was changed to weekly to ensure people who were vulnerable to skin damage had their mattress set correctly.

People were kept safe by a clean environment. All areas we visited were clean and hygienic. One relative told us, "It always smells lovely, mum has never had an infection, everything is always polished, washed, cleaned; walls are sterilised…the staff in the laundry do a lovely job, clothes are always folded, always returned spotless." Protective clothing such as gloves and aprons were readily available throughout the home to reduce the risk of cross infection and hand gel was visible in the communal areas for people and staff to use. Staff were able to explain the action they would take to protect people in the event of an infection control outbreak such as a sickness bug.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks obtained prior to commencing their employment with the service. A probation period was in place for new staff to help ensure the service recruited staff with the values and competence they wanted. The registered manager took action promptly to address any shortfalls with new staff. This helped ensure people were kept safe.

Staff, people and relatives told us there were sufficient numbers of staff on duty to keep people safe. A dependency tool was used to ensure staffing levels met people's needs. Staff were visible throughout our inspection and conducted their work in a calm, unhurried manner. People told us staff were there when they needed them and they responded to their call bells usually within five minutes. The registered manager checked call bell response time regularly. In the event of sickness staff worked flexible to provide continuity

of care for people. The service did use agency staff as a last resort but the registered manager advised this had reduced significantly over the past 12 months.

Due to the local challenges of recruiting qualified nurses the PIR and registered manager informed us a 'nursing assistant' role had been developed. This extended clinical role supported the registered nurses and staff enjoyed the extended skills of the role. The service was actively recruiting to a deputy manager.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine administration records were accurate and fully completed. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. People where possible had signed to consent to staff administering their medicine. People had been asked whether they preferred liquid or tablet medication, for example if they had swallowing difficulties and allergies were recorded and known. People who were on particular medicines which interacted with certain foods were known to staff and this information was clearly recorded in their medicine records and their care plans. The use of homely remedies was monitored and GP advice sought if necessary. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used in a care home (with and without nursing) for the short-term management of minor, self-limiting conditions, e.g. headache, cold symptoms, cough, mild diarrhoea, occasional pain.
Regular audits were undertaken to ensure the ongoing safety of medicine storage and administration. Medicines which required additional storage under legislation were checked regularly and there were safe systems in place. We spoke to the registered manager about developing care plans for people who had "as required" medicines for anxiety or pain. We saw this was part of the registered managers action plan to be fully completed by the end of June 2017., These additional care plans help ensure all staff follow the same process and know when to offer / give these medicines. One nurse told us how because they knew people well they were often guided by people's non-verbal communication to assess the need for pain relief, "I can tell by their facial expressions, if they are grimacing, people's arm movements – I know my residents."

People's needs with regards to administration of medicines had been met in line with the Mental Capacity Act (MCA). The MCA states that if a person lacks the capacity to make a particular decision, then whoever is making that decision must do so in their best interests. For example, some people were unable to consent to their medicine. People's doctors had been involved in these decisions. This showed the correct legal process had been followed. A pharmacist told us, "Medicines are well managed by X and Y (the registered manager and nurses) – they have a good team there. They changed their auditing systems to ensure medicines arrived in time. Antibiotic prescriptions are always put through promptly. From a pharmacist point of view they are a well-structured, organised service. The girls are conscientious, you feel patients come first."

The registered manager action plan included further improvements to enhance safety for example changes to advertising for new staff to reduce agency staff, a policy for relatives on the use of CCTV equipment and ensuring patient safety alerts we actioned. Patient safety alerts are issued via the Central Alerting System (CAS); they convey important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care.

Good

Is the service effective?

Our findings

People felt supported by knowledgeable, skilled staff who effectively met their needs. They told us "Yes, staff are well-trained."

Staff, including temporary agency staff, undertook an induction programme at the start of their employment at the home. The registered manager made sure staff had completed an introduction to the home and had time to shadow more experienced staff and get to know people. The Care Certificate induction was in place and used for new staff. This is an identified set of standards that health and social care workers adhere to in their daily working life to promote consistency amongst staff and high quality care.

Staff had undertaken the appropriate training for their roles and had the right skills and knowledge to effectively meet people's needs before they were permitted to support people. Training was ongoing in areas such as first aid, dementia care, moving and handling, skin care, diet and nutrition and food hygiene. All staff were encouraged to develop themselves and undertake additional health and social care qualifications to support their work. Some staff had particular interests in certain areas such as end of life care and dementia care. The service linked with organisations that provided sector specific training and link groups where best practice was discussed. For example, end of life link groups and the local dignity care forum. During the inspection the activities co-ordinator was on specialised training to enhance their role within the service. These staff shared their knowledge and skills in staff meetings. Staff told us "We're always doing training." Staff felt encouraged to improve their knowledge and skills by the registered manager and appreciated this.

Staff felt supported by a regular system of supervision and appraisal which considered their role, training and future development. Comments included, "Yes, we have regular one to ones." In addition to formal one to one meetings staff also felt they could approach the registered manager and registered nurses informally to discuss any issues at any time. Staff competency was informally observed in areas such as handwashing, moving and transferring people and communication. If any issues were identified additional training was provided for staff. Staff found the management team supportive saying, "Doors are always open, and the registered manager is approachable and helpful." The registered manager and nursing staff regularly worked alongside care staff to encourage and maintain good practice.

Staff communicated effectively within the team and shared information through regular verbal and written handovers. This supported staff to have the relevant information they required to support people's needs on a day to day basis. Regular weekly meetings were held to discuss the care and treatment of the short term residents (Discharge to Admission people) to ensure they were progressing with their rehabilitation. Healthcare professionals confirmed communication was good within the team and treatment plans were progressed. The Discharge to Admission (DTA) beds were for a maximum of six weeks to support people to be discharged from hospital as soon as possible and enable their on-going recovery in the community. A team of healthcare professionals supported the nursing home to ensure people's on-going rehabilitation to prepare them for returning home within this period.

A regular, weekly GP visit supported care for people at the service. Staff told us the local GP surgery valued their judgement and opinion and relationships were good. During the inspection one person had stomach ache, staff had monitored this over previous days and the pain had not reduced. The GP was called and visiting later that day. Staff were mindful of each individual's behaviours and mannerisms which might indicate they were not well or in pain. Staff were alert to signs of urine infections which may cause or increase confusion. Prompt referrals to external healthcare professionals such as GPs, physiotherapists, and occupational therapists enabled people to maintain good healthcare and receive the appropriate treatment they needed quickly. In addition, chiropodists, dieticians, tissue viability nurses (skin care nurses) and opticians visited people to ensure they had access to healthcare services and ongoing support to maintain their health.

People when appropriate were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection to make sure their safety is protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The registered manager was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body.

People's capacity was regularly assessed by staff. Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. A staff member told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to drink or wear and what they wanted for lunch. However, when it came to more complex decisions the relevant professionals were involved. This process helped to ensure actions were carried out in line with legislation and in the person's best interests. The MCA states, if a person lacks the mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf, must do this in the person's best interests. Staff understood this law and provided care in people's best interests.

People confirmed and records evidenced consent was sought through verbal and written means and detailed the areas where people had capacity to consent and the areas where staff needed to care for people in their best interests. Staff enabled people to make an informed choice and supported people to understand what was being planned. Those who were unable to consent and those who did not have people with the legal authority to make decisions on their behalf had advocates involved in their care to support their decision making. For example, an independent mental capacity advocate (IMCA) had been involved to support someone's wish to return home where there was family disagreement and another person had been supported to attend their son's wedding following a best interests meeting.

Ensuring good nutritional intake was important to the home. People told us, "The food is magnificent"; "I can't complain about the food and it's always hot when they bring it to my room"; "The food isn't bad at all"; "The chef is excellent and gives us plenty of choice" and "My wife has been enjoying the food and it's always nice and hot when it comes to her room."

The head cook was passionate about ensuring people maintained their well-being through a good diet. People received healthy, nutritious home cooked meals to help maintain their appetite and keep their weight stable. People were involved in decisions about what they would like to eat and drink. Regular meetings were held and people were asked what they would like to eat and the menu was developed from people's preferences. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet. For example, some people had diabetes

but liked sugary foods. Staff supported them to make an informed choice so they were aware of the potential risks of sweet foods and monitored this closely. Most people preferred to have their meals in their rooms and staff supported people's choice.

We noticed staff helping people to eat where this was required. The staff and kitchen were aware of those who needed their food cut up and those on special diets. Staff confirmed the kitchen staff were notified of any dietary needs as soon as people came to live at Merafield. Care records confirmed where people had nutritional needs. Relatives told us how they had been taught to assist with mealtimes and how that had meant a great deal to them.

People's care records highlighted where risks with eating and drinking had been identified. Staff were able to tell us how they would respond to any nutritional concerns they had. Care records noted health conditions such as diabetes, if the person was of a low weight and choking risk assessments were evident. Staff were mindful of those at risk of weight loss and monitored their weight, food and fluid intake closely. Staff confirmed if they were concerned about weight loss / gain they would discuss people's care with their GP.

People had adapted drinking aids where this was indicated. This helped people maintain their independence and not spill drinks or burn themselves. For example, we met one person with a health condition that made them shake; they were using a beaker with handles and a lid to support them to drink independently.

Outstanding ☆

Is the service caring?

Our findings

Throughout the inspection, we observed that respect was a mutually shared value between people, relatives, professionals and staff. People and relatives all praised the staff and were consistently positive about the care they received. People told us and we observed they very well cared for, they spoke highly and fondly of the staff and the quality of the care they received. Comments included, "Very nice here, all the girls are lovely; we have a chat and a laugh, friends with all of them"; "They give me a lovely shower, help me make the bed, so kind"; " Very happy here"; "The staff are very good and helpful"; "The girls are excellent, can't help you enough"; "The staff have made me feel better in myself"; ""What more could you want, everybody is excellent"; "The girls are so nice" and "It's only down to the staff how well mum is now after being in hospital with a chest infection".

Relative feedback about staff and the care of their loved one's was exceptional. Comments included, "I just felt so reassured they would look after her"; "All her needs were met – she was fed well, cared for spiritually, clean, they cared for her mind. She was always included in activities like Pet Therapy – puppies would visit and her hand placed upon them"; "Staff here taught me how to have a meaningful relationship with my mum; they taught me to respect her as a human being again – it's been such a positive experience where I haven't lost my relationship with mum" and "Every single area in this place is a total delight – every department has enabled my mum to live this long, seven years ago she came here to die!"

We reviewed comments people and relatives had left on the internet review sites and thank you cards. Comments included, "Everyone here is so kind and friendly, I couldn't ask for better care"; "It was lovely to see him smile and laugh even in his last days…he thought highly of all of you"; "You are all wonderful people and it's been a pleasure to meet you. The profession is a better place with you all being part of it"; Thank you everyone who cared for my Mother, she was given the upmost. She often said to me she was in heaven and the girls angels."

Staff told us, "It's like a family here, we get to know them so well – I love it here, homely." Staff and the registered manager repeatedly told us "People come first" and throughout the inspection that was evident.

Staff interacted with people in a patient, calm manner. They engaged with them at their eye level, using gentle tones to persuade when required, for example with food and those reluctant to take their medicines. We overheard staff talking with people with tenderness and warmth, this made people feel they mattered. Staff told us, "I love working here and the one to one time I have with people"; "We are all kind, caring and compassionate, you will see the love – we all go above and beyond – staff will come in if someone has no family, give relatives a phone call and take them out for coffee".

People were respected by all staff within the service. Staff honoured how people wanted to be addressed and adjusted their manner to suit people's preferences. For example, some people liked to be called by their first names; others preferred a more formal address. People told us their privacy and dignity was respected. Staff told us they always knocked or doors and bathrooms, they ensured people were dressed in the way they liked and which made them feel good about themselves. Relatives told us, "Staff always ask me to leave

the room even though I'm her daughter, any questions I have are always private conversations out of earshot of mum."

People's independence was encouraged even though this sometimes carried risks. Staff told us this was an area they felt had improved since the previous inspection and they were more creative with positive risk taking to promote and encourage people to be independent for as long as possible. Staff gave examples how they had supported one person through best interest decision making to attend their grandchild's first christening before they passed away.

Staff gave us examples of how they used different forms of communication to encourage people to make decisions. Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people's views and opinions were heard. For example, picture cards were used to enable people to communicate when they were verbally unable to express their views. Staff also gave an example of individualised training they had received from the speech and language team to meet one person's speech challenges and another person had been supported to communicate through computer voice technology. These different ways enabled people to have an active say in their care.

People told us staff listened to them and took appropriate action to respect their wishes. Staff knew people well so observed facial expressions and bodily movements if they were unable to communicate verbally. We observed staff always talked to people regardless of their cognitive state. For example, one relative told us their mother spoke Italian and how the staff had learned Italian to try and communicate with her, "Some of these girls are only 18 years old and they are trying to speak Italian!"

People told us the things which mattered to them, for example their laundry and receiving care as they liked were respected. Staff gave examples of meaningful roles given to people, for example one person liked to call out the Bingo numbers, we were told they enjoyed the responsibility. Another example was staff asking one lady's opinion about clothing which needed sewing up, they had previously been a seamstress. Asking her opinion on how to repair items made her feel her views were still important.

Staff knew, understand and respond to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. Staff described how they had learned about the beliefs of one person who was a Jehovah Witness, "They explained it all to me, how they don't celebrate birthdays or Christmas, I took the electronic tablet down so she could download her religious magazine and maintain her faith."

To ensure people were listened to and their wishes respected, information about advocacy services was available to people and advocates used to support people's decision making when required. Staff understood the processes involved when staff had lasting power of attorney. This enabled staff to protect people's rights around decision making and to also support families.

People were given information and explanations about their treatment and support when they needed them so they could be involved in making decisions about their care. Staff said, "I don't sugar coat, I'm honest – I explain what is happening so people feel involved."

Those people who had relatives and significant others involved in their care were always kept up to date in a timely way. Relatives were fully involved and staff described how one family had been supported to maintain a bedside vigil and how staff had supported them all when a genetic condition had been identified One relative said, "I feel blessed to have met staff that care about mum as much as I do, and care about me." Staff gave an example of how they supported one husband whose eyesight had deteriorated to visit his wife daily. Staff dropped him home after the visits so he could maintain daily contact which meant so much to

him. Staff noticed when visiting spouses were not caring for themselves and not eating, for one person the service arranged for them to have lunch and tea at the home for the duration of her husband's stay to ensure she was eating.

Friends and relatives were able to visit without unnecessary restriction. Visitors told us they were always made to feel welcome and could visit at any time. Skype (Skype is an instant messaging app that provides online text message and video chat services. Users may transmit both text and video messages and may exchange digital documents such as images, text, and video. Skype allows video conference calls) was used at people's bedsides so they were able to maintain contact with family unable to visit, for example those who lived abroad. Relatives all confirmed they visited at all times of day, could stay as long as they wished and participate in their loved ones care as much as they wanted. One relative told us, "When mum was poorly, they brought tea and a sandwich and staff sat with me."

Relatives were invited to the residents' meeting. One family member told us, "I have been to so many of these meetings and the only criticism I ever here is the portions being too big!" Newsletters and posters in the entrance hall way also kept family informed of the events within the service and fundraising activities.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. End of life care was compassionate, dignified and pain free. Services, equipment and medicines were provided promptly when needed. Nursing staff were well trained in the use of syringe drivers, verification of death and end of life care. Staff had supported "Dying Matters" week and their training had included tours of a funeral home to understand life after death. Bereavement packs were available for families to support their needs following death of a relative.

Merafield had just received its accreditation for good end of life care for the 5th year running. A healthcare professional from the local hospice told us, "St Luke's Hospice completed a SIX Steps re verification inspection in this home in February 2017, against the NICE quality markers to assess the ongoing skills and processes that support the provision of good end of life care. The home has sound treatment escalation plans for residents (TEP) and identifies those who are in the last 12 months of life. They also complete post death audits to ensure quality issues are raised. Up to date end of life (EOL) resources are within the service for example, the Ambitions for Palliative Care document and NICE guidelines 'Care in last days of life', March 2017 edition. Staff have demonstrated a caring approach when we have visited, for example, kneeling down when talking to residents. Those residents who are at end of life have an end of life plan" and "[The registered manager] is passionate about delivering good care for those at end of life and if end of life care is right, then general care should be. The home has two end of life champions that promote person centered end of life care and act as a resource to others within the home."

People's end of life wishes were discussed with them and, where possible, documented as part of their care plan. Those who mattered to people were fully involved in all discussions. Staff gave examples of how people's last wishes were met by the home. For example, one person wanted all their wedding photographs put into an album before she passed so they could leave this for their family. Another person was an eager football supporter and although unable to attend a football match due to his health, staff arranged for a football shirt to be brought in and re-runs of their favourite football matches on a computer.

End of life boxes contained meaningful things people might want, for example rosary beads, candles, special music. Staff told us one person had requested his favourite music and a photo of his wife as he passed away and this was made possible by staff. A relative told us, "Sometimes I need the staff to be stronger than me – they are there with sympathy, empathy, understanding and guidance – they have

changed my outlook and given me lovely memories rather than blank memories."

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Staff told us they felt a good assessment was fundamental to ensuring people's care needs could be met. The PIR told us this meant "we can be confident and prepared to meet these needs on admission."

People had care plans that clearly explained how they would like to receive their care, treatment and support. The PIR advised these were devised with people's preferences in mind. On admission the activities co-ordinator met with people to discuss the social aspects of their lives, their hobbies and their interests so holistic care plans could be developed. Staff told us support plans were kept up to date and contained all the information they needed to provide the right care and support for people.

People who were able, and where appropriate, those who mattered to them, were actively involved in all aspects of their care to help ensure their views and preferences were recorded, known and respected by all staff. Relatives told us they were invited to discuss people's care at all times Developing care was a partnership between those involved, this meant people and relatives felt listened too and valued.

People's needs were reviewed regularly and as required. Where necessary the health and social care professionals were involved, for example regular multi-disciplinary meetings discussed people's care and recovery in depth.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Diaries and white boards held essential information about people's care, for example those who required their weight monitoring.

Everyone at the home was recognised as an individual and empowered and supported to make choices regarding their care. People were encouraged to have as much control and independence as possible. Staff gave us examples of how they used different forms of communication to encourage people to make decisions and for those unable to verbally communicate staff were familiar with their non-verbal communication methods. For example, staff told us knowing people well meant they were familiar with their facial expressions, gestures and sounds and this information was included in people's care plans.

People told us they were able to maintain relationships with those who mattered to them. Relatives visited throughout the inspection. They described how the staff at the home had educated them about their relative's care needs which enable them to be an active part in care and maintain relationships. For example, showing relatives how to safely assist their loved one with meals.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. The activity timetable was

clearly displayed and given to people so they knew what was on throughout the week.

The activities co-ordinator was available four days a week and passionate about her role. We were told that over the past few years the role had evolved as people's needs had changed. Previously more outings had been possible but the people who were currently residing at Merafield needed more individualised one to one support. Activities included reading poetry, quizzes and baking and crafts with some people. Advancing technology had been embraced by the activity staff enabling electronic tablets to be taken to people's rooms so they could choose their own music and a range of activities.

Most people at Merafield preferred to spend time in their rooms which meant the communal areas were quiet. People were encouraged to attend group entertainment such as music and pet therapy if they wished. The activities co-ordinator did the morning tea round so people knew what was planned for the day. People also had a newsletter informing them of special events.

People were supported to follow their interests. Individual preferences and disabilities were taken into account to provide personalised, meaningful activities. Staff said there was always time for nail painting, hair styling, reading or poetry and we saw this during the inspection. Special events such as Harvest Festival and Easter Services, The Great British Bake Off and harpists were enjoyed by people. Fetes were held at the home to raise money for the residents fund and charity.

Community links and relationships were facilitated and encouraged to ensure that people did not become socially isolated. The activities co-ordinator was working alongside the University to trial Skype explain within settings, the aim was to encourage and foster relationships with the outside world and family and friends unable to visit.

Staff had a good understanding of people's social and cultural diversity, values and beliefs and these were acknowledged and met. People and family told us how they were supported to meet their faith needs and how that had helped them at difficult times.

People's needs were met as they moved between services, for example if people needed to attend for appointments or go to hospital, external services were given detailed information about people. Staff attended appointments if required to ensure good communication and handover. The service worked closely with external agencies for example social workers, occupational therapists and advocates to support if they wished to return home or their needs changed and they required a different care setting.

There was a positive, open and transparent culture when dealing with concerns or complaints. The policy was clearly displayed in areas of the home. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. People's concerns and complaints were encouraged, investigated and responded to in good time. Reflection and any areas of improvement were considered following any complaint to the service. For example, due to a complaint that people were cold a blanket station was created in the lounge and temperature monitoring systems placed in specific areas to evidence the temperature. Relatives told us they never felt discriminated against for raising any issue and any concern, however minor was listened to and taken seriously. One relative told us, "If they said this is your last 5 minutes here, I could not think of a single criticism."

Good

Is the service well-led?

Our findings

Merafield View Nursing Home (Merafield) was owned by AJ & Co. (Devon) Ltd. It was one of two services owned by the provider. The provider and director of Merafield supported the registered manager in their role and received regular updates via a 'weekly report' system. This update included occupancy, staffing, environment and management information. Priorities for the following week were identified in this report and any specific requests or requirements for the provider. These were then implemented by the registered manager and the provider updated by email or at their next visit to the service. Following the inspection we spoke with the provider who told us since buying the service two years previously, a focus had been on ensuring consistent staff and reducing temporary agency staff use. This cost saving in maintaining a more stable permanent care staff team meant the home could be further invested in to improve people's care and outcomes.

The service was well-led. All people, relatives and staff we spoke with applauded the leadership of the registered manager, "I thank God for [the registered manager], so kind, just listens, firm but fair"; "It's a well-led, very happy place"; "Efficient but in an elastic way"; "If I say I'd like to see [the registered manager] she is straight down"; "[The registered manager] is kind but firm, mum comes first"; "Always approachable, always has an answer or will find one. Knows what is going on with everything" and "[The registered manager] is client centred, people's well-being is paramount…approachable, displays discretion. Outstanding qualities as a leader and manager. Blessed my mum is in her safe hands." Feedback from professionals was equally exceptional commenting on the passion and dedication of the registered manager.

There was a management structure in the service which provided clear lines of responsibility and accountability. A registered manager was in post that had overall responsibility for the service and knew people and staff well. They were supported by other nursing and care staff who had designated management responsibilities, for example medicine audits. Key staff held lead roles in specific areas for example end of life care and there was a new Health and Well-being Champion. Staff had created a new health and well-being board in the main entrance signposting people, relatives and people and the work being undertaken on reducing falls would help reduce the likelihood of injury. The reduction of agency staff to permanent staff would enable staff to have further developmental roles. Staff, people, relatives and external health and social care professionals all told us they knew who to speak to in the office and had confidence in the management and staff team.

During our conversations with the registered manager they displayed integrity, kindness, commitment and good leadership skills. They led by example, were passionate about what they did, cared deeply about the people and staff at the home and would not ask any staff member to do anything they would not. We were given an example by one person who wanted to move their bedroom furniture quickly when staff were busy so they were assisted by the registered manger to change their room around.

People and staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. Staff were very positive about how the service was run. External professionals we contacted appreciated the views and thoughts of the registered manager in the

pilot groups and steering groups they had participated in, for example the discharge to admission pilot (DTA) and the nursing assistant role new to the local area. They were a leader visible within the service and in the local health and social care groups, respected by people, relatives, staff and colleagues alike.

The home worked in partnership with key organisations to support care provision. Social care professionals who had involvement with the home confirmed to us communication was good. The service worked in partnership with them, followed advice and provided good support. A nurse consultant told us, "Having worked for a number of years with the registered manager, I can confirm that the leadership style of the home is one of openness and accountability. "X" has worked in partnership with hospital and community services, to develop working relationships and community links across the health system, improve transfers of patients and improve standards of care. "X" has engaged with the local network of Care Homes, striving to improve quality of services and partnership working; she has offered input to developments, challenges to practice and questions of her own staff/team – in order to improve experiences and outcomes for residents."

The registered manager was actively involved in key local and national intiatives to help ensure best practice was known and used to drive the service forward. They had attended a local leadership and management course and we reviewed their learning and reflections. This had resulted in an improved induction process, reviewed supervision process and a clinical competency checklist for agency staff. A professional told us, "Merafield has been providing a DTA (faster discharge from hospital) service and has been a valuable part of this service. Particularly I can comment in relation to leadership and partnership working as I have always [the registered manager] to be open, engaged, and professional. She is one of the only managers who has attended meetings to discuss and develop the DTA service, has undertaken specific pieces of work requested of her, such as multidisciplinary team good practice guidance, and has agreed to 'host' visitors from another area wishing to review our DTA service." The registered manger supported their qualified nursing staff through the new revalidation process ensuring they were trained, competent and prepared.

The registered manager was constantly striving to improve the service. Developments included responding to one resident's feedback about the use of volunteers within the home, bringing younger people in to Merafield. The registered manager registered with Education Business Partnership South West and was approved for placements for work experience from schools; the second student to come through this programme was due in July 2017. Links with Plymouth University had meant the service was part of new research involving "Skpe" (a teleconference / instant message technology) meaning relatives could stay in touch with family. Information technology was also being used in the service to support people to remain active and who were unable to join in with the group activities.

The registered manager had been a part of a steering group to improve medicine management in care homes and contributed to newsletters from a care homes perspective. In March 2017 they had represented all Care Homes at an end of life conference regarding end of life provision in Devon. This input highlighted the importance of care homes as part of the community in planning and transforming this area of care for people.

Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people. Staff talked about personalised care and promoting independence and had a clear aim about improving people's lives and opportunities. Staff were kind and valued their individual responsibility towards people's care, valuing each team member. The registered manager said part of the recruitment process was to ensure any new staff would fit in and understand the values of the service.

The registered manager told us staff were encouraged and challenged to find creative ways to enhance the service they provided. Staff told us they felt empowered to have a voice and share their opinions and ideas they had. Staff meetings were regularly held to provide a forum for open communication. Any staff unable to attend were encouraged to leave notes of any issues they wanted taken forward. Staff told us they were encouraged and supported to question practice and action had been taken when they had raised issues. Improvements to the storage of medicines had been made and an additional storage unit bought following staff feedback. Improvements to the storage of money and valuables had also been improved and a large safe ordered. Nurses were now able to access care plans emailed to the service in the absence of office staff and had their own email and visiting professionals now had access to a separate photocopier available 24/7 to support their work within the service.

People benefited from staff that understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately. The registered manager's action plan advised this information and important information about safeguarding would be added to the employee handbook.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Questionnaires about the quality of care and the service provided were available in the entrance way and people's rooms. Feedback was excellent. Where minor issues had been noted these were actioned promptly for example some people had said access to the call bell in the dining room was difficult so the maintenance man devised a pulley system for people to improve this. A "You said, we did" board was to be placed in the foyer by the end of July 2017 and "exit" surveys for residents when they left the service.

There was an effective quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Areas of concern had been identified through training and audits and these formed part of the registered manager's action plan. For example, the medicine room temperature had been consistently noted as on the high side and action was being taken to put in a cooling system.

The registered manager was always looking to improve and plans for the future included a sensory garden for people and commencing the Dementia Quality Mark within the service. This is an accreditation which demonstrates the service provides good dementia care. Recruiting a dynamic deputy manager to support the management home and enable the service to progress was part of the plan for the next 12 months. The registered manager was also keen to further embrace technology and look at how information technology (IT) advances could improve people's care and outcomes.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We used this information to monitor the service and ensure they responded appropriately to keep people safe.