Hampshire County Council

Copper Beeches Care Home

Inspection report

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Andover
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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

About the service: Copper Beeches is a care home. It does not provide nursing care. It can accommodate up to 36 people, some of whom could be using the homes 'short stay' or 'interim' beds. These were beds used to facilitate an early discharge from hospital whilst a package of care, or equipment, was being organised to enable the person to return to their own home. At the time of our inspection, there were 24 people using the service which is located in a residential area, close to the centre of Andover.

People's experience of using this service: Risks to people's health and wellbeing had mostly been appropriately assessed and planned for.

Planned staffing levels were usually met and overall people were having their needs met in a safe and responsive manner. The registered manager provided assurances that the numbers of staff deployed would continue to be kept under review to ensure that the deployment of staff facilitated people's safety and preferences at all times.

Overall the management of medicines was safe although there were some areas where best practice frameworks needed to be further embedded.

Most of the home was visibly clean although we did note some areas where the infection prevention and control measures could be improved.

Accidents and incidents were documented and investigated. They were reviewed monthly for trends and patterns so that remedial actions could be undertaken.

Appropriate policies and procedures were in place which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

People's capacity to consent to their care had been appropriately assessed.

Overall assessments of people's needs were suitably detailed and holistic.

Staff were using evidence based guidance to enhance the care provided and to achieve positive outcomes for people.

Staff had received an induction, ongoing training and supervision which helped them to perform their role effectively.

There was a clear focus on the importance of good nutrition.

Overall the design and layout of the home was homely and appropriate for people's needs.

Where necessary a range of healthcare professionals including GP's, district nurses, community mental health nurses, chiropodists and occupational therapists had been involved in supporting people to maintain good health.

People continued to be treated with kindness, respect and dignity and had developed strong relationships with people. Staff understood the importance of supporting people to maintain their independence.

Staff had a good understanding of people's needs and care plans informed staff how they should support people in a way that met their likes, dislikes and preferences and of the things that were important to them.

People were supported to take part in a range of activities which supported them to lead a full and more active life.

There were systems in place to ensure complaints were investigated and responded to.

People's end of life wishes were recorded and staff had training in end of life care, which assured us people's wishes would be respected in their final days and following their death.

The registered manager managed the service well and had nurtured a positive person-centred culture within the home. They knew people well and displayed a commitment to putting person-centred care first and of trying new ways of meeting people's needs and to improve their quality of life.

There was a clear leadership and management structure in place which helped to ensure that the service could deliver effective care and that staff at all levels were clear about their role and responsibilities.

A range of audits were being undertaken to monitor the effectiveness of aspects of the service including care documentation, infection control and medicines management. Along with other quality assurance systems, these measures demonstrated that there was a culture of developing the service and seeking continuous improvement.

The registered manager and senior team continued to nurture strong links with the local community who were welcomed into the home. This had had a positive impact on people.

Rating at last inspection: At the last inspection in October 2016, we rated the service as 'Good'. At this inspection we found the evidence did not continue to support a rating of 'Good' in all areas and we have rated the service 'Requires Improvement' in the 'Safe' key question.

Why we inspected: This was a planned inspection based on the rating at the last inspection in October 2016.

Follow up: Going forward we will continue to monitor this service and plan to inspect in line with our re-inspection schedule for those services rated good. If any concerning information is received, we may inspection sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Effective findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Effective findings below.	**Good**
Is the service well-led? The service was well led Details are in our Effective findings below.	**Good**

Copper Beeches Care Home

Detailed findings

Background to this inspection

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

Inspection team: The inspection team included a lead inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of care service.

Service and service type: Copper Beeches is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is information we request on at least an annual basis about what the service does well and improvements they plan to make.

During the inspection we spoke with eight people who used the service and three relatives. We spoke with the registered manager and deputy manager, two assistant unit managers, three care workers and the chef. We reviewed the care records of five people. We also looked at the records for four staff that had been recruited since our last inspection and other records relating to the management of the service such as medicines administration records, audits and staff rotas. Following the inspection, we received feedback from one of the three health and social care professionals we contacted.

Requires Improvement

Is the service safe?

Our findings

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

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely

- Medicines, including controlled drugs, were stored securely and only administered by staff that had been appropriately trained and assessed as competent.
- Medicine administration records (MARs) contained relevant information and provided assurances that people received their medicines as prescribed. These were checked daily by staff to look for any gaps or omissions.
- Staff administering medicines wore a red tabard to discourage people and staff from disturbing them during the medicines round. This reduced the risk of errors being made.
- We observed a medicine round. This was managed in a person-centred manner.
- Staff used appropriate tools to assess the level of pain in people who might not be able to verbally communicate this.
- The use of homely remedies was well managed. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.
- We did note some areas where best practice frameworks for the management of medicines needed to be further embedded.
- For example, new MARs generated by the service had not been checked for accuracy by a second member of staff.
- The temperature of the medicines room was not being monitored. This is important to ensure that medicines remain effective. This has now been put in place.
- Where people were prescribed topical creams, the service had developed topical medicines administration records which were comprehensive, but sometimes contained conflicting information about the frequency with which creams could be applied.
- On the first day of our inspection the medicines round took three hours to complete and did not finish until 11.30am. As staff were not recording the time the medicine was administered, we were concerned that this could increase the risk of people being given their next dose of medicine too close to the last.
- The registered manager assured us that this was not the usual length of time required to complete a medicine round and was not a systemic concern but assured us that this would be kept under review.

Staffing and recruitment

- Whilst the home consisted of four units, only two of these were routinely being used throughout the day and therefore there were currently four care staff rostered to provide care and support daily. Rotas showed

that these planned staffing levels were usually met. Consistent agency staff were used to cover gaps in the rotas.
● Whilst we did see that one of the units was left unattended by staff on two occasions for a short period of time, overall our observations during both days of the inspection, indicated that people were having their needs met in a safe and responsive manner by staff.
● People told us they felt safe. For example, one person said, "Yes I feel safe here. If I wasn't happy I'd soon speak out".
● The number of care staff deployed was based upon a ratio which was determined by the provider and compliance with this was monitored.
● Recently in response to a reduction in numbers of people using the service, the number of care workers on duty during the day had been reduced from five to four.
● Staff raised some concerns with us about this reduction in staffing levels. For example, one care worker said, "No to be honest, [there are not enough staff] …. Recently it's been four carers, up to a few months ago there were five. I'm ashamed that a few days ago I was having to rush care". Another care worker told us it was hard to provide adequate supervision of people across the home and a third felt the reduction had impacted upon their ability to always provide care in a person-centred manner.
● A fourth member of staff said, "The team we have is good, we know how to adapt. If we are short, we have people on Lilac unit over on Poppy instead". We were concerned, however, that this approach was based more on availability of staff rather than meeting people's choices and preferences. For example, one person residing on the Lilac unit, told us that at times, they had to go to the main dining room for their lunch, even though this was not their preference. This was because there were insufficient staff to cover both units.
● We discussed this feedback with the registered manager. They told us that both they, their deputy and the assistant unit managers were also available to provide support to the care staff and felt that improved communication would help with avoiding periods when areas of the home were not supervised. They assured us they would work with the staff team to make sure this happened in practice and to ensure that the deployment of staff fully facilitated people's safety and preferences.
● A range of recruitment checks took place before staff started working at the service. Records showed staff completed an application form and had a formal interview as part of their recruitment. ● Checks had been made with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post.
● In the staff files we checked we noted that one staff member did not have a full employment history documented. We brought this to the attention of staff and this information was obtained on the day.
● The references obtained for another staff member had not been provided by the manager of their previous employer. We were concerned that this could impact upon the validity and strength of the reference.
● The service was currently undertaking a full audit of all staff files, to ensure that they all contained the required information based upon current regulatory requirements.

Preventing and controlling infection

● Most of the home was visibly clean including the communal bathrooms and toilets.
● A team of housekeeping staff were employed seven days a week to help maintain the cleanliness of the service.
● Where there had been an outbreak of illness in the service, records showed that relevant agencies had been notified and guidance followed.
● There were, however, some areas where improvements could be made.
● Rooms were deep cleaned on a regular basis and daily cleaning schedules were in place, although the

schedule for the week prior to our inspection did contain some gaps.
● The walls and skirting boards in the dining area on Lilac Unit were noted to be dirty on both days of the inspection.
● Protective clothing, including gloves and aprons, was available and was used by staff, however, we saw two staff wearing long sleeved garments over their uniforms, including whilst serving lunch.
● The kitchen was noted to be clean and relevant food safety records were completed in full. However, in one kitchenette, milk was being stored in a fridge without a date of opening.
● The registered manager has reminded all staff of their responsibilities to follow correct infection control procedures and policies at all times.

Assessing risk, safety monitoring and management

● Overall risks to people's health and wellbeing had been assessed and planned for.
● Where people were at risk of falls, risk assessments and management plans were in place. Post falls observations were completed for 24 hours to monitor whether the person was experiencing increased pain, bruising or loss of mobility that might require a review by a healthcare professional.
● People were screened to assess their risk of choking due to dietary needs and a nationally recognised tool was used to monitor people at risk of malnutrition.
● Where people had lost any significant weight, this was shared with the GP to enable them to have oversight of this.
● Peoples' risk of developing skin damage or pressure ulcers was also effectively monitored.
● We did note that one person who was living with insulin dependent diabetes was managing their own insulin regime, but staff had not carried out a risk assessment to find out how much support the person might need in continuing to do this safely. There was no care plan in place to help ensure their medical condition remained well managed. These have since been put in place.
● Care workers were well informed about people's risks and knew how to deliver their care safely.
● The culture within the home was not one of being risk adverse. People were encouraged to stay mobile and exercise choice and stay in control of how their care was provided.
● The maintenance of the environment and equipment within it continued to be well managed by the maintenance team. Regular checks took place of the fire systems and to protect against risks associated with legionella for example.
● Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home.
● The provider had developed a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home.

Learning lessons when things go wrong

● Accidents and incidents were documented and investigated. These were reviewed monthly for trends and patterns so that remedial actions could be undertaken.
● If a person experienced a high number of falls within a period of time, this was flagged by the provider's incident reviewing group who then asked for a more in-depth report to be completed identifying what remedial actions were being taken to reduce the risk and impact of further falls.

Systems and processes to safeguard people from the risk of abuse

● The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

- Staff received training in safeguarding adults from harm and had a positive attitude to reporting concerns.
- Staff were confident concerns would be acted upon by the registered manager to ensure people's safety.
- Information on the importance of speaking up about poor practice was available for staff.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- There was a clear focus on the importance of seeking people's consent, supporting them in the least restrictive way possible and to uphold their right to be involved in decisions.
- Where there was doubt about people's ability to make significant decisions about their care, mental capacity assessments had been completed to check whether people could consent to the care and support being provided.
- Consultations with relevant people had and continued to be undertaken to assist in reaching a shared decision about what was in the person's best interests.
- It had already been identified through care plan audits that further action was needed to clarify whether people had legally appointed representatives, and to ensure that where this was the case, that copies of the documentation was obtained.
- Whilst staff had received training on the MCA, some lacked confidence in describing how they might need to put the principles of the Act into practice when providing care and support. The registered manager has requested additional training to support this learning need.
- Applications for DoLS had been submitted where appropriate and there was a clear tracking system in place to monitor the dates these were authorised or needed to be reapplied for.

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

- People told us they consistently received a good service that met their needs and this view was shared by the relatives we spoke with. For example, one relative told us, "Medically, [person] is tons better, we feel

relieved and have put in for rooms ourselves". Another relative told us, "This is my first experience of this sort of place. I can't think anywhere would be better".

● Overall assessments of people's needs were suitably detailed and holistic.

● Those staying at the service permanently had more detailed care plans which covered a broad range of needs, including health and wellbeing, communication, personal and continence care, moving and handling, falls and nutrition.

● The care plans for people in the short stay were more simplistic but provided in most cases an adequate summary of the person's needs.

● There was evidence that staff were using evidence based practice and guidance to enhance the care provided and to achieve positive outcomes for people.

● Staff were following National Institute for Health and Care Excellence (NICE) guidelines on oral health for adults in care homes to assist people with maintaining good oral health. As a result, a number of referrals had been made to the special care dental service.

● Dementia Care Mapping (DCM) was being used to observe the behaviour of people living with dementia and the quality of the care they received. Dementia Care Mappers record their observations to improve the way people are supported in formal care settings, such as care homes and hospitals. It aims to capture small things which lead to happiness or distress and use this information to enhance people's care.

● Staff had used the approach to recognise that one person became more settled when spending time in a certain area of the home. In response a sitting area was made in this location, which we saw the person made regular use of for sleeping and resting. The registered manager told us, "If you watch someone enough it can make a difference".

● Once training had been delivered, the deputy manager told us there were plans in place to implement RESTORE2. This is designed to support homes to recognise, through the use of clinical observations, that a resident may be deteriorating and supports staff escalating any concerns quickly to health care professionals.

Staff support: induction, training, skills and experience

● All new staff were required to attend the provider's eight-day induction programme called 'Stepping Forward Stepping Back'.

● This provided a range of learning experiences mapped to the Care Certificate standards and included health and safety, moving and handling techniques, first aid, person centred care, safeguarding people, the MCA and risk management.

● In addition to this provider induction, staff had an onsite induction which introduced them to their role and responsibilities, fire procedures, core values, team work and infection control.

● Agency staff had also completed a comprehensive induction which included reading about each person's needs.

● The provider required staff to complete their mandatory training in dementia care, emergency first aid, safeguarding, moving and handling, infection control, the safe use of medicines and food safety. This training was up to date and refreshed periodically through the 'Next Steps' Programme.

● Staff could complete a range of additional training. For example, the senior staff completed training in positive behaviour support, assessing mental capacity and the Mental Capacity Act 2005 and more detailed training in safeguarding and undertaking safeguarding investigations.

● Staff were trained to use the onsite automated external defibrillator (AED). An AED is a portable electronic device that can be used to restart the heart of person with sudden cardiac arrest.

● The registered manager and an assistant unit manager had undertaken a dementia leadership programme. The registered manager told us it had given them greater confidence in recognising exploitation of, and, empowering people with dementia to make choices. Two staff had undertaken

qualifications in dementia care mapping.
● A range of monthly in-house training was also delivered covering areas such as hand hygiene and performing stair evacuations.
● Staff said that the training provided was adequate to enable them to perform their role effectively. New systems were being embedded to support the completion of training so that the registered manager and provider could continue to have oversight of this.
● Periodic supervisions and annual appraisals were used effectively to support and provide professional development to the staff team. One staff member said, "Yes [supervision] is useful, especially since I have been in this job, there was a lot I didn't know, I can talk about it and have it resolved in supervisions".

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

● There was a clear focus on the importance of good nutrition.
● People had access to sufficient food and drink and a varied menu was available from which people could choose daily.
● Snack boxes were available in each lounge containing crisps and other snacks and fresh fruit was offered after lunch.
● Most of the food provided was prepared by the onsite chefs. On occasion due to sickness or leave, staff used ready prepared meals delivered by an external provider which were then heated in the kitchen.
● People told us they enjoyed the food provided. One person said, "The food is good...I think I'll have shepherd's pie today" and another said, "Lunch was lovely, I had too much, but I enjoyed it". A relative said, "[Person] loves [the food] and has put on weight".
● The mealtime experience was quiet and appeared to be positive for people.
● People had nutrition plans and 'Dinning experience forms' which described people's dietary needs and the level of support they required to eat and drink. These also provided a range of useful information to support person-centred care such as whether any aids or equipment were needed, whether dentures were worn and preferred portion size.
● We saw, for example, that the dining experience form for one person noted that staff should use a tea spoon when supporting the person to eat. We saw that this was happening in practice.
● The systems in place to monitor people's nutrition were effective.
● Food and fluid charts and nationally recognised tools were used to assess people's risk of poor nutrition or hydration.
● After each meal, staff undertook a 'hydration review' of people's charts to assess whether their fluid intake was adequate or needed to be escalated as a concern to the senior team.
● Where people were noted to have lost weight, this information was shared with the GP and a programme of more frequent weight monitoring put in place. In addition, people's meals were fortified and if appropriate nutritional supplements prescribed.

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

● Overall the design and layout of the home was homely and appropriate for people's needs.
● Each person had their own room which they could individualise with their own personal belongings.
● Specialist or adaptive aids and equipment were available and there were plenty of communal bathrooms and toilets.
● There were a number of spaces around the home where people could spend private time alone or with their relatives and there was access to a secure, paved courtyard and a garden.
● Personalised memory boxes were located outside people's rooms to assist them in recognising their room

and there was some accessible signage identifying the toilets for example.
● There was evidence that technology was used to support people's care. Equipment such as chair, door and bed alarms were used to monitor people's safety.
● There were no mobile call bell points available to be used by people when sat in the communal lounges. Since the inspection, the registered manager has advised that the provider is seeking a quote to make these available.

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

● Where necessary a range of healthcare professionals including GP's, district nurses, community mental health nurses, chiropodists and occupational therapists had been involved in supporting people to maintain good health.
● This was confirmed by people and their relatives. For example, one relative told us, "They [staff] have been brilliant, they brought in the dentist and the optician to see [person]!"
● Due to their knowledge of people, and their past medical histories, staff recognised when people might be deteriorating and in need of medical treatment such as blood transfusions.
● Staff arranged for GP's to conduct annual medicines reviews to help ensure that long term health conditions were being appropriately managed.

Good

Is the service caring?

Our findings

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

Good:People were supported and treated with dignity and respect; and involved as partners in their care.

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

- The service continued to provide caring and kind support and people told us they were happy living at the home. For example, one person said, "The staff are very nice, they are helpful and polite". Another person told us, "The staff are lovely".
- Throughout the inspection, the atmosphere within the home was calm, relaxed and cheerful with staff readily engaging with people.
- It was clear that people had developed good relationships with staff. For example, we saw one staff member greet a person by giving them a cuddle and kiss on the cheek. The person clearly valued this interaction.
- At lunch time we saw one person and a staff member enjoying some natural and spontaneous banter.
- We saw a staff member kneel beside another person and engage them in a conversation whilst gently holding their hand.
- One person was frequently distressed and sought constant reassurances about when their family member was going to visit. Staff were not dismissive and each time provided a person-centred response to the person.
- Staff spoke about people in a manner which indicated that they genuinely cared about them and wanted to give them the best care possible. For example, one staff member said, "It's not your usual 9-5 job, its different every day, you make a difference to their lives".

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

- Where people could make decisions about their care, they were encouraged to do so. For example, we saw people being asked for their choice of lunch.
- We observed a staff member patiently support one person to decide which cardigan they would like to wear by showing them a range of options.
- Staff maintained records of all contact with people's families. These demonstrated that relatives were updated promptly when people's needs changed or if they were unwell. One relative told us, "They phone me about anything".
- People and their relatives could comment on the quality of care as part of the periodic care reviews that took place.
- People's relatives and friends felt welcome and could visit without restrictions. One relative told us, "Staff here have shown us where to make a hot drink or get a biscuit and told us to just help ourselves".

Respecting and promoting people's privacy, dignity and independence

● Staff were mindful of people's privacy and dignity.
● They spoke with people in a polite and respectful manner.
● Staff knocked on people's doors before entering their room and doors were kept closed when staff attended to personal care tasks.
● Staff respected people's right to privacy. One person told us how they preferred to spend time in their room. They said, "They [staff] are ok, they leave me alone and don't bother me".
● A staff member told us how one person gained confidence from knowing that a staff member was close by when they used the toilet. To manage this in a way that was mindful of the person's privacy and dignity, the staff member left the door slightly ajar and stood in the gap to reassure the person they were there.
● During the inspection, a person fell. To protect their dignity whilst they were assessed, staff placed a privacy screen around them.
● People were encouraged to remain as independent as possible.
● Each person had a 'I can do' assessment which described the elements of their care and support they were able to manage independently and those they needed support with.
● Staff understood the importance of supporting people to maintain their independence. For example, one staff member told us that although one person had a riser / recliner chair, they still first tried to see if the person could stand independently.
● Staff spoke proudly about their role, the care provided and commitment to supporting people to make steps towards greater independence. For example, one staff member told us how one person was now walking again. They said, "She is doing it all on her own, it is fantastic".

Good

Is the service responsive?

Our findings

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

Good:People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Care plans informed staff how they should support people in a way that met their likes, dislikes and preferences and of the things that were important to them.
Each care plan contained a document called, 'All about me, my life and what is important to me'. These captured a range of information about the person's life before coming to live at the home including any religious beliefs and preferred leisure activities.
● People had communication plans which described the ways in which staff might adapt their approach to enable the person to understand. For example, we saw that one person's plan stated that staff should use short sentences and allow the person plenty of time to digest the information.
● Staff had read people's care plans and alongside this, they spent time speaking with people and their families which helped them to learn about what people needed and wanted or had previously valued.
● All of the staff we spoke with had a good understanding of people's needs.
● This was confirmed by a relative who told us, "All the staff understand [person] and that they can be grumpy". They went on to share that staff were being successful in encouraging this person to accept support they had always declined when living in their own home.
● Handover meetings were conducted daily and clearly documented. This allowed staff to effectively share information about any new risks or concerns about a person's health.
● People had keyworkers who helped them settle and adjust to their new environment when they first came to live at the home. Keyworkers took a special interest in the person's wellbeing, bringing any concerns identified to the management team.
● Three dedicated activities staff provided 54 hours of planned activities and one to one support each week.

● The activities included reminiscence sessions, chair exercises, quizzes and arts and craft sessions. Staff had arranged for an ice cream van to visit the home and were making plans for a fish and chip van to visit next.
● On occasion external singers and musicians also provided entertainment.
● During the inspection, we observed a care worker leading a 'Balloon toss' game. The staff member was very encouraging and engaging and people really seemed to be enjoying the session.
● Staff were also seen to involve people in discussions about current affairs and playing board games.
● Despite our positive observations during the inspection, some people felt that the activities provided could be improved. One person told us there were times when they felt bored and another said, "There is nothing I like to do".
● There was evidence that the activities team continued to review the activities and planned to introduce more one to one time so that people's individual interests could be catered for.

● In response to identifying that there were some keen gardeners using the service, staff had started projects called, 'My dream garden' and 'Copper Orchards'. A number of apples trees had been planted and further edible plants were planned, enabling people to pick these and use to cook meals.
● Another person had expressed a wish to own a dog for the day, so the registered manager had brought their dog in for the person to care for.
● Trips to local events such as the Armed Forces Day had taken place and the activities team were exploring ways of undertaking more trips out to local places of interest.
● The registered manager said that staff readily gave up their own time to take part in Tot's tea parties and to enable people to have an annual holiday. Previous holidays had included a week's cruise and a stay at a holiday park.
● These initiatives were supporting people to lead a full and more active life.
● People received information in a way they could understand. For example, there was a large pictorial breakfast menu on the wall in the dining room. This was in line with the 'Accessible Information Standard'. This framework was put in place from August 2016 and made it a legal requirement for all providers to ensure people with a disability or sensory loss could access and understand information they were given.

Improving care quality in response to complaints or concerns
● At the time of the inspection there had been no recent complaints received at the service. However, there was a system in place to ensure complaints were investigated and responded to.
● The registered manager also maintained a 'Minor concerns' log as an additional tool to assist them in having oversight of any areas where improvements might be made.

End of life care and support

● People's end of life wishes were recorded and staff had training in end of life care, which assured us people's wishes would be respected in their final days and following their death.
● Staff worked in partnership with other healthcare professionals such as, district nurses to ensure people had a comfortable and pain free death.

Good

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- Many of the areas of concern we noted during our inspection, had already been identified by the registered manager and based upon our conversations with them, we were confident that, these would be addressed, and that the culture within the home was one of seeking continuous improvement.
- For example, a range of audits were being undertaken to monitor the effectiveness of aspects of the service including care documentation, infection control and medicines management. The completion of supervision and quality of activities was monitored and checks made to ensure that DoLS applications were being submitted in good time. The provider also undertook periodic visits to the service to undertake quality audits aligned to the key lines of enquiry.
- Unannounced spot checks were carried out to ensure the safety of the service and monitor staff performance including at night.
- There was a clear leadership and management structure in place which helped to ensure that the service could deliver effective care and that staff at all levels were clear about their role and responsibilities.
- The registered manager was supported by a deputy manager, a team of assistant unit managers (AUMs) and a night care co-ordinator (NCC) who over saw the delivery of people's care.
- A detailed daily 'To do' list had been devised to support the AUMS and NCC to have oversight of all aspects of care including checks of anyone that had fallen and that food and fluid and cleaning charts had been completed fully.
- The senior team all had designated areas of responsibility such as hydration, infection control and medicines. This encouraged staff to take ownership for quality and driving improvements in these areas.
- The registered manager understood the responsibilities of their registration.
- The rating of the last inspection was on display within the service and on the provider's website.
- At provider level there had recently been a number of new systems and processes introduced and, during the inspection, this had an impact upon us obtaining timely assurances and further evidence about aspects of how the service was being managed. These systems need to be further embedded to ensure they support the registered manager to monitor quality and compliance with the Regulations.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The registered manager managed the service well and had nurtured a positive person-centred culture within the home. They knew people well and displayed a commitment to putting person-centred care first and of trying new ways of meeting people's needs and to improve their quality of life. They told us, "I value my resident's safety, that's what drives me. I want their families to be safe in the knowledge that their family member has the very best care everyday".
● They also displayed a commitment to upskilling and developing their staff team saying that this was important to ensuring the longevity of the service as people's home.
● A recent compliment from another professional had praised the organisation of the service and competency of staff. It read, 'I had a great experience carrying out assessments…your staff were extremely helpful, [staff member] had everything so wonderfully organised…your staff were very well informed…. they had a very caring, friendly and personalised approach with all service users…I would like to congratulate you and your team for being so fantastic and amazing in what you do'.
● Staff commented positively on the registered manager and of their leadership of the service.
● One staff member said, "[The registered manager] is brilliant, you can just talk to her, if anything needs to change she deals with it, like a friend but you know there is the authority as well…she is out on the floor, she always comes down around lunch to help out".
● A second staff member said, "She knows her staff, she has been here a long time. She is very supportive, I have never felt I could not approach her about anything. She would not make me feel bad. She is the reason most of us get our work done".

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

● People and their relatives were encouraged to give their feedback about the quality of the service through monthly meetings.
● Minutes showed that people were consulted on the activities, menus or anything new they would like to see in the home. One person had requested chocolate cake and so this had been added to the menu.
● Satisfaction surveys had been completed with relatives and residents in 2018. Most of the feedback had been positive. Where areas for improvement had been noted an action plan had been developed to address these. For example, 'open door' drop in sessions for people and relatives to meet with the registered manager had been arranged for the first Friday of every month.
● Seven days after admission, a short survey was undertaken with people to check they were settling well and were happy with their care and support.
● A monthly newsletter was published informing people about upcoming events, staffing changes and birthday celebrations that were taking place that month.
● Staff meetings were also held monthly during which staff could discuss matters affecting people using the service or recruitment and staffing matters. They were encouraged to comment and share ideas about how practice and care might be improved.
● A number of staff told us that morale was currently variable. They mostly put this down to staffing concerns. For example, one care worker said, "Morale is not a 100% mostly because of lack of staff. You're trying to do everything that is needed it is frustrating…you don't get satisfaction from the job always" and another told us, "Morale is usually quite good but staffing levels can stress people out".
● There was evidence that staff meetings continued to be used to explore staffing concerns and the registered manager continued to keep this under review.
● The registered manager and senior team continued to nurture strong links with the local community who were welcomed into the home.
● A local children's nursery visited the home on a bi-monthly basis to enjoy interactive visits with people who then also visited the nursery in return. One person who had worked in a school had spent the day with

the children which had been an enjoyable and special experience for them.
● Staff from one of the local supermarkets visited the home as volunteers to spend time with people but also to perform jobs such as painting the garden furniture.
● At Christmas staff had sent a request to the local community to send cards to people using the service. They had received in excess of 150 cards. In addition, local families were welcomed into the home on Christmas Day to spend time with people and share their celebrations.

Working in partnership with others

● The management team were committed to working in partnership with other organisations to improve outcomes for people which meant people received good holistic care. This included GP's community nurses and other healthcare professionals.
● To ensure that people received better joined up care when they transferred in or out of the service, staff had developed a hospital transfer pack that included key information such as the persons medicines, a summary of their needs and next of kin details. This helped to facilitate a smoother handover of care between the care home and ambulance or hospital staff.