South West Care Homes Limited

Manor House

Inspection report

135 Looseleigh Lane
Derriford
Plymouth
Devon
PL6 5JE

Tel: 01752777572
Website: www.southwestcarehomes.co.uk

Date of inspection visit:
03 July 2018
04 July 2018

Date of publication:
16 August 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Manor House is a residential care home for up to 30 older people, most of whom live with a degree of dementia. Nursing care can be provided through the local community nursing services if appropriate. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Manor House is an old Georgian building set over various floors and extensions with a range of communal spaces leading onto a secure garden and outdoor spaces in Plymouth. South West Care Homes Limited also operates 10 other services in the South West from a head office.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. There had been a recent safeguarding concern resulting in the dismissal of three night care workers but this had been managed well and in partnership with the local authority safeguarding team.

We made a recommendation to ensure that despite audits identifying improvements were required that timely actions were taken to maintain a comfortable and pleasant environment for people.

We carried out an unannounced inspection of Manor House on 3 and 4 July 2018. At the time of the inspection 27 people were living at Manor House. The registered manager was on sick leave during our inspection. The service was being managed by a deputy manager with the support of another registered manager from the provider's other service locally and a regional manager based at Manor House. They were supported by team leaders and care workers and ancilliary staff. The provider oversaw the running of the service from a head office and completed regular visits and audits. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. People were able to choose what they wanted to do and enjoyed spending time with the staff who were visible and attentive. There was a lot of staff interaction and engagement with people, most of whom were living with dementia and unable to tell us directly about their experiences. They looked comfortable and happy to spend time in the communal areas or in their rooms.

People were encouraged and supported to maintain their independence, emphasised by some people being supported to return home to the community. There was a sense of purpose as people engaged with staff, watched what was going on, played games and pottered around the home or went outside. The majority of people were living with dementia and were independently mobile or required some assistance from one care worker. Staff engaged with them in ways which reflected people's individual needs and

understanding, ensuring people mobilised safely from a discreet distance.

People were provided with good opportunities for activities, engagement and sometimes trips out. These were well thought out in an individual way and the regional manager was looking at developing a more robust way of ensuring all individuals had their social needs met with the help of a new activity co-ordinator in the near future. People could choose to take part if they wished and when some people preferred to stay in their rooms, staff checked them regularly spending one to one time with them.

People and relatives said the home was a safe place for them to live. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. Any safeguarding concerns had been managed well with provider involvement and staff support and the service worked in partnership with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns and issues would be addressed and people seemed happy to go over to staff and indicate if they needed any assistance. Staff were vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia. They used chatting and distraction techniques as they knew people well, showing patience and understanding. People and relatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally.

People were well cared for and relatives were involved in planning and reviewing their care as most people were not able to be involved due to living with dementia. The computerised person centred care planning system enabled relatives to safely access care records and share information and photographs from afar. Care plans showed that people were enabled to make smaller day to day choices such as what drink they would like or what clothes to choose. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's repeated stories.

There were regular reviews of people's health, and staff responded promptly to changes in need. For example, care records showed many examples of staff identifying changes in need and appropriate and timely referrals to health professionals with positive results for people.

People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. Staff knew when people did not appear 'right' and acted as advocates to ensure they received the right health care.

Medicines were well managed and stored in line with national guidance. Records were completed with no gaps and there were regular audits of medication records and administration and to ensure the correct medication stock levels were in place.

Staff had good knowledge of people, including their needs and preferences. Care plans were individualised and comprehensive ensuring staff had up to date information in order to meet people's individual needs effectively. Handover and communication between staff shifts was good so there was consistent care.

Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. The care staff team was stable and many care staff had worked at the home for some years. Training was inclusive, each staff member attended, for example the maintenance person had been trained in specialist dementia care. Staff felt well supported through recent changes in management provision whilst the registered manager was on sick leave.

People's privacy was respected. Staff ensured people kept in touch with family and friends, inviting friends and family to events regularly. Relatives told us they were always made welcome and were able to visit at any time, use the quieter lounges and make hot drinks. People were able to see their visitors in communal areas or in private. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The staff and managers showed great enthusiasm in wanting to provide the best level of care possible and valued their staff team. They identified staff skills and matched staff to people's personalities. Staff gave examples of particularly rewarding work with people. Staff showed a caring ethos and this showed in the way they cared for people in individualised ways. During the inspection staff had a lovely sing song and dance with people and knew and respected how people living with dementia viewed their world.

Observations of meal times showed these to be a positive experience, with people being supported to eat a meal of their choice where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom, often taking their meal with people too. Nutritional assessments were in place and special dietary needs were catered for as well as specialist crockery and cutlery and finger foods to aid
independence for people living with dementia.

There were effective quality assurance processes in place to monitor care and plan on-going improvements overseen by regular provider audits. There were systems in place to share information and seek people's views about the running of the home, including relatives and stakeholders. All responses were positive from the recent quality assurance questionnaire. People's views were acted upon where possible and practical, and included those living with dementia. Their views were valued and they were able to have meaningful input into the running of the home, such as activities they would like to do, which mattered to them. A monthly newsletter and notice board kept people up to date with regular 'tea and chat' with the manager. encouraged families and children to attend, with face painting and a bouncy castle.

Further information is in the detailed findings below.

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Manor House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 3 and 4 July 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case experience of caring for people living with dementia.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.
We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

At the time of this inspection there were 27 people living at the home. During the day we spent time with all 27 people who lived at the home and four relatives. We also spoke with the new deputy manager who had worked at Manor House for some time, the registered manager supporting the deputy from the provider's other service nearby, five senior care workers and care workers, a domestic and housekeeper, the cook and maintenance person. The registered manager was on sick leave at the time of the inspection.

We looked at a sample of records relating to the running of the home, such as audits, quality assurance, medication records and care files relating to the care of five individuals and three staff personnel files.

Good

Is the service safe?

Our findings

The service was safe. People and relatives told us they felt the home was safe and they were well supported by staff. One person was able to tell us, "Well given that I was often falling over when I lived at home, I must be safe here as I haven't fallen over now for a long time."

The provider and managers had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. Any safeguarding concerns had been managed well with provider involvement and the service worked in partnership with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns and issues would be addressed and people seemed happy to go to staff and indicate if they needed any assistance. This helped ensure they felt safe.

Staff were vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia. They used chatting and distraction techniques as they knew people well, showing patience and understanding. One relative said, "I know my husband can be challenging but the staff know how to keep him busy and monitor where he is. He feels that he has a role here which keeps him happy. I can't praise them enough, they have saved my life!" They told us they would not hesitate to report any concerns if they had any; they felt they would be listened to and action would be taken to address any issues raised. Another relative told us, "I can go home and know [person's name] is safe. I know they are happy here, when I have taken them out they come back and say 'This is my home'."

Most people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other. Staff encouraged and supported people to maintain their independence safely and in a caring way. Where people were at risk of recurrent urine infections which could affect their safety such as mobility, dementia and cognition for example, staff were vigilant in sending samples off for testing and ensuring the person had appropriate treatment to keep them safe.

People's independence was supported. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order and had suitable footwear. People were wearing appropriate clothes for the weather which was very hot. Risk assessments had also been undertaken for people who liked to be as independent as possible with a focus on enabling. For example, one person was able to come and go outside, to a space generally used for staff. The managers had fitted a sensor to the outside fire door so they knew the person had gone outside and would need to knock to come back in. We saw them enjoying time pottering around in this area safely throughout both days.

The balance between people's safety and their freedom/choice was well managed. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help if they needed assistance. Staff had noticed when one person was struggling with a handbag and a walking frame

and had presented them with a frame basket. The person was so amazed such a thing existed. The environment was easy to navigate with clear dementia friendly signage including easily recognisable 'front doors' for peoples' rooms and memorable items on the walls. People and staff told us they used the four named 'zones' with people saying 'I'm going down to Memory Lane' or telling us they lived at 'The Meadow'. The circular corridors enabled people to walk purposefully and there were spacious communal areas. Ramps had been installed around the home where floor levels varied.

Risk assessments and actions for staff to take were included for risk of pressure area skin damage, falls and nutrition. For example, staff noted that one person ate better when they were in a social situation with others and monitored intake on a food chart, encouraging finger food. Where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, for example, were moved with the person when they moved. One person had a pressure area on their heel which was healing, with regular input from the district nurse. No-one else at the home had any skin pressure damage. One person was nursed in bed due to their condition and they were checked for re-positioning every two hours. Staff ensured the person moved in bed to minimise the risk of skin pressure damage and an alert also showed on their computerised care plan on staff handheld devices as a reminder.

Computerised care plans provided detailed information about specific risks such as malnutrition, dehydration, constipation, pressure ulcers, and illnesses such as diabetes. The care planning system alerted staff and the management team to potential risks such as insufficient fluid or food intake, or essential tasks being missed, through the use of a red, amber, green 'traffic light' warning system. The staff monitored risks closely and recorded the outcomes throughout the day, including fluid and food intake, personal care given, and the person's health and well-being.

The records showed staff sought medical intervention promptly when risks to a person's health and well-being was noted. Where people were at risk of choking staff sought specialist advice and intervention. Staff were knowledgeable about the risks and able to explain the advice they had been given and how this was followed. The records showed that two people had very low fluid intake levels in recent days. However, staff were aware of this and they had offered drinks frequently throughout the day. We observed staff encouraging people to drink during the inspection and noted that some people refused to drink more than a few sips at a time. The managers were seeking advice from their GP and were making sure people were safe.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. Staff told us staffing levels had been a problem in the past but the regional manager was developing a new dependency tool to ensure staffing levels were enough to meet people's needs at all times. Since May 2018 staffing levels had increased to one team leader and four care workers in the mornings and one less care worker in the afternoons. Staff said they were very happy with these levels and we saw people receiving care, time and support in a timely way by a well organised staff team. The regional manager was looking at laundry provision to ensure staff had more time to spend with people. Most people at the time of the inspection required the assistance of one care worker, with three people using a hoist to mobilise. Staff were allocated to support people living in one of the three named areas, which worked well, and people were able to receive support when they needed it. Some people were enjoying a lie in or late breakfast and staff had time to sit and chat or have a coffee with people.

People were monitored regularly by staff according to their needs. Care plans detailed whether people could use their call bells effectively and monitored people accordingly again, with alerts for staff on their handheld devices. For example, one person was supported in bed and staff were seen chatting or ensuring the person had what they liked on their television, such as the football World Cup. Night staff had to use their handheld devices at night to scan that they had checked people regularly if necessary.

The home was clean and tidy with clear domestic task lists and checks, including regular deep cleaning of carpets. However, there were some offensive odours. These were due to inappropriate furnishings that were difficult to clean, rather than a lack of continence support for people. This had been identified through audits and the carpet in the dining room, for example, was about to be changed for a washable surface which would help; and an odorous chair which was no longer able to be cleaned was disposed of during the inspection. Some areas of the environment were cluttered with inessential items which did not make Manor House very homely but these had all been addressed by the second day of our inspection. The new lounge layout and tidier feel made a real difference, which people commented on. The managers said they had now included monitoring of repeated requests from staff for deep cleaning of areas and items of furniture on the domestic job list in the future. This would enable a more timely consideration of the appropriateness of equipment to minimise odour more speedily.

Staff followed good infection control practice. Staff used personal protection equipment (PPE) when delivering care and changed aprons and gloves between rooms or when dealing with food. Staff had had training in infection control. A maintenance person was available who checked the maintenance book regularly ensuring small jobs were done very quickly. The kitchen had been awarded a three star in food hygiene (Highest award is five stars). The service had already addressed the recommendations in the food hygiene report.

People were protected from the risk of harm or abuse because safe recruitment procedures had been followed. We looked at the recruitment records of three staff, one who had been recruited since the last inspection. These showed that risks of abuse to people due to unsuitable staff were minimised because the provider carefully checked prospective new staff to make sure they were suitable to work at the home. These checks included seeking references from previous employers, photo identification and carrying out Disclosure and Barring Service (DBS) checks. These checks made sure the applicant had not been barred from working with vulnerable people. All new applicant recruitment files were sent to the provider support office for scrutiny before an appointment was made.

All staff who gave medicines were trained by the local pharmacist and had their competency assessed before they were able to administer medication. Medication administration records detailed when the medicines were administered or refused. Medicines entering the home from the local dispensing pharmacy were recorded when received. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. The care worker stayed with people whilst they took their medication at their own pace. Medicines were thoroughly audited by the managers monthly and by the team leaders weekly. Medicines on an 'as required' basis were well managed with good information about initial actions for staff to take. Medicines were stored according to national guidelines. Where medication which required additional secure storage and recording systems were used in the home, this was well managed in line with relevant legislation.

The provider had systems in place to manage emergency situations such as fire. Each person had a personal evacuation plan (PEEPS) to enable emergency services to know how to manage people. Accidents and incidents were recorded to show they were well managed and appropriate actions taken and these were reviewed monthly using the computerised care record system.

Good

Is the service effective?

Our findings

The service was effective. Most people who lived in the home were not able to choose what care or treatment they received, due to living with dementia. The managers and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments had been carried out to determine each person's individual ability to make decisions about their lives.

Where restrictions were in place, appropriate applications had been made to the local authority to deprive the person of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Where people were restricted, for example by the use of bed rails, best interest decisions had been made in consultation with other people involved in their care, and the decisions had been recorded. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff were aware of the implications for people's care and had also included discussions about enabling people to use the outdoor spaces as independently as possible with their independent mental capacity advocates, for example.

Managers and staff had kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes. One person was at risk of falling out of bed and safety measures had been put in place with the person's consent. Another person with capacity had discussed what made them feel safe in relation to their anxieties so staff had ensured they had the equipment they needed and made sure they spent time with them in their room. This ensured people's choice was taken into account.

There was a stable core group of staff who worked well as a team. All staff on duty in each role had their photograph in the foyer so people and relatives knew who was around. Staff had very good personalised knowledge of people's needs and received good handovers using the computerised care plan system. They said, "The key is to know people well and then you know what they like." Most staff had been employed at the home for a number of years. Staff and the managers were able to tell us about how they cared for each individual to ensure they received effective care and support. For example, one person was reluctant to accept personal care. Staff had found that talking about their pet and using engagement with a soft toy was very effective in distracting the person and developed a relaxed atmosphere where the person felt comfortable.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. New staff new to care completed a detailed 12 week Care Certificate induction (a recognised national training standard). This included working with more experienced staff for a period until each new staff member felt confident to work independently. During the inspection, a new care worker was shadowing

more experienced staff and was not included within the normal staffing levels. They were seen enjoying chatting and spending time with people getting to know them. Staff said they liked working at the home and felt they could say if there was an area of training they were interested in. Policies and procedures were accessible to staff and managers could see when they had been read. The managers told us how they tried to ensure good quality staff through the interview and induction/probation process. For example, they and the staff team were currently very pleased with the new night staff and noticed a lovely atmosphere when they arrived in the mornings.

There was a programme to make sure staff training was kept up to date. This was managed on a computerised training matrix. Training due was highlighted and then booked. Staff could access a wide variety of training such as dignity and respect, equality and diversity, diabetes, epilepsy and challenging behaviour. Training was inclusive and the maintenance person said they also attended all training, including specialist dementia training which helped them interact meaningfully with people throughout the inspection. They were working on providing some activities for one man who liked to use tools. Staff received regular one to one supervision sessions. This enabled staff to discuss career and training needs, any issues and for the managers to assess competency using a set format. Staff felt supported by current management at the home and the provider. They commented, "We have had a bumpy ride recently with safeguarding but the new operations manager is a breath of fresh air, its brilliant." They added, "People are the priority and we go with their flow." We heard examples of how staff with additional needs were supported in their working and personal life.

People had access to health care professionals to meet their specific needs. Records showed people attended appointments with GPs, dentists, chiropodists, district nurses and speech and language therapists. Staff made sure people saw the relevant professional if they were unwell and there were lots of recorded examples. Staff said they had a good relationship with local GP surgeries and the district nurses. A relative told us the staff had requested a GP visit a couple of times recently when the person showed signs of illness. They told us "They are hot on these things". They also told us the person had seen an optician, chiropodist and hairdresser regularly. We saw examples where staff had been advocates to ensure people received the right health care. For example, one person had been diagnosed with diabetes when staff noticed health changes. Staff said, "We would know if people weren't right." One person had been frail and underweight but was now being supported to go home. Staff said they hadn't thought the person would stand but now they were able to go home.

There were regular reviews of people's health. Each person had a 'hospital passport'. This was intended to be given to external health professionals/paramedics so they would know how to respond to people's care for consistently. Some people also had 'Catheter passports' so health professionals would know what equipment and when to change this. Staff at the home responded to people's changing needs. For example, staff recognised when people were not eating so well, were not themselves or had a sore place on their skin. Only one person had a small sore and skin care was well managed. There were examples where people's health and wellbeing had improved since living at Manor House. For example, one person who had been frail and underweight had been able to trial going home. They had managed a week at home and then returned but now was able to be independent with eating and their weight was healthy. Records showed how staff were attentive to any changes such as sore skin. Staff had noticed one person's skin was reddening so they had asked a district nurse to check them over and recommend a pressure mattress, which was sourced straight away. Body maps were used to identify and monitor areas requiring topical creams or bruises.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment and took appropriate actions. Computerised care plans included nationally

recognised nutritional assessment tools to ensure staff knew who was at high risk and what action to take. During the inspection the weather was particularly hot so staff were ensuring there were drink stations and regularly checking that people were drinking. One person living with dementia was very active so staff ensured they had 'pit stops' around the home where the person paused for snacks and sachets of juice. Staff told us, and people's care records showed, that appropriate professionals had been contacted to make sure people received effective treatment.

Everyone we spoke with was happy with the food and drinks provided in the home. A relative told us the food was good and assured us "She eats plenty". We took lunch with the 17 people eating in the lounge and dining room. People could eat where they wished. The cook and staff knew what people liked to eat including their favourite foods and dislikes. Staff were able to understand what people would like by using their knowledge of their preferences in the past and also brought people plates of choices of meals so they could choose at the time of the meal. Staff were changing the pictorial menus in peoples' rooms and would be posting photographs of the meals on offer on the dining room notice board. One person did not like their main meal as they felt the weather was too hot, so the cook made an attractive salad.

There was a varied menu. Staff had consulted with people and the menu was changed to include more traditional British meals which people had said they preferred. At the time of the inspection people were enjoying attractive meals. Relatives were encouraged to visit over mealtime if they would like to assist and share the experience. One relative had joined their spouse at the table and was enjoying chatting with the group. People were not rushed but food was served in a timely way. One person was reluctant to eat so a care worker had a plate of food with them and chatted which meant the person ate well. Care workers said they had trouble with condiments going missing so they were ordering portable baskets they could use. There was friendly banter between people and they were offered seconds and regular snacks throughout the day, including homemade cakes. This helped to make mealtimes pleasant, sociable events which also encouraged good nutritional intake.

People had the equipment and environment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home, including the garden and people had individual walking aids, wheelchairs or adapted seating to support their mobility. There were enough hoists and a stand-aid available. There had been audits of the environment and investment in the older style premises. Lots of work was being done to improve carpets and replace the lift and update the exterior. However, we found that although furniture and the environment had been audited and areas for improvement identified, some areas and furniture was very shabby and old. This meant that people did not always have a pleasant outlook. For example, some skirting boards and paintwork was very shabby, the front porch was dirty with dead flowers and some furniture was very stained and old. One ground floor bathroom was very small and was not suitable for people to use if they required staff assistance. This had all been identified by the home but improvements were slow in these areas. Staff began to work on these areas by the second day of our inspection.

As this had been identified we recommend that all areas are re-audited and actions taken to ensure these are rectified in a more timely way to ensure the home is a pleasant one for people to live in at all times.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. One person said, "I think they care for us well. They see to it that you can have a visit from the opticians, or the dentist, or the hairdresser". Staff were attentive, passing time with people and relatives. Relatives told us how they always felt welcomed and all staff were able to give them an update on their loved one. Relatives comments included, "I'm very happy with the care here. The girls are lovely and help me so I can do people's hair." One relative praised the staff saying "Nothing is too much trouble". Another relative told us that since their loved-one had moved into Manor House they had gained happiness, friendship, and their independence and mobility had improved significantly. Other comments included, "I visit two or three times a week, at different times of the day. The care my relative receives is really good – it's certainly improved of late. The carers now have smiles on their faces and seem to have more time to do their jobs", "The carers here go above and beyond in my view. They're all so very kind to my relative and to me, nothing is ever too much trouble" and "I can't fault the care my relative receives here. The staff are wonderful".

There was a calm and friendly atmosphere with people doing what they wanted to do throughout the day. Staff recognised groups of people who had made friends and facilitated these friendships. For example, one couple had become friends who gained comfort from one another. Staff said they liked to stay up late playing dominoes, listening to music and holding hands. They ensured both parties were comfortable with each other and family had also become friends when they visited. We saw the couple having lunch together with a glass of red wine. One person found peace with a particular doll. Staff were kind and respectful, telling us, "To them it is a real baby" so that's what we see for them."

Staff were observed speaking with people in a friendly, caring and positive manner. They were constantly checking people were happy, comfortable and well. For example, a member of staff was heard asking a person if they were in pain. We heard staff asking people "Is that Ok?", "Would you like me to…", and "Shall I get you a cushion?" In the lounge there were a variety of chairs providing differing seat heights and positioning options. A member of staff noticed that a person was not entirely comfortable in the chair they were sitting in and commented, "This chair is too low for you. We will find a better chair for you." All interaction was respectful. Staff understood people's moods, recognised when people appeared low and were compassionate and understanding. When a person who had been asleep woke up and started to walk around a member of staff noticed immediately and went to offer assistance. They walked with the person arm in arm, chatting as they went in a friendly and caring manner.

The service supported people to express their views and be actively involved in making decisions about their care support and treatment as far as possible. This was evident in the care plans which clearly set out people's views, personalities and wishes.

Rooms were very personalised. Relatives said they could decorate them as people wished. Photographs showed relatives enjoying time with people. People said, "Your room is your own, and they make you feel at home in it. You can be as private as you wish, and they respect that". Laundry was managed by care staff

and was well organised with people's clothes well cared for and folded neatly, showing that staff cared about people.

Most people were not able to tell us about their choices directly due to their dementia. Care plans contained people's preferences which gave staff detail to work with. Staff said they could update care plans as they learnt more about people. They knew what people liked to do and their preferred routines and topics for starting conversations. Tea and biscuits and snacks were offered throughout the day including relatives and there were accessible drink and snack tables.

There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people they explained what they were doing first and reassured people. Staff ensured people's clothes were well ordered and maintained their dignity. For example, discreetly encouraging a person who liked to be independent to change their clothes. People's continence was well managed to maintain dignity, although as noted previously timely attention needed to be paid to the suitability of some furniture and flooring to minimise accidental offensive odours.

Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. Staff were vigilant of checking people who preferred or needed to be cared for in their rooms, supported by the care plan and computerised alerts, sometimes just spending quiet time with people.

Good

Is the service responsive?

Our findings

The service was responsive.

People benefitted from staff who clearly liked to spend time with them. Although currently there was no designated activity co-ordinator, staff said, "We have people who come in to entertain, otherwise we have time to do things with people in the lounge or wherever." All staff worked as a team to provide activities including the maintenance person who was often making 'groups of ladies' cups of tea during the inspection. Staff knew people's preferences and how they liked to spend their day. For example, one person was very private so staff ensured they had a task with an alert on their care plan that ensured they had one to one time with staff and were checked regularly. Another person was anxious and had hallucinations. Staff were seen chatting with them in their room or having a coffee with them, which the person clearly enjoyed. Much of the interaction was with staff sitting with people, having a meal with them or using personal care time to enjoy a meaningful chat. Staff said, "We give people a lot of company, we are not just doing tasks." One person loved to be active and staff said, "We often go outside with them, even if its raining, they love it." One relative said, "I love to see her with the tambourine. They are very happy here. Sometimes we could do with more activities but everyone is included."

The home provided leisure and social activities that were appropriate for people living with dementia. When we arrived people were enjoying a late breakfast, chatting with staff, napping or pottering around the home and garden. Due to most people choosing to spend most of the day in the communal areas, they were able to interact with visible and attentive staff and watch what was going on so there was a low risk of isolation. There was an activity programme with regular activities. Care plans noted who liked to be informed to join in. For example, one care plan said, "I like to spend the morning in my room and then in the lounge. I don't like to bother people so offers, encouragement and support are beneficial to me." The plan went on to detail how their habits had arisen from their employment such as being traditionally masculine, well mannered and allowing 'ladies first.' Activities included puzzles, movies with nibbles, exercises, potting plants, group relaxation, games and pets as therapy visits.

Care staff all came together during the inspection in the communal areas to join in with an afternoon sing song. It was a fun session and people were smiling and laughing. The room was full and people clearly wanted to join in the fun. Those people who were unable to get up and dance were holding hands with staff, waving hands, singing and smiling. Staff were attentive and encouraged people to join in. In the afternoon musical entertainers visited the home. In the conservatory there was a range of books, games, and music to meet individual interests. Another resident was helped by a carer to undertake a crossword, and a third was actively involved in polishing cutlery and engaging in dialogue with a carer. There was a happy and joyful environment.

In the lounge there were tables close to people with things of interest such as book and quizzes. They also had items which may be of interest to people living with dementia, such as dolls, and reminiscence items. Where people were in their rooms they had drinks and snacks and items to stimulate them such as dementia friendly knitted 'Twizzle' muffs and books. Care plans were very detailed and drawn up over time

following an initial pre-assessment by managers to ensure the service could meet people's needs. The computerised care planning system enabled staff to use their handheld devices to check what people's individual needs were. Details included, "Please leave the toilet light on and keep my door open at night" for example. Each care file had a background information form which was completed with relatives if possible. The new computer system care plans had details of what social activities people liked and who was important to them. This was reflected in talking to staff who knew what topics to use to facilitate conversations with people. The regional manager was developing a more robust method of auditing whether each individual was having their social needs met as, at present, records did not reflect individual time spent with people. However we saw a lot of engagement and interaction which helped to prevent social isolation. An overview would ensure that some people did not receive less interaction than other more vocal people. A new activity co-ordinator was being employed to cover two homes with the support of care staff. There were currently few trips out but staff said this would be addressed as the activity programme developed with the new activity co-ordinator. However, some people did go out. One person enjoyed regular swimming and shopping with a care worker who had developed a particularly close relationship with them.

People's care plans showed how they liked to be addressed and then went on to detail people's past experiences. This was used for example to minimise people's anxiety and distress linked to living with dementia. One person had been very busy in their previous job and liked to feel useful. Staff ensured they respected the person's assistance around the home and had even developed a way of them having a 'pay day' using a 'cheque' as the person got anxious their 'staff' had not been paid. Other people with similar purpose were encouraged to help with chores around the home. For example, a new laundry washing line was being fitted so people could help with hanging out washing and one person was happily helping to serve lunches. Some people loved music and loved to dance and staff enjoyed a fun dancing sessions where people became very animated, smiling with staff.

Another person had been very subdued and depressed on arrival. They now had one to one time with a named staff member they related to who ate with them. Staff knew they liked to be quiet and staff were matched to their needs to enable meaningful engagement which we saw. Another person liked loud, jokey staff and reacted well to banter, enjoying a 'good gossip'.

Most people were unable to be directly involved in their care planning but relatives were able to be involved if they wished. Relatives felt they were able to chat to staff or the managers/staff at any time. The computerised system had a password protected sharing function so some relatives were able to see their loved ones care records and share photographs two ways. This was a lovely way to promote relationships with family and friends. There was a newsletter and regular 'tea with the manager' sessions where people could chat about what was happening in the home. Minutes were available in the foyer.

There were good care plans relating to people's wishes for end of life care. Staffing could be increased if people needed additional support. One person received gentle care in bed and staff often popped in to check they were ok. The person said they were perfectly happy. Care plans discussed religious needs, the future and who they wanted to be involved. There were clear records about people's treatment escalation plans about resuscitation instructions which were reviewed over time. Where people may require anticipatory medicines at end of life records showed when this had been sourced in preparation with the GP.

People and their representatives said they would not hesitate in speaking with staff if they had any concerns. One relative told us, "There are regular family meetings where you can raise concerns. I've never needed to complain, but if I were to, I am confident that [staff name] would respond quickly and positively".

People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. We saw complaints had been dealt with well, showing investigations and feedback to complainants in an open way. Issues were taken seriously and responded to in line with the provider's policy.

Good

Is the service well-led?

Our findings

The service was well led.

There was a registered manager at Manor House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was on sick leave so a new deputy manager was in place supported by another registered manager from one of the provider's other services as a 'buddy' and a regional manager who was currently based at Manor House.

The South West Care Homes brochure described the philosophy of the service stating, "We believe in the importance of choice" and their philosophy to encourage and support people to make choices whilst striving to provide good quality care in a relaxed, dementia friendly environment. Each person had a copy of the brochure and statement of purpose explaining the philosophy and what people could expect and how the home was run in large print. We saw the ethos of choice embraced throughout the inspection by staff who knew people well. There had been a period of change at the home following a safeguarding concern which was now resolved. Staff felt well supported through these changes and were positive about the deputy and regional managers. They said, "There's been a real turn around in the way everyone gets on with each other now. I've noticed the residents now seem happier." The provider had ensured that the regional manager was based at Manor House to ensure there was some stability in management going forward. The deputy manager was new to the role but had worked at the home for some time. They were very knowledgeable and displayed great passion for the people in their care.

People and relatives spoken with during the inspection described the management of the home as open and approachable. People were comfortable and relaxed with the management team who clearly knew them and their family well. Relatives said they were happy to talk to management and all the staff at any time and could not fault the care. People and relatives had lots of communication about the home such as user friendly service user guide and home's statement of purpose, newsletters and notice boards. There were systems in place to share information and seek people's views about the running of the home. A recent quality assurance survey had been completed. Comments were all very positive. A recent health professionals survey had included comments such as , "Very organised, friendly home", "Staff are considerate and caring", "Looking after residents and communicating with families good" and "From the interactions we have had with you 10/10".

The managers had an open door policy and they were available to relatives, people using the service and health professionals. There was a sense of good team work and communication with live updates such as, "remind [person's name] to drink". The managers kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area and attending regular managers meetings with other managers.

Staff received regular supervision support in a meaningful way. They were able to air their views and be listened to. However, most staff had commented on the slow decoration and attention to detail in ensuring the environment was pleasant for people. We also noted this and made a recommendation in effective as despite the audits identifying these, improvements were still required. A recent complaint had also commented on the lack of prompt decoration. However, there was an ongoing programme of investment mostly focussed on larger issues such as new carpets, exterior and the driveway. The managers were immediately taking actions by the second day of our inspection.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care including medication audits, care plans audits and falls. Managers could access the computerised system from home and ensure all alerts were looked at, for example. They could also check that two staff had used the hoist. There was an administrative audit every six months from head office. And an overall action plan which had good oversight. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen individual risk assessments were reviewed and preventative measures taken. There were few falls and risk and independence was well balanced. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. The managers had an ethos of honesty and transparency. 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.