Coate Water Care Company (Church View Nursing Home) Limited

Mockley Manor Care Home

Inspection report

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Date of inspection visit:
17 January 2017
18 January 2017

Date of publication:
08 February 2017

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

We inspected this service on 17 and 18 January 2017. The inspection was unannounced.

The service provides accommodation, nursing and personal care for up to 52 older people who may live with dementia or physical disabilities. Forty-six people were living at the home on the day of our inspection.

The registered manager had been in post for seven years. 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 our previous inspection in November 2015, we identified improvements were required in keeping people safe, in delivering effective care and treatment and in the leadership of the service. We gave the home an overall rating of requires improvement. The provider sent us an action plan, setting out the actions they planned to take to improve the quality of the service. At this inspection, we checked whether the actions they had taken were effective.

Since our previous inspection, the registered manager had recruited additional staff. There were enough suitably skilled and experienced staff on duty to meet people's care and support needs safely and effectively. The registered manager had sufficient time and support from the provider to carry out their management role effectively.

People's medicines were managed, stored and administered safely and staff kept accurate records of people's treatment, which evidenced risks to people's health and wellbeing were managed effectively.

The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence. The premises were regularly checked to ensure risks to people's safety were minimised.

People were safe from the risks of harm, because staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies.

The registered manager checked staff's suitability to deliver care and support during the recruitment process. People's needs were met effectively because staff had the necessary skills and experience and received appropriate training and support from the registered manager.

Staff understood people's needs and abilities because they worked with experienced staff until they knew people well. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests.

People were offered meals that were suitable for their individual dietary needs and met their preferences. They were supported to eat and drink according to their needs. Staff monitored people who were at risk of poor health and obtained advice and support from other health professionals to maintain and improve their health.

People were cared for by kind and thoughtful staff who knew their individual preferences for care and their likes and dislikes. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed and updated when people's needs changed. Complaints were responded to, investigated and appropriate actions taken to the satisfaction of the complainant.

Staff were guided and supported in their practice by a management team that they liked and respected. Quality audits included reviews of people's care plans and checks on medicines management and staff's practice.

The provider had taken action to improve by supporting the whole staff team to recognise how their contribution had an impact on the quality of care and treatment. Staff felt valued by the provider because their views and ideas were taken into account in planning continuous improvement plans.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home and nurses were supported to maintain their professional qualifications and skills. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who had the skills and training to meet their needs. Staff understood their responsibilities under the Mental Capacity Act 2005. The registered manager understood their responsibilities under the Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain a balanced diet that met their needs and preferences. People were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff understood people's preferences, likes and dislikes. Staff promoted people's independence, by supporting them to make their own decisions. Staff knew people well and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff supported and encouraged people to maintain their interests, to socialise and to maintain relationships with the people that were important to them. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Good

The service was well-led. Improvements had been made in the level and deployment of staff, which enabled the registered

manager to focus on their managerial responsibilities. The provider had implemented a schedule of audits and checks to make sure people received appropriate care and treatment. The provider's management team regularly visited the home to check the improvement plan was implemented and effective at improving the quality of the service. People and their relatives were encouraged to share their opinions about the quality of the service. Staff were encouraged by the provider's and registered manager's leadership to deliver a quality service.

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Detailed findings

Background to this inspection

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

The inspection took place on 17 and 18 January 2017 and was unannounced. The inspection was undertaken by two inspectors, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service. A specialist advisor is a qualified health professional.

The provider had completed a provider information return (PIR) before our previous inspection, so we did not ask them to resubmit this information. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We spoke with 14 people and two relatives about what it was like to live at the home. We spoke with the deputy manager, a nurse, six care staff, two support staff and a volunteer about what it was like to work at the home. We spoke with the registered manager, operations manager and operations director about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Many of the people who lived at the home were not able to tell us in detail about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the

experiences of people who could not talk with us.

We reviewed four people's care plans and eight people's daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015, we had identified there were not always enough skilled and experienced staff appropriately deployed to support people safely. At this inspection we found the provider had taken the action they said they would take and recruited additional staff. There were enough skilled and experienced staff on duty to meet people's needs.

The registered manager had recruited additional care staff and nurses since our previous inspection. The operations director had implemented a dependency needs analysis to determine how many staff were needed on each shift. People's abilities and needs for support were analysed and scored to identify how many staff were needed to deliver care safely. The registered manager told us they had recently appointed a deputy manager and two clinical lead nurses, which gave them more scope for creating staff rotas and ensured there was always an appropriately trained and skilled person to lead the care team. The number of permanent nurses employed meant there were two nurses on duty all day, where there had previously been one. The registered manager did not need to be on the nurse rota, so they had sufficient time for their managerial duties.

People and relatives told us there were enough staff. One person told us, "I press the button there (nurse call bell) and they come. They never take long." One relative said, "There seems to be a lot of staff. They are always popping in." Care staff told us, "There are always enough staff, day and night. The manager goes out of her way to get sick cover" and "Staffing levels have improved. At the moment, we have got good staffing levels." However staff also said sometimes in the afternoon they felt more rushed, particularly because 14 of the 17 people on the first floor required support of two care staff with personal care and transfers. They explained, "It depends who you are on with and whether you can get in a routine. You just have to get into that routine, start and work your way round or prioritise." We noted the registered manager was trialling having a supernumerary member of care staff on duty throughout the day, specifically to support people to drink sufficient for their needs. There had been positive feedback about this role in a recent relative's meeting.

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. The registered manager showed us records of the checks that had been made of staff's suitability for the role and explained how they risk assessed any adverse information they received, although these were not always recorded in writing. They told us they would keep a written record of their risk assessments in the recruitment files in future.

The provider checked that nurses had up to date professional identification numbers (PINS) and that there were no restrictions on their practice. The operations director told us the provider planned to manage the recruitment process centrally at head office level in future, to ensure consistency and to relieve registered managers of some administrative tasks. Records showed that any concerns about agency staff were shared with the agency concerned so they could carry out their own investigation. Agency staff were not allowed

back into the home if there were any concerns raised about their practice.

All the people and relatives we spoke with told us they felt safe at the home because there were always staff around to support them. One person said they felt safe because, "There are always staff around to help, I just ask" and "You know you can press your buzzer and they will respond. You know you can call somebody." Relatives told us, "The home is secure which gave us confidence and I always see plenty of people about" and "I feel very privileged to have [Name] here. I know they are safe." The front door had an external keypad, which meant only people known to the management could enter.

Staff told us they had training in safeguarding and protecting people from the risks of harm or abuse. Staff understood the type of concern they should report and how to report it. One member of care staff told us, "Abuse can be physical, emotional or social. It can be done by a member of staff, a family member or anyone who visits the home." Another member of care staff said safeguarding people meant, "Keeping them safe and well and keeping them safe from abuse."

Staff told us they had confidence in the provider's whistleblowing and safeguarding policies and procedures because when they had followed the procedure, the registered manager had listened and taken action. One member of care staff said, "You need to tell them and report it to the nurse in charge or the manager for the safety of the residents. You need to be a whistle-blower."

The registered manager assessed risks to people's health and welfare and wrote care plans to minimise the identified risks. For example, for people who were unable to mobilise independently, their care plans described the number of staff and the type and size of equipment needed to support them safely. Nurses made sure care staff understood the importance of their role in supporting people to minimise risks. One nurse told us, "I showed a new care staff how and why we were applying a dressing for one person. After I explained it, it made sense to them." Records showed care staff followed the guidance and supported people to minimise the risks of sore skin, by making sure they regularly changed position. A member of care staff told us, "[Name] has red areas, so we tilt them, left, right, or back with a 30% tilt to change pressure and move their weight around."

The registered manager monitored and analysed accidents, incidents and falls to identify any trends or patterns. They analysed the information by the person, the time of day and location to check whether action was needed to minimise the risks of a re-occurrence. Records showed action had been taken to minimise identified risks, for example, a sensor mat had been placed by the side of a person's bed, to alert staff, to check whether they needed assistance.

Staff told us they had health and safety, first aid and fire training when they started working at the home. They said they felt prepared to deal with emergencies safely. A member of staff told us, "They regularly test the fire bell. There are two fire exits" and "Fire doors give protection for 30 minutes." Staff were able to explain the actions they would take in the event of an emergency, such as supporting people to move to safe zones behind closed fire doors, while they waited for the fire service.

The provider checked the premises were maintained to minimise risks to people's safety. Records showed the management oversight team checked that essential supplies and equipment such as water, gas, electricity, the lift and hoists were tested and maintained. The registered manager told us the improvement action plan included a maintenance improvement plan, which had resulted in ongoing refurbishment of the premises. The dining room had been refurbished, which encouraged people to socialise and move from their chair to another room, and thereby reduced the risk of acquiring sore skin. A ground floor bathroom was in the process of being converted into a wet room with a ceiling hoist, to enable people to shower

safely.

We saw medicines were being managed and administered safely and in accordance with best practice. Medicines were stored in a locked room, which was tidy, well organised and at the recommended temperature to ensure they remained effective. Nurses followed recommended procedures for disposing of unwanted medicines. Medicines were delivered from the pharmacy in bio-dose pots, with the contents, the person's name and the time of day they should be administered written on the packaging. Everyone had an individual medicines administration record (MAR) with their photo, to minimise the risk of errors. Records showed staff signed when people's medicines were administered and recorded when people declined to take their medicines.

Nurses sought advice from other health professionals when people were at risk of not taking their medicines regularly. When people lacked capacity to understand the benefits of their prescribed medicine, they were referred to their GP. Records showed the GP had authorised staff to administer some people's medicines covertly in their best interests, that is, without their knowledge, if they declined to take them. The pharmacist had confirmed it was safe to administer the prescribed medicines dissolved in food or drinks. We saw a nurse gave people the opportunity to agree or decline their medicines before administering them covertly, which meant medicines were never given covertly unnecessarily. The nurse waited beside the person to make sure they had swallowed the medicine, before they moved away to update their MAR sheet.

Improvements had been made ensuring medicines were administered in accordance with people's prescriptions. There was guidance for nurses to ensure medicines were administered at the right time, when the time was specified in the prescription. There were written protocols for people's 'as required' (PRN) medicines. The protocols included guidance about how to identify the signs that a person might need medicine, particularly if the person was not able to express themselves verbally. A member of care staff told us, "The nurses are very good at pain management. They use a pain chart and observe people's body language and facial expression to know when a person is in pain." Nurses had also implemented 'variable dose medicines' care plans, which supported safe administration, to ensure an appropriate length of time elapsed before offering a person more of the same medicine.

Good

Is the service effective?

Our findings

People and relatives told us they thought the staff were well trained because people's needs were met effectively. People said they could choose what time they got up and what to eat, which was important to them. One person said they had a choice, "In everything." Another person told us staff were 'efficient' at supporting them to mobilise using a hoist, but they were happy that they would soon start receiving physiotherapy to try to 'get mobile' again.

Nurses and care staff told us they felt effective in their role and knew what to do, because their induction programme included training and supervised practice, that is shadowing experienced staff, before working independently with people. Staff told us this gave them the opportunity to get to know people from the beginning. Staff training included moving and handling, dementia awareness and nutrition. A member of staff told us they had to pass the 'knowledge papers' of the Care Certificate, in order to be assessed as competent to work. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life.

There were improvements in staff's training and confidence since our previous inspection. Staff training was tailored to meet their individual needs and the requirements of their role. For example, the cook had training in preparing meals suitable for people who had difficulty in chewing or swallowing. Nurses had training in wound care and dressings and in supporting people who needed to be fed via a tube directly into their stomach. All the staff and nurses we spoke with said their training was effective and useful, because it gave them confidence in their practice. Care staff told us they felt supported because they had regular opportunities to discuss their practice throughout the day with senior staff, at handover and at team meetings. One member of care staff told us, "At weekends there is always the manager, deputy or a clinical lead on duty."

The provider had recently appointed two staff as mentors for new staff or those staff who required additional support. The mentors were consulted about the allocation of staff to ensure there was the right mix of skills and experience on each shift to meet the needs of the people living in the home.

The recently appointed deputy manager told us, "I have spoken with care staff and am I happy with their practice." They told us they had worked some night shifts, "To understand for myself what is involved" and had met individually with clinical leads to ask what support they would need to carry out their responsibilities effectively. All the staff we spoke with told us they felt supported. They told us they were happy to make suggestions and they felt listened to. A member of care staff told us, "Last week we changed fluid charts and the nurse and manager asked what I thought of the changes." Records of team meetings showed staff discussed developments within the service, best practice and areas of concern, which ensured all staff understood how their work contributed to people's well-being.

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 an assessment shows a

person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had applied for a DoLS for 26 people who lived at the home, because they did not have the capacity to understand the risks associated with the restrictions to their liberty. At the time of our inspection, six DoLS applications had been agreed by the local supervisory board and the rest were in progress.

For people who lacked the capacity to make decisions about their treatment and care, decisions were made in their best interests, by a team of health professionals and the person's relatives. The registered manager showed us the list of relatives who had the right to make decisions on their relation's behalf. The registered manager had asked relatives to show them the court documents that gave them the decision-making power. This made sure decisions were made by a person who had the legal right to do so.

Staff had training in the MCA and understood they could only deliver care and support with people's consent. A member of care staff told us, "You have to ask [people] what they would like. If you are going to wash and dress them you have to ask." One person who had bed rails at the side of their bed told us, "They said, do you want them up and I said 'you can leave them up'." Another person told us they had requested that staff did not check on them through the day but only went to their room if they rang their bell for assistance. Staff we spoke with were aware of this person's preference and respected that it was this person's choice.

At lunchtime we observed staff asking people for consent. Staff asked, "Shall we sit you up a little?" and "Are you ready for your lunch?" One staff member told us how they watched people's body language and facial expressions to ensure they were consenting to care and support if they were unable to do so verbally. They told us, for example, they knew when people had enough to eat because, "Some will just close their mouth or push your hand away."

People told us the food was 'good' and they had a choice every day. One person said, "The breakfast is good. I have a cooked breakfast every day, and toast and marmalade. They do ask what I would like for lunch." Other people said, "The food is nice and I have lots of choice" and "This (lunch) is nice and hot." The cook, who had worked at the home for five years, told us, "I ask everyone who is up what they want for breakfast. The lunch menu is planned with people, the manager and staff and second helpings are always available. I know people's appetites and preferences now."

People were supported to maintain a balanced diet and to enjoy their meals. At lunchtime we saw there was a choice of main meals and people were supported to eat where they chose, in the dining room, lounge or in their own room. Staff made sure people were supported according to their needs and in accordance with their care plan. For example, some people needed their meals pureed or cut up to make it easier to eat. Staff were knowledgeable about people's dietary needs and preferences. A member of care staff told us, "[Name] pulls a face if they don't like their meal. They have a pureed diet and thickened fluid. If they don't want one thing, I will try another – meat, potato, vegetables are all served separately for different tastes. [Name] loves pudding and has their own supplementary yoghurts as well."

The cook served each person's meal by name and staff took their meals directly to them, so the meal was delivered while it was still hot. People's preferences, allergies and special dietary requirements were

recorded in their care plans and shared with the cook. There were lists in the kitchen to remind the cook and staff about people's preferences, allergies and needs for assistance with meals. People who needed assistance to eat were assisted by staff sitting beside them. Staff spoke reassuringly with people who needed assistance and allowed them sufficient time between each mouthful to enjoy the taste and texture of their meals.

Nurses used a recognised assessment tool to identify whether people were at risk of poor nutrition. People's care plans included a nutritional assessment and an appropriate care plan for those identified as at risk. Staff monitored people's weight and whether they ate well, and referred them to other health professionals, such as the speech and language therapists or dieticians if they had any concerns about a person's nutrition.

Since our previous inspection, improvements had been made in recording what people ate and drank, when they were identified as being at risk of poor nutrition. Staff kept fluid charts for those people who were identified at risk of not drinking enough for their needs. A member of care staff told us, "Nurses work out the person's weight and their fluid needs to provide a target for fluid. If a person is below target, we 'push' fluids" (that is, encourage people to drink) and "If a person declines to drink, we tell the nurses." Records showed that care staff kept a running total of how much people drank, so they could see at a glance whether a person needed to be encouraged to take more fluids. The registered manager was trialling the use of an additional member of care staff to work as a lounge assistant, offering people hot and cold drinks to make sure everyone was supported and encouraged to drink enough.

People were supported to maintain good health and to access healthcare services when needed. All the people we spoke with told us they thought staff would get a doctor if they needed one. The registered manager had made arrangements for the GP to visit the home and hold a surgery there every week, for those identified as in need of a GP consultation. They told us they made a list in advance and talked through each person's symptoms and conditions, before the GP went round the home. They kept a log which showed the medical conditions people lived with, their current planned medical treatment and the date the GP had last visited them, to make sure their health care needs were regularly reviewed and their treatment remained appropriate to their needs. Records showed people were referred to other health professionals, such as chiropodists, dieticians and the mental health team when needed.

Good

Is the service caring?

Our findings

People told us they were happy living at the home, because the staff were friendly and thoughtful. People told us, "Staff are kind to me", "They make you happy and make you smile" and "The girls are lovely and very helpful." Relatives said, "It's like an extension of home" and "They (staff) are absolutely amazing." Staff told us, "It's a lovely place to work", "It is really enjoyable and there is a good atmosphere between the staff and the residents" and "It feels more like family here."

Everyone we spoke with told us the staff knew their needs, likes and dislikes well. One member of staff told us, "People's care plans include their social, religious and dietary needs, and we can all contribute our knowledge." The care plans we looked at included information about people's history, likes, dislikes, wishes and aspirations and guidance for staff in how best to support them. We saw staff engaged with people as individuals and understood them well. A member of care staff told us, "Person centred care is encouraged all around the home (not just in the dementia unit)."

Staff were supported to develop positive, caring relationships with people by working with experienced staff at the start of their employment and by working across the whole home. This meant they could get to know people well and ensured a consistent approach to people's needs, whichever staff were on duty. Some staff told us they did not always know enough about people's history and backgrounds to understand their motivations or reactions. One member of staff understood this kind of information would be valuable in providing person centred care because, "You could understand why the people are like they are and how they react to you with personal care and things like that."

The registered manager told us they were improving person centred care by implementing a tool promoted by the Alzheimer's Society, called 'This is me'. The activities co-ordinator was in the process of completing these records, by steering conversations with people away from everyday topics to their life stories, notable events and important relationships and experiences and what they were most proud of. Half of the records had been completed, and they were put into people's personal folders in their rooms on the day of our inspection. The records will support staff to better understand each individual and promote meaningful relationships between people and staff. For those people who were unable to explain themselves verbally, the registered manager had written to people's families to ask more about the lives they led before they moved into the home.

When staff supported people they worked at the person's pace and did not rush them. We observed one member of staff walking alongside someone as they walked to the dining room. They said, "Take it steady, there is no rush at all." We saw staff ensured people had knee blankets and took time to make sure they were comfortable. While one person was being assisted to transfer from their chair to a wheelchair, care staff explained the process to the person and reassured them throughout.

Staff were patient and kind with people who were not able to express themselves clearly. Staff recognised people's anxieties and provided support to reduce people's anxiety. For example, one person did not like their clothes being taken from their room. Staff encouraged the person to take their own clothes to the

laundry, so they knew exactly where their clothes were and they were reassured by knowing. We observed how staff supported a person who displayed signs of agitation at lunchtime. All three staff that engaged with the person were gentle and consistent in their approach. They all encouraged the person to talk slowly so they could understand what was concerning them. One member of staff was able to encourage the person to eat and talked to them gently, explaining what was on their plate and asking if it was nice.

Staff told us they had learnt some useful techniques to support individual people when the cause of their agitation was not clear. Care staff told us their techniques included, "If they are a bit agitated, you just leave it and go back again ten minutes later", "We give people tea, play cards, play ball" and "It is easier to distract [Name], we put music on and dance."

The provider encouraged people to regard Mockley Manor as their home and be involved in making choices about their environment. One member of staff told us, "They are in the middle of decorating the home. The residents like it because they got to choose the curtains and the chairs, what fabrics and what colours. They got to vote on it so they felt included."

People were encouraged and supported to bring in small items of furniture, pictures and ornaments to make their bedrooms their own personal living space. One person told us, "The room and the view are lovely. I haven't been around it all, because I am not mobile, but the rooms are of a good standard."

People told us staff respected their privacy and dignity when providing personal care. One person told us, "Yes certainly, they shut the door and draw the curtains." We saw staff knocking on people's doors and where people were able, waiting for a response before entering. We observed domestic staff chatting to people as they cleaned their rooms and explaining what they were going to do. "I'm just going to wipe your table [Name]."

Relatives told us their relations were treated with respect appropriate to their lives and experience. The registered manager told us they recognised that changes in how families organised themselves, meant some staff had not experienced a daily shared family mealtime, so they had talked with staff about the importance of maintaining this habit for people who had grown up with the tradition of shared mealtimes. A member of staff told us, "Sometimes [Name] eats independently and is always better out of bed, at the table at lunchtime." We saw the tables in the dining room were covered with tablecloths and condiments were available for people to help themselves. People who were at risk of spilling their food were offered clothes protectors, to avoid the need to change their clothes halfway through the day.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs and knew and respected their preferences for how they spent their time. People said, "It is good, they look after you well. I've got no complaints" and "I am happy here and like to be in my room. If I ring the bell, staff come, anytime." A relative told us, "Staff give everyone their time."

Care plans were detailed and included personal details which were specific and relevant to the needs of the person. Records showed people's care plans were regularly reviewed and updated when needed. Records showed people and their relatives being involved in care planning. A relative told us they always knew about any changes to their relations care because, "They always keep us informed." Each person had a 'snap shot' of their needs in a folder in their bedroom, which was a prompt and guide to ensure people received safe and appropriate support. The 'snap shot' listed the equipment people required when being supported to transfer or mobilise and information about their dietary requirements and the level of assistance they needed. We found that one person's 'snap shot' had not been updated when there had been a significant change in their needs. The registered manager assured us this would be updated straight away.

However, staff were confident that their practice was up to date and knew about changes in people's needs because they attended a handover meeting when they started on each shift. Records showed handover notes were written down and available for staff to check if they needed to. The handover records included critical information and care tasks to ensure people received care and treatment, such as thickened fluids and time-specific medicines, when they needed them and a brief description of each person's moods and behaviours for staff to understand how the person was feeling that day.

The registered manager told us they had recently introduced a new process to ensure all staff were involved in contributing their knowledge and understanding of people's needs, which would remove the need for the 'snap shot'. They had replaced the 'key worker' and 'named nurse' system with a 'resident of the day' review. The registered manager told us this meant a full review of the person's needs happened on an allocated day, involving all staff, including domestic staff, the chef and maintenance staff, (who checked the person's room and mattress were in good order.)

People were supported to maintain their interests and hobbies. The registered manager had employed two activities coordinators to make sure people had the opportunity to engage in activities and events they were interested in. Activities on offer included folklore, bowls, exercise, tai chi, basketball and storytelling. People told us they enjoyed spending time with the activities coordinator. They told us, "He's brilliant", "He always makes us smile" and "I have laugh." On the morning of the second day of our visit a vicar from a local church came and gave Holy Communion and enjoyed singing with others. In the afternoon there was a card game in the lounge. We saw one person, who had told us, "I love singing and dancing", was dancing in the lounge during the afternoon.

A timetable of events was displayed in the entrance hall, but people who spent time in their rooms said they could not always remember what was on offer. One person told us, "I am happy here and like to be in my

room. My family visit and I enjoy my own company. I have books, crosswords and watch a bit of TV." However, they did say they would like to join in with any exercise activities but did not know when they were on. We shared this feedback with the registered manager, so they could make sure everyone was aware of the timetable of planned events.

The registered manager told us the weekend activities coordinator had taken the lead in capturing information for the 'This is me' records, by spending time talking with people one-to-one about their lives. They told us an assessment of people's interests and hobbies would be included in their initial assessment of needs in future. We saw staff used the information they knew about people's previous lives and supported them to maintain their interests. For example, we saw one person, who used to be a mechanic, handling a camera with interest as they talked to the activity coordinator about the components and how they functioned. Another person had worked on a farm and it was an important part of their day to wash the eggs collected from the home's hens. The weekend coordinator had supported another person to make a box to keep their treasured possessions safe.

No-one we spoke with could remember making a complaint. People said, "I would tell the manager if I'm unhappy" and "I would talk to the nurses and they will pass it on." A relative told us, "I would speak to [name of registered manager], her door is normally open." Staff told us they would support people to make a complaint. A member of staff said, "I would report it to the nurse and we have a complaints form they need to fill in. They would always have the opportunity to speak to someone senior." We saw the complaints procedure was available in each person's bedroom in an easy read format and there was information about raising complaints on display in different areas of the home.

Records showed the registered manager had responded appropriately to complaints received. They had investigated, taken action to put things right and written to complainants. In their letters to complainants they had apologised and explained the actions they had taken to make sure the issue would not happen again. Records showed a verbal complaint made some months previously had been recorded as an incident and had not been included in the complaints log. We were assured the matter had been dealt with and action taken to resolve the issues. The registered manager showed us a 'grumbles' book they had implemented since that time, which included verbal complaints. They said they were better able to analyse the nature of complaints by using the additional 'grumbles' book. The operations manager had reviewed complaints and 'grumbles' to make sure appropriate action was taken to minimise the risks of a reoccurrence.

Good

Is the service well-led?

Our findings

People and relatives told us they were happy with the quality of the service and that they knew and liked the registered manager. People told us, "They are approachable" They are very good" and "They will roll-up their sleeves if they don't have enough staff." Relatives told us, "I can't fault it. I would recommend it to anyone. We have had no problems here" and "[Name of registered manager] is often pitching in. She was on one night because they were a bit short."

At our previous inspection, we found that due to staffing issues, the registered manager frequently covered shifts which impacted on the time they had for their managerial responsibilities. Since that inspection they had recruited additional nurses and care staff and had introduced two clinical lead roles within the home to provide support and leadership, which allowed the registered manager more time for their managerial duties. The deputy manager was also given supernumerary time to carry out their managerial responsibilities. The increase in managerial time had enabled improvements to be made in providing written guidance for nurses to ensure medicines were administered at the right time, when the time was specified in the prescription.

The provider had recognised the registered manager needed more support and guidance to improve the quality of the service. The newly appointed operations director and operations manager had coached and mentored the registered manager to make sure staff were deployed appropriately through effective performance management. The registered manager spoke positively about the support they now had and said, "I am doing things now that 12 months ago I didn't manage to do."

The director of operations explained how the management team were promoting a more cohesive approach to care within the home. They told us, "We want the leads (senior staff) to own their bit and understand where it fits in with everything else in the home. It is a more co-ordinated approach. We want staff to understand why they are doing things and doing them purposefully." Staff confirmed that staff worked well together as a team and teamwork had improved in the last twelve months. Staff said, "We have a more supportive work team. It seems more friendly and relaxed" and "We all communicate with each other. We are all there for each other. You feel you have got support in all areas which you didn't feel you had before."

Staff respected and appreciated the registered manager's leadership. Staff told us, "[Name] is really passionate about their job and works really hard" and "[Name] is brilliant and very committed." Another member of staff member described the registered manager as, "Fair, good and approachable."

Staff told us they had regular opportunities to get together and discuss the service, any issues or good practice. Staff told us, "They (staff meetings) are usually quite good, a lot of things get covered" and "The majority of time things get sorted and whatever has gone wrong, is put right." Staff told us they felt valued, because the registered manager, nurses and senior care staff listened to them. Records showed meetings were an opportunity to discuss developments in the service, best practice and areas of concern. They were also used to thank staff and recognise their achievements. For example housekeeping staff were thanked for

the work they had done to achieve a good result in a recent infection control audit.

The registered manager had sufficient managerial time to make sure improvements were made and sustained in their oversight of staff's practice. People's care plans were regularly reviewed and improvements had been made in how the registered manager and staff responded to clinical incidents and medicines' audits. Records showed accidents and incidents were analysed to identify any trends or patterns, such as the time of day they occurred or whether any particular individual was more prone to falls. Where people had been identified as being at increased risk, action had been taken to minimise the risks. For example, investigations had been carried out to identify or rule out any medical causes and the use of equipment, such as sensor mats by the side of people's bed, had been included in care plans to keep the individual safe. The registered manager had notified us appropriately when important events had occurred at the home. Clinical incidents were investigated and used as a learning tool to drive improvements in the delivery of care and to safeguard people from harm. The operations manager explained, "There has got to be learning from incidents. We have to ask ourselves 'how can we wrap some measures around this to ensure safe practice'."

Staff told us the provider's new management team were approachable and demonstrated a genuine interest in people's individual wellbeing. They told us the operations manager had provided their email and phone number to staff to make sure staff could speak to them directly. Staff said, "If we can't contact the manager, it gives us an opportunity to contact somebody in authority. They are easy to talk to and will answer you. It is nice to have someone senior who is happy to work at (our) level. They walk around, talk to the residents and sit with them. They come and talk to us on our breaks."

The provider had revised the process for the registered manager to demonstrate effective governance of the service. The registered manager conducted a series of management checks and audits, which were reported to the provider in a monthly management report. The audits included checks of the environment and equipment, medicines management, accidents, incidents and complaints and how people had responded to their nursing treatment and care. This enabled the provider to maintain oversight, identify any emerging patterns or trends and assure themselves that appropriate action had been taken to ensure people received consistently safe and effective care.

The operations manager and operations director conducted two-monthly oversight checks of the service to confirm that audits were effective and that the quality of the service was maintained. The checks were reported under the same headings of 'safe, effective, caring, responsive and well-led' as a CQC inspection. This demonstrated understanding by the provider of how care should be delivered in accordance with the fundamental standards of care. The operations manager told us that future plans included registered managers from across the group of homes being involved in oversight visits at other homes in the group. The most recent oversight visit in December 2016 had identified some gaps in two people's care plans. Both care plans had been updated by the time of our inspection in January 2017.

The deputy manager had identified some improvements could be made to recording. For example, the charts staff kept to monitor when people exhibited challenging behaviour included a description of the person's behaviour, but did not include any detail about preceding events that might have triggered the behaviour. The deputy manager was not able to analyse the charts effectively to know how to minimise the risks of a re-occurrence. They planned to review how this type of incident was documented.

People, relatives were invited to share their views of the service and suggest improvements. A quality questionnaire had been completed in December 2016 and the results were displayed at various points throughout the home. We saw very positive responses in respect of the cleanliness and management of the

home and the promotion of privacy and dignity by staff. Where responses had not been so positive, there was information about the action taken to make improvements. For example some people were not clear about the provider's complaints policy. In response, the service user guide had been reviewed to include the policy and we saw a copy was available in an easy read format in each person's room.

People and their relatives were invited to attend meetings to gather their views on such things as the level of activities in the home. The registered manager had also organised a series of 'dementia cafe' meetings, or workshops, on Saturday mornings for relatives to learn more about the condition and how it progressed. The dementia cafe was also open to people who lived in the local community.

The operations director explained the provider's plans to continuously improve the quality of the service, included sharing learning and expertise across the seven homes in the provider group. They told us, "We are promoting people's development and recognising pockets of expertise within the company." For example, the chef had recently completed some training in nutrition and soft diets and was currently providing mentorship and leadership in this area for the rest of the provider group.

The registered manager showed us a presentation they had recently prepared and shared at a registered manager's meeting, about the improvements they had made since the previous inspection and their plans for continuous improvement. An activities co-ordinator at another home in the group had completed training in a recognised tool to assess the level of ability of people who live with dementia to engage in purposeful activity. The activities co-ordinator at Mockley Manor was meeting with that staff member so the learning could be shared and used for the benefit of the people living in the home. The operations director explained that using registered managers to visit other homes was a system of 'peer reviewing' and provided an opportunity to share good practice and share ideas. They explained, "We have encouraged homes to work in partnership with other homes."

The operations director told us they were working in partnership with other agencies to improve the quality of the service. They had joined a nutrition steering group with the local authority in a bid to 'cut the use of supplements' in care homes. The chef had agreed to lead on sharing the objective to reduce prescription drinks by improving nutrition and hydration management in the home. A dietician had already attended a 'taster session' event with people who lived at the home. Plans to improve people's nutritional intake ranged from collecting more detailed information during their initial assessment, obtaining timely professional advice and better recognition of calorific values of individual ingredients during menu planning. Specific activities to engage people's sensory experience of, and improved appetites for, meals included involving people in cooking, a wider range of snacks and treats, picture menus, conversations about food and an improved dining experience.