Bupa Care Homes (CFHCare) Limited

Colonia Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place over two days, on the 6 and 7 December 2017.

Colonia Court is a 'care home'. 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.

Colonia Court provides care for up to 123 people including nursing care across four, purpose built bungalows each with its own specialism. Paxman house provides nursing care support for up to 35 people. Mumford House accommodates up to 28 people who have a non-nursing need who are living with dementia for long term or respite care. Blomfield house accommodates up to 30 older people who require non-nursing residential care for long term or respite care. Amber Lodge provides specialist-nursing care for up to 21 people diagnosed with Huntington's Chorea. Within Amber Lodge a designated wing of the bungalow, known as Catchpool provides care and support for up to nine people living with dementia who also require nursing care. At the time of our inspection there were 105 people living at the service.

At our previous inspection in July 2016, the service was rated as Requires Improvement. We found staff were not appropriately monitoring or completing food and fluid charts for people who had been assessed at risk of inadequate food and fluid intake. This meant the provider was not fully meeting the requirements of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvement had been made with systems now in place to ensure the safe management of people's nutrition and hydration needs were met. Risks to people's health and wellbeing were assessed and regularly reviewed. However, whilst people's fluid input was recorded we noted that for people diagnosed with Huntingdon's Chorea their fluid output was not always monitored. This meant that there were ineffective systems in place to identify any deficits or circulatory (fluid) overload.

During this inspection we recommended the provider review the way in which they determine their staffing levels to ensure that people receive effective and meaningful engagement at all times and throughout the service. During our visit people were supported by sufficient numbers of care staff. However, staffing levels were allocated according to occupancy as opposed to being flexible according to assessed need. Due to designated activity staff absences we found insufficient hours allocated to provide people with group and personalised activities. This meant that people in particular those living with dementia, were left unoccupied lacking stimulation for significant periods of time.

We also recommended a review of the current arrangement whereby senior staff on individual units do not have easy access to IT equipment and resources they need to carry out their roles in a safe, timely and effective way.

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

Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. Potential risks to people had been identified and appropriate measures had been put in place to reduce the risk of harm.
The service had a robust recruitment process which ensured that staff were recruited safely and an induction programme was in place to support new members of staff when they starting working at the service.

There were safe systems in place for the management of people's medicines. People were supported to receive their medicines as prescribed. Staff administering medicines were regularly competency assessed to ensure people received their medicines as prescribed.

Lessons were learned and improvements made when things went wrong. The registered manager had systems in place to monitor accidents and incidents with action plans in place to minimise the risk of re-occurrence. The provider had in place a system for overall clinical governance and analysis of accidents and incidents to monitor for trends.

People received care and support from staff that were trained, skilled, experienced and knowledgeable within the roles they were employed to perform. Staff knew the people they supported well and had received the necessary training to equip them for their roles. People were supported by staff who were kind and compassionate in their approach.

The re-validation of nurses was closely monitored. There was a system in place for regular checks to ensure nursing staff maintained their registration and had been supported to keep up to date with clinical good practice guidance.

People were supported to live healthier lives and had access to healthcare services when required. We saw that there were good links with local GP's and health care professionals with multi-disciplinary meetings attended by the management team to ensure planning to meet people's health care needs.

The staff and registered manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. Applications had been submitted to deprive people of their liberty, in their best interests; therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The majority of staff and people we spoke with were complimentary about the culture of the service and the management team support they were provided with. There were clinical governance systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of the people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's health and wellbeing were assessed and regularly reviewed. However, whilst people's fluid input was recorded we noted their fluid output was not always monitored.

During our visit people were supported by sufficient numbers of care staff. However, staffing levels were allocated according to occupancy as opposed to being flexible according to assessed need.

The provider had systems in place and staff were trained in identifying acts of abuse. Staff were aware of the whistleblowing procedures and were confident that poor practice would be responded to appropriately.

There were safe systems in place for the management of people's medicines.

Lessons were learned and improvements made when things went wrong.

Is the service effective?

Good

The service was effective.

People received care and support from staff that were trained, skilled, experienced and knowledgeable within the roles they were employed to perform. Staff were knew the people they supported well and had received the necessary training to equip them for their roles.

The staff and registered manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to live healthier lives and had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and were kind and compassionate in their approach.

People's privacy was respected and they were treated with dignity.

Is the service responsive?

Good

People's care plans were individual to them and covered a range of needs. For the majority of people this included people's health needs and any long-term medical conditions, their pressure care and their mobility needs. Care plans were reviewed on a regular basis to ensure they remained accurate and up to date.

Further work was needed on Paxman unit to ensure specific health conditions and associated needs were sufficiently detailed to guide staff in steps they should take to meet people's assessed needs.

In relation to the assessment and planning for people needs, wishes and preferences at the end of life, information was limited to whether or not people had a funeral plan and their wish to stay at Colonia Court. We made a recommendation that further work be carried out to ensure people are supported to express their wishes as to how they would prefer to receive person centred care, based on current best practice in the last days of life.

People expressed mixed views about the support they received to follow their interests and participate in social activities.

There was a complaints process in place. People had access to clear information about how to raise concerns and complaints.

Is the service well-led?

Good

The service was well led.

The registered manager had reported incidents when required to do so to CQC. The provider had displayed the rating from the last inspection in the service and on their website.

Most people and staff felt the registered manager was approachable and would listen to any concerns. Staff had regular access to staff meetings and supervisions where they could discuss their performance and training needs and air their views.

The provider had systems in place to continuously learn and improve the service it provided. They worked well in partnership with other agencies.	

Colonia Court Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place over three days on the 6, 7 and 15 December 2017 and was unannounced.'

The inspection team was made up of three inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience of providing care and support for an older person.

Prior to our inspection we reviewed the previous inspection report to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

Prior to our inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Some people living at the service were unable to tell us, in detail, about their experiences of how they were cared for and supported because of their complex needs. However, we spoke with 16 people who were able to verbally express their views about the quality of the service they received. During our site visit and later on the telephone, we spoke with 12 people's relatives. We also spoke with one visiting healthcare professional.

We looked at records in relation to 16 people's care. We spoke with the registered manager, the clinical services manager, the deputy manager, and two regional managers. We also spoke with, five nurses, the cook, one activities coordinator and eleven members of care and domestic staff.

We carried out an inspection of the premises. We also looked at records relating to the management of medicines, staff recruitment, staff training and systems for monitoring the quality and safety of the service.

Prior to and during our inspection we spoke with stakeholders such as the local authority and health care professionals.

Requires Improvement

Is the service safe?

Our findings

Risks to people at risk of choking were not always effectively managed. 's safety We found people on Paxman unit were given their meals in bed and not always assisted to sit up sufficiently and therefore were not positioned properly to enable them to eat comfortably and safely. If not sat up sufficiently this could put people at risk of aspiration, inhaling food. We also observed on this unit a relative left to assist one person to eat who was very drowsy and they were trying to feed the person whilst they were not fully roused. This person had Parkinson's and their swallowing or choking risk had not been assessed. Some people with Parkinson's experience eating, swallowing and saliva control difficulties because they lose control of their mouth and throat muscles. We brought this to the unit manager's attention.

People who received their nutrition and medicines via a enteral percutaneous tube (PEG), this is where liquid food and medicines are administered directly into the stomach, there was clear guidance for staff in care plans with safe procedures for the administration of their medicines and care to ensure the cleaning of the tube entry site. However, whilst people's fluid input was recorded we noted their fluid output was not monitored. This meant that there was no system to identify any deficits or circulatory (fluid) overload. We discussed this with the unit manager on Paxman House. They told us the output of fluid was not monitored because people with a PEG in situ were all incontinent of urine and faeces and so staff looked for other signs and symptoms that would indicate any problems.

We recommend the provider review their systems to ensure that people's fluid intake and nutritional support is safely managed at all times

During our visit there were enough direct care support staff on duty to meet people's personal care needs. Given the size of the service there was low usage of agency staff as staff shortages were covered from within the staff team. This meant that people in the main received consistency of care by staff who knew them well. However, people who used the service also told us, "When they are short staffed we see staff from another unit at least once or twice every week, they don't always know your needs or how you would like to be helped." And "Staff are very busy. I wait longer in the afternoon for help. Last week I told one of the carers I wanted to go to bed to rest at 1:30pm but I had to wait until 3pm. My bottom was getting sore from sitting in the wheelchair for so long."

Relatives told us, "Staff are very attentive and pleasant. I think there is staff around for people when they need them. There just needs to be a bit more activity to keep people occupied." Another said, "They could always do with more staff but they do their best with what they've got."

We observed in Mumford House, people were left for significant periods of time with a lack of staff social interaction and mental stimulation. We observed staff were busy across all units and told us when the activity staff were not on the units they were expected to provide social activities for people in addition to their day to day responsibilities and said it was not always possible to provide meaningful activities other than task related activity. Staff did not always have time to provide social and emotional support when required. The registered manager told us they were provided with resources to employ up to 120 activity

staff hours for deployment across all five units. However, they also said due to staff absence only 104 hours were currently provided which was insufficient to meet people's needs for social interaction and reduce the risk of isolation across all units.

Where units provided care for people with complex needs, such as palliative care or at the end stage of their life, this meant that their needs may change quickly and significantly. Staff told us staffing levels were not always adapted to reflect people's changing needs. Unit manager's told us they had no control over staffing levels as they were set by senior management. Staff told us, "Usually staffing levels are sufficient but difficulty arises when there is sickness particularly at short notice. We use our own staff where possible to avoid the use of agency and sometimes staff have to come from other units." Discussions with the registered manager showed us that staffing levels were calculated according to the level of occupancy and not according to people's changing need.

People were supported by staff to attend hospital appointments. However, they also said the provider, placed an additional charge for this support on top of their care home fees paid. One person said, "This just isn't fair. They don't make it clear before you move in. They charge you more than the hourly rate paid to the staff who support you to go to hospital, I just don't get it." We discussed this this with the registered manager who confirmed this was the corporate charge made to support people to attend hospital appointments.

We recommend the provider review the way in which they determine their staffing levels to ensure that people receive effective and meaningful engagement at all times and throughout the service.

The provider had systems in place and staff were trained in identifying acts of abuse, which included guidance as to what steps they should take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow. The provider operated a whistle-blowers helpline, managed centrally known as 'Speak Up'. This system enables staff to make contact anonymously should they have any concerns about people's wellbeing and safety. This was reinforced by information posters located in the main office and staff rooms. Staff demonstrated a good understanding of how to recognise and report any signs of neglect and abuse. The registered manager had been proactive in reporting safeguarding concerns to the local safeguarding authority for investigation and to the Care Quality Commission (CQC).

People told us, "I am safe, I have a bed, fed well and happy here and the staff appear to be well trained." Another told us, "I am safe here, safer than when I was at home. Of course, I would rather be at home but that's the way things have turned out. I feel at ease with all the staff."

Comments from relatives included, "It is fine, really good. The care is good, they make an effort. [Relative] has never complained, the food is good and we don't have to worry as we know [relative] is safe", "[Relative] is safe here and happy. We have not had any concerns about safety. I cannot fault the care of staff." Another said, "Moving here has saved [relative's] life. I couldn't ask for better care. [Relative] has been very ill and they have gone to town to care for [relative].

Risks to people's health and wellbeing were assessed and regularly reviewed. Risks assessed included, falls with associated falls diary put in place, the use of recliner chairs, choking, pressure ulcer risk with prevention guidance and weight loss. The provider had a bed rails use policy. Risk assessments had been carried out for all people with a bed rail in situ. This review had included consultation with people and their relatives where appropriate. Bedside rails are pieces of equipment that are intended to prevent people from falling out of bed and sustaining injury. Where it had been assessed, people were at risk of unlawful restraint, entrapment or where people lacked capacity to consent and may be at risk of injury when trying to climb over the bed

rail, these had been removed and crash mats provided and beds lowered to prevent people from the risk of harm.

Personal Emergency Evacuation Plans were in place for each individual. These were detailed and included the relevant information required for each person to enable staff to support them effectively to evacuate the building in any emergency. These provided guidance as to people's mobility level, evacuation method and type of equipment and level of assistance they needed.

Where people had been assessed as being at high risk of developing pressure ulcers, we found control measures in place with guidance for staff as to the action needed to maintain their skin integrity. Pressure relieving equipment such as airflow mattresses and pressure relieving seat cushions were in place where needed to help manage their skin integrity. The management team told us there was currently no one with a pressure ulcer across the whole service.

The service recruited staff in a way that protected people. A review of staff recruitment files showed us that application forms had been completed which identified any gaps in applicants previous work history. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record, which would exclude them from working in this setting. References and DBS checks had been confirmed before staff started working at the service.

Medicines were managed and administered safely. People told us they received their medicines when they needed them. Medicines were stored safely and securely. Staff had received training in the safe administration of medicines. Alongside senior staff, we looked at systems and processes in place for the management of people's medicines across four units. We checked medicine administration records (MAR) and checked balances of stock against these records. We found that the provider operated an effective system, which monitored the management of people's medicines on a daily and monthly basis, which included an audit of medication stocks and records of people's medicines. This meant that there was a system in place to identify any medication administration errors in a timely manner.

We saw that controlled drug records were accurately recorded. The administration of the medicine and the balance remaining was checked by two appropriately trained staff. Each person's (MAR) contained a photographic record of them and there was detailed medicine and allergy information.

Staff told us they had received up to date training in medicines management and included the use of specialist equipment. For example, nurses had received up to date training in the use of syringe drivers to enable them to administer pain relief medicines to people at the end of life.

People told us they received their medicines including pain relief medicines when required and in a timely manner when they requested them. Where people were prescribed as and when required pain relief medicines and were unable to verbally communicate their needs, staff had recorded guidance, which described for them potential indicators of pain.

There were infection control systems in place and people protected from the risk of cross infection. Staff were provided with and used personal protective equipment such as gloves and aprons. Sufficient handwashing facilities had been provided. Cleaning schedules were in place and monitoring records for staff to record the cleaning of the environment and equipment. For example, the inspection and cleaning of people's rooms, communal areas, wheelchairs, mattresses and clinical equipment. We found the environment in the main to be clean and free of offensive odours. The clinical services manager carried out regular checks of the units to check that infect ion control processes were in place and monitored by staff.

Lessons were learned and improvements made when things went wrong. Staff recorded and reported on any significant incidents or accidents that occurred. Records showed the registered manager had systems in place to monitor accidents and incidents with action plans in place to minimise the risk of re-occurrence. The provider had in place a system for overall clinical governance and analysis of accidents and incidents to monitor for trends.

Where people had a high number of incidents of falling we saw the falls prevention team had been referred to for guidance and support. Recommendations made by this team were updated into their care plans. Falls risk assessments were updated to guide staff in steps they should to take to avoid further incidents. Where people had been assessed as requiring regular checks to monitor their safety and wellbeing, observation charts had been put in place to evidence this.

Emergency evacuation plans were in place and we saw that in the event of an emergency staff were aware of how to safely evacuate people. We found that following specific incidents, root cause analysis had been carried out with action plans in place and control measures in place to avoid repeat events.

Good

Is the service effective?

Our findings

People received care and support from staff that were trained, skilled, experienced and knowledgeable within the roles they were employed to perform. Staff knew the people they supported well and had received the necessary training to equip them for their roles. There was a process for induction and training of newly employed staff.

Staff recently employed told us their induction prepared them to work at the service with opportunities to work alongside more experienced staff and training opportunities which included recognising and safeguarding people from the risk of abuse, infection control and food safety awareness. There was a training programme, which provided computer, e-learning for staff, with additional face-to-face courses in more practical areas such as moving and handling and first aid. When we asked staff about the availability and quality of dementia training available, we found that not everyone supporting people living with dementia had been provided with training to enable them to fully understand their needs. We discussed this with the registered manager. They told us, this shortfall had been identified and plans were in place for staff across the service to have access to dementia training by March 2018. This they said was to be provided to approximately 130 staff, which would include all ancillary staff.

Amber Lodge where specialist-nursing care was provided to people diagnosed with Huntington's Chorea, staff had been trained and qualified in this specialist area in order to meet the needs of people. Training staff had received included enteral PEG feeding support, supporting people with swallowing difficulties and responding to people presenting with distressed behaviours that may present as a risk to the person and others. This training enabled staff to recognise and understand people's change in behaviour and techniques they should use to develop a supportive environment to manage these behaviours.

Further training for staff had been accessed via Essex County Council's Prosper project. This is a social care scheme to improve safety and reduce harm, primarily from falls, pressure ulcers and catheter infections, for people living in care homes across Essex and is funded by the Health Foundation, an independent charity working to improve the quality of healthcare in the UK. Unit manager's described to us how access to this resource had influenced the quality of clinical monitoring and enhanced staff skills and knowledge.

The re-validation of nurses was closely monitored. There was a system in place for regular checks to ensure nursing staff maintained their registration and had been supported to keep up to date with clinical good practice guidance. Nursing staff were supported with regular supervision and took part in clinical risk meetings where current best practice and NMC guidance was discussed. Nurses produced documented evidence of their research into current nursing practice, which involved the reading of nursing journals, updates from the National institute for Health and Care excellence (NICE) and articles from other social care journals.

The majority of staff we spoke with told us that they felt well supported by the management team. Annual appraisals of staff performance had been completed or planned for all staff and provided an opportunity for managers to look at staff's performance and to support them in their continued professional development.

Unit managers told us that they received regular, planned supervision sessions with the registered manager and in turn, they provided supervision sessions for the staff on each of their units. This was confirmed by staff, who told us they had been provided with regular formal supervision sessions and were able to access informal support and guidance from senior staff if and when required. The manager had a system in place for monitoring the progress of supervisions and performance reviews and determining when these were due.

At our last inspection in July 2016, we found that staff were not appropriately monitoring and recording the food and fluid intake of people at risk of losing weight and the impact of insufficient fluid intake. Care plans did not always reflect people's changing needs, this meant that some people had not been referred for specialist advice to enable the service to support them in the most effective way.

We found some improvement had been made with systems now in place to ensure the safe management of people's nutrition and hydration needs were met. We saw that for people with swallowing difficulties, those at risk of choking and people at risk of insufficient intake of nutrition and hydration improved monitoring systems were in place. Care records showed us that people's weights were regularly monitored. Where people were consistently losing weight, referrals had been made for specialist dietetic advice.

We received mixed feedback from people regarding the quality of the food provided. Comments included, "I have celiac disease and sometimes I don't get gluten free gravy. I did not get it yesterday and so had a dry meal. I get enough drinks and get mostly what I want to eat. I just have to tell staff what I want they [staff] do their best to get it", "I am given a choice of food, we have sandwiches at night, I am fond of prawns and these are ordered in for me", "Meal times are enjoyable we have a nice laugh and a joke", "The food is not always edible, the meat can be tough but the vegetables are ok", "The food isn't five star but its edible. I can choose something else on the menu if I don't like what is available" and "They don't provide you with gravy or custard in jugs, they just pour it on whether you want it or not." We provided people's feedback to the registered manager.

We observed the midday meal on each unit. We saw that people who required support with eating their meal, staff in the main supported them at an appropriate pace and engaged them in encouraging conversation. We noted that where people could be supported to maintain their independence in helping themselves to vegetables, gravy and custard this was not provided.

One relative spoke of the efforts made by staff including kitchen staff to encourage their relative at risk of inadequate food and fluid intake to eat to maintain their health and wellbeing. They told us, "They are so patient. Kitchen staff go out of their way to provide fish as this is their favourite. Another relative told us "Staff go out and buy the particular brand of cereal [relative] likes."

We saw that there were good links with local GP's and health care professionals with multi-disciplinary meetings attended by the management team, which took place every six weeks at the local GP surgery. The aim of these meetings was to reduce unplanned admissions to hospital and planning to meet people's health care needs. Where people required specialist support, referrals had been made when needed to dieticians and speech and language therapists. People also received regular access to visiting optician's chiropodists. The registered manager told us they worked closely with North East Essex Diabetic team in meeting the needs of people diagnosed with diabetes.

All relatives we spoke with told us they were kept informed of changes in people's healthcare conditions and informed of incidents affecting people's wellbeing. One relative told us, "I am always kept informed. There are no surprises when I visit." Another said, "We are kept well informed. The communication is pretty good."

We found moving and handling equipment such as hoist slings had been individually assessed and provided. Individuals had their own hoist slings, which were kept in their bedrooms. The hoist and slings were regularly inspected to ensure their safety for use. It was policy for each hoist sling to be used for a maximum of two years only and then they are replaced. Wheelchairs were regularly checked and maintained by the maintenance person and people were asked if they were experiencing any problems with their wheelchair.

There continued to be a need to enhance the environment in Mumford House, a unit for people living with advanced dementia. Further work was needed with access to current research and good practice recommendations in providing a more enabling, dementia friendly environment. For example, improving the signage, changing the bland corridor walls and door colours and providing tactile objects for people to access. This work had been identified at our last inspection and we noted had also been identified by relatives as an area that required improvement. The management team told us there were plans to decorate this unit and create a more dementia friendly environment but approval was still required from Bupa senior management to approve the financial resources required to enable this work to take place. We discussed this with the senior management team and were informed that approval to enable this work to start would be approved immediately.

People's rooms were seen to be personalised with pictures and items important to individuals. Overall, the environment was in a good state of repair apart from skirting boards, which required painting in some areas.

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

The management team understood the basic principles of the MCA and Deprivation of Liberty Safeguards (DoLS). Records showed people had mental capacity assessments undertaken when a need had been identified. Where required DoLS applications to the local safeguarding authority had been made appropriately. This meant that where people's freedom of movement had been restricted to keep them safe and ensure their well-being, this had been assessed as in their best interests by those qualified to do so.

Throughout our inspection, we observed staff asking for people's consent prior to their undertaking a task. For example, prior to personal care support. People told us staff respected their choices and preferences regarding their choice of times to rise and when to go to bed.

Good

Is the service caring?

Our findings

When asked if staff treated them with kindness, dignity and respect people told us, "They are mostly very friendly, they spoil me, I cannot fault them", "Some staff are very nice and friendly whilst some don't even say hello", "I like the home, they are caring. They respect me and spoil me. They come in and sit and we have a natter and a laugh" and "They respect me in the way they treat me and I respect them."

Relatives gave positive feedback as to the caring and respectful interactions they observed from staff. They told us, "The staff are amazingly patient. They help my [relative] to have as much choice as possible"; "They are a caring bunch of staff. They work as a team and are all very welcoming. Choice is promoted here, [relative] is offered choice, if [relative] wants to come out for meals they will but if [relative] chooses not to, this is respected" and "The staff are always kind. [Relative] is always well groomed and their property respected which would be important to them. I cannot fault the care here."

We observed some positive interactions between staff and people living in the service, such as a staff comforting people when distressed or speaking to people, positioned at eye level when communicating and when supporting them with eating their meals. Staff were observed to be respectful in their interactions with people. For example, when offering care, respecting people's wishes and refusals and when supporting them with their personal care. The quality of interactions varied across the three units observed. Whilst in some areas we observed staff sitting and chatting with people, with lots of laughter and friendly interactions in other areas staff were busy with interactions more related to the completion of a task such as supporting people with their personal care or serving meals and drinks.

We observed the lunchtime meal on the first two days of our inspection and saw some good examples of staff supporting people in a kind, compassionate and un-rushed manner. For example, staff sat at eye level, talking and encouraging people to eat sufficient for their needs. Staff were observed to identify people with limited verbal communication and used non-verbal cues when seeking consent before carrying out any activity.

Staff appeared to know people well. The majority of staff had worked at the service for a number of years and were able to tell us about people and their needs wishes and preferences. However, we found limited information recorded in relation to people's life histories, which is recognised as good practice in particular in planning for the needs of people living with dementia. A life history book is a book compiled to capture memories and stories about a person's life. Making a life history book can be an enjoyable and empowering activity for a person living with dementia, which may enable greater interaction and open up communication between the person living with dementia and their care staff, family and friends. A life history book can be referred to by professionals to learn more about the person they are providing care for.

Good

Is the service responsive?

Our findings

People's care plans were individual to them and covered a range of needs. For the majority of people this included people's health needs and any long-term medical conditions, their pressure care and their mobility needs. Care plans were reviewed on a regular basis to ensure they remained accurate and up to date.

Further work was needed on Paxman unit to ensure specific health conditions and associated needs were sufficiently detailed to guide staff in steps they should take to meet people's assessed needs. For example, one care plan for a person who had limited abilities due to a recent stroke, did not identify what the person could do for themselves and the type and level of support they needed and how this should be delivered by staff. For people on other units diagnosed with diabetes and insulin dependent there was limited information as to how their diabetes was to be managed and steps staff should take to maintain their health and wellbeing.

In relation to the assessment and planning for people needs, wishes and preferences at the end of life, information was limited to whether or not people had a funeral plan and their wish to stay at Colonia Court.

We recommend further work be carried out to ensure people are supported to express their wishes as to how they would prefer to receive person centred care, based on current best practice in the last days of life.

Some people's care files contained a completed 'This is me' document. "This is me", is a recognised assessment tool to help staff supporting people living with dementia understand their needs, interests, preferences, likes and dislikes. When planning people's care and support, consideration was sometimes given to their cultural and religious needs.

People expressed mixed views about the support they received to follow their interests and participate in social activities. Some people said there were sometimes few activities on offer, adding, "I've always been used to an active life and I don't enjoy just sitting around." However, other people said they were pleased with the range of activities organised, adding they particularly enjoyed the visiting entertainers especially the musicians.

There was a consensus amongst those we spoke with that activities provision could be improved. One person said, "The activities staff are great but there just isn't enough of them and we have days with nothing going on." Another said, "It would be good to go out more. Although we do occasionally have outings, which we enjoy, they are few and far between. I have always been an outdoor person."

There was a complaints process in place. People had access to clear information about how to raise concerns and complaints. There was a written procedure available throughout the service on notice boards. There was a suggestion box in the reception area, available to enable people to log any suggestions and concerns easily and anonymously if they chose.

One relative told us, "I have had no concerns and believe me I would be the first to complain." Another said,

"I feel confident to speak directly with the manager and also the staff. They seems to be transparent and approachable."

For the majority of complaints received there was a clear audit trail with actions taken in response and with outcomes evidenced. The provider did not have any effective observational tool currently in use, which would support the experiences of people with limited verbal communication including those living with dementia where their attendance at residents meetings would not prove to be meaningful.

Good

Is the service well-led?

Our findings

There was a manager registered with the Care Quality Commission (CQC) with overall responsibility for the service. They were supported by a deputy manager and a clinical service manager responsible for the clinical governance of the service. Each unit also had a designated unit manager responsible for the day-to-day management of their unit and the direct supervision of staff.

The registered manager had reported incidents when required to do so to CQC. The provider had displayed the rating from the last inspection in the service and on their website.

Apart from staff on one unit who were not, so positive all other staff said the morale of staff was good. One said, "The morale is pretty good here. We work as a team and try to support each other as best we can. The manager is approachable and their door is open to us." Another said, "We can discuss things openly at meetings and supervision. This has been one of the better places I have worked."

Staff told us they had regular access to staff meetings and supervisions where they could discuss their performance and development needs and air their views. They told us these meetings were informative and helpful at improving communication across the units.

We noted that the unit manager's had limited time allocated when they were not on shift, where they were expected to accomplish staff supervisions, update care plans, answer the telephone and complete audits of their units. This they told us was a stretch at times and in particular, when short of staff, they would lose their hours to cover on the staffing rota.

Staff and people's relative's told us the manager operated an open door policy and were confident that any issues they raised would be dealt with promptly. Staff told us they could make positive suggestions and people could speak up if they had concerns or ideas. We saw that both staff and resident meetings were held on a regular basis so that people were kept informed of any changes to work practices or anything, which might affect the day-to-day management of the service.

We saw that there were systems in place for continuous quality and safety monitoring of the service. People and their relatives were encouraged to express their views through the provider's website and annual satisfaction surveys. Annual surveys feedback had been formulated into action plans. We saw monthly newsletters kept people informed of staff changes and events organised. The registered manager told us in their PIR survey that comments and feedback they received helped them to plan to improve future service development

The management team carried out regular quality and safety monitoring of the units. This included a daily walk around each service, regular clinical audits all of which were documented and included a record of their findings and responses to any shortfalls identified. Daily, lead staff from each department came together to meet. These meetings were known as 'Take 10' meetings and were documented with what was discussed and actions taken in response to any concerns including actions taken identified.

The provider had employed a clinical services manager with clinical oversight of the service. There were clinical audits, which included the monitoring of hospital admissions and discharges, safeguarding concerns, falls, wound and weight monitoring, and the audit and management of medicines errors. Other quality audits included a review of care plans and safety of the premises. We saw documentary evidence that these took place at regular intervals and any actions identified were addressed with timescales for actions to be completed.

The registered manager told us in their PIR return that the management team within Colonia Court met regularly to discuss operational issues and share knowledge. Quality and safety monitoring information collected over the month about people was formulated into a metrics report and this was reviewed by the provider to analyse trends in areas like falls, infection rates and pressure areas. By identifying trends the management team planned action they would take to reduce the amount of incidents occurring and so fulfil their purpose to promote people with longer, healthier and happier lives. This they planned in partnership with other healthcare agencies.

We recommend the registered provider review the current arrangement whereby senior staff do not have easy access to the IT equipment and resources they need to carry out their roles in a safe, timely and effective way. We observed senior staff did not have access to IT equipment on individual units. Their work required them to have access to equipment such as computers and photocopiers. To enable them access to this equipment they were required to leave individual units, to walk outside and across to the main building where the management team and administrators were located. This impacted on their ability to carry out their work in a timely and efficient manner including their ability to communicate easily with other health and social care professionals. For example, when needing to make referrals via email to specialists such as dieticians and falls prevention teams and when processing records for medicines ordering and management. Staff also told us that when people required admission to hospital they needed quick access to photocopiers to ensure that clinical staff had copies of care plans and medicines administration records. Staff also told us that they feared for their personal safety in particular during night time hours when having to leave the unit and walk outside across to the separately located main building to use IT services. This often left staff isolated in the main building working alone. We recommend that the provider review this current working arrangement and risk assess across all their multi-site services where there are similar issues experienced by staff.