Medici Healthcare Ltd

Temple Grove Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Temple Grove Care Home [formerly known as Manor Gardens] on 29 and 30 November 2016 and the inspection was unannounced. Temple Grove Care Home provides accommodation and support for up to 64 people who require nursing or personal care. The service was split in to four units: one unit was for complex care and the other three units were general nursing. There were 55 people living at the service at the time of our inspection. People living at the service had a range of diagnoses form general frailty, multiple sclerosis, tumours, cancer, end of life care and spinal injury. Accommodation for people is arranged on two units on the ground floor and two units on the first floor. Each floor had its own dining room and people could choose where to have their meals. Each unit had a nurse in overall charge and a nurse's station in the middle of the unit; however, the service was homely, welcoming and people were free to decorate their rooms as they chose.

The service had 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. We previously inspected Temple Grove Care Home on 24 and 25 September 2015 and found improvements needed to be made, relating to environmental risk assessments, safe recruitment procedures, the lack of a registered manager in post and quality auditing systems not being established. At this inspection we found that improvements had been made in all of these areas.

People were safe. The home's equipment was well maintained. Staff understood the importance of people's safety and knew how to report any concerns they may have. Risks to people's health, safety and wellbeing had been assessed and plans were in place which instructed staff how to minimise any identified risks to keep people safe from harm or injury.

There were sufficient staff employed to meet people's needs and staff knew people well and had built up good relationships with people as they tend to work consistently on the same unit within the service. The registered provider had effective recruitment and selection procedures in place.

The registered manager and staff had received training and were knowledgeable about of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were needed for people who may not be able to consent to, for example, bed rails.

Staff treated people as individuals with dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. Staff were skilled to approach people in different ways to suit the person and communicate in a calm, friendly manner which people responded to positively.

Peoples' health was monitored and they were referred to health services in an appropriate and timely manner. Any recommendations made by health care professionals were acted upon and incorporated into

peoples' care plans. People with complex care needs were given excellent care and the service is used as a first point of call for local health commissioners.

People who wanted to be occupied had busy lifestyles which reflected their lifestyle choices and likes and dislikes. Complaints were recorded appropriately and were used as a tool for improving services.

There was an open, transparent culture and good communication within the staff team. Staff spoke highly of the registered manager and their leadership style. There was an atmosphere of support and inclusion among the staff at Temple Grove. The whole management team had positive relationships with the care staff across and there was a genuine sense of collaboration and teamwork.

The registered manager took an active role within the home and led by example. There were clear lines of accountability and staff were clear about their roles and responsibilities. The registered manager had ensured networks were in place to offer excellent care to people with complex needs. The registered provider had robust systems in place to assess and audit the quality of the service.

There were suitable arrangements in place for the safe storage, receipt and management of people's medicines. Medicine profiles were in place which provided an overview of the individual's prescribed medicine, the reason for administration, dosage and any side effects

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People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met. People had access to healthcare services and had their health needs met.

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.

People were protected from avoidable harm and abuse by staff who understood their responsibilities under safeguarding.
Risk assessments were comprehensive and reduced hazards.
Staffing numbers met people's needs safely and people.
Medicines were managed safely and stored and administered within best practice guidelines.

Is the service effective?

Good

The service was effective.

Staff were well trained and told us that they felt supported by the registered manager.
Consent was being sought and the principles of the MCA complied with.
People received adequate food and drink and people with special diets had their food and fluids safely.
People's healthcare needs were being met well. People with complex health needs were receiving a good service.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information about people to effectively support them and build up caring relationships.
People and their families were involved in their lives and could make decisions about their care.
People were treated with dignity and respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs.
Complaints were responded to appropriately and were used as a

tool for improving services.

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive and the registered manager had ensured effective networks were in place to support people's complex needs. The management team provided clear leadership to the staff team and were a visible presence in the service.
Quality monitoring systems had been effective and led to change.

Temple Grove 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 inspection took place on 29 and 30 November 2016 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service and was specialised in older people and dementia care.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

As some people who live at Temple Grove Care Home were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As part of the inspection we spoke with the registered manager, quality care manager, maintenance manager, training manager, two activities co-ordinators, the chef, five nurses, the visiting GP, nine care staff, 15 people and nine people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at 11 people's care plans, medication administration records, risk assessments, accident and incident records, maintenance records, complaints records and quality audits that had been completed.

Good

Is the service safe?

Our findings

People felt safe living at the service. One person told us, "I feel safe because they answer the call bells quickly if I give 2 rings they know I need them to come quickly, and I know they are always around." Another person told us, "I can take a shower when I want to. I need two carers and having two makes me feel safe." A relative commented, "My husband has a huge amount of medication and I know that here they take care of that and he has them regularly." Another relative told us, "I feel mum is safe as I feel confident in her support here, the same people are on the same floors every day."

At our last inspection on 24 and 26 September 2015 we found that environmental risk assessments had not been effective in ensuring people's safety in the premises. At this inspection we found that improvements had been made. The registered provider had ensured that the environment was safe for people. There were up to date safety certificates for gas appliances, electrical installations, portable appliances, lift and hoist maintenance. The registered manager ensured that general risks such as slips, and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the risk and what actions were required of staff to reduce the risk. The fire risk assessment was effective and up to date; it included risks such as oxygen used in people's rooms and people had detailed personal evacuation plans to use in the event of a fire. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. People had individual room risk assessments that covered all areas of a person's day to day life. One team leader told us, "The room risk assessments are very good especially if a carer has been away for a few days they can read through it learn about any changes or falls."

At our last inspection on 24 and 26 September 2015 we found that safe recruitment procedures were not in place. At this inspection we found that improvements had been made. We looked at the recruitment records for four people who had been recruited in the 12 months prior to our inspection. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible. There were detailed and scored records of interviews, using role-specific questions.

People were protected against the risks of potential abuse and avoidable harm by staff who were knowledgeable about safeguarding risks and their roles in protecting people. One staff told us, "My priority is to make sure people are safe. We've got the numbers on the desk for social services [local safeguarding team]. I've had safeguarding training and the on-line training is very good. A lot of residents have capacity and keep their own money here so we're really hot on financial abuse." The staff member was able to describe different types of abuse including newly classified types, such as modern slavery. The service kept a safeguarding folder in which they collated all safeguarding referrals and tracked their outcome. The

safeguarding referrals had been completed appropriately and demonstrated that the service took their responsibilities around safeguarding seriously. For example, an unwitnessed fall in the service was referred to the local safeguarding team who asked the registered manager to investigate. This investigation led to disciplinary action against two staff members and an agency nurse for not following an established protocol. Other investigations also showed transparency and an open approach when dealing with families and external agencies.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. Positive risk taking was being encouraged in the service and there were examples of this in how the service supported people with known hazards. This approach to risk meant that the person was able to maintain their important routines and maintain personal safety. Risks associated with moving and handling were in place, and reflected the 'Health and Safety Executive (HSE) Guidance.' People who required the support of two staff members to mobilise were assessed and the safety of people and staff was taken into account. One person who was at risk when getting up and walking independently had been moved so their bedroom was next to the nurse station. There had been a 30 minute check put in place and records showed that this was implemented. The person enjoyed sitting in their wheelchair and time was factored in for this to happen regularly with the constant supervision of one member of staff. Mobility risk assessments were effective and we observed that staff members followed the guidelines in practice.

People told us they felt there were enough staff on duty to meet their needs. One person told us, "The staffing is enough. They answer the bells quickly, but staff are in and out all day anyway so I don't often need to ring the bell. All staff spend time having chats." The person named a welfare worker as one of two staff who particularly spent time with them and helped make sure they had the books the person wanted to read. Each unit had a set number of staff for each shift and there was a team leader on each unit who was a carer. For example, Victoria unit had four carers in the daytime and George unit had 5 carers. In addition there was a nurse who led the shift who was not counted in the staffing numbers. At night time there were two carers on each of the four units plus one nurse on the top floor and one nurse on the bottom floor. Staffing levels were determined using a dependency tool. However, the registered manager had identified that there were sometimes shortfalls in this system and did a daily walk-around to see what staffing levels were like and spoke to team leaders. When required the registered manager informed us that they increase the staffing levels above the levels indicated by the dependency tool. Call bell response times were monitored and any call bells that were unanswered for longer than five minutes were alerted directly to the registered manager.

There were safe medication administration systems in place and people received their medicines when required. We observed a medicines round on the complex care unit. The medicines were administered by a registered nurse who wore a tabard indicating she was not to be disturbed during the medicines round. The nurse clearly cross-referenced information between the medicines administration record (MAR) chart and the blister packs and was careful to check the identity of each resident. The nurse took time with each resident supporting them to take the medication, and to gain the person's consent, if they were able to consent, prior to administering the medicines before the MAR was signed. The service used as required (PRN) medicines and there was a clear protocol stating the maximum dosage allowed within a 24hour period. Controlled drugs (CD's) were in use and managed safely in line with national guidance. CD's were stored securely. There was a bound Controlled Drugs book with numbered pages, and a separate page for each CD for each person and remaining balances were checked at each administration of a CD. In addition staff also performed a weekly audit of all CD's.

Good

Is the service effective?

Our findings

People received effective care and support. We observed people being supported as directed in their care plans. Staff were well trained and knowledgeable about people's support needs and provided care that was effective in promoting a good quality of life. Staff were familiar with people and knew how people liked their care to be delivered. People had choices around their food and drink. We observed staff members interacting with people and noticing when someone seemed agitated or needing some attention. One person told us, "All the nurses and staff are brilliant. If not for them I'd be in a worse state. I had a large pressure sore on my back, now it's minute."

Staff told us they had the training and skills they needed to meet people's needs. Comments included: "I've just completed my QCF level 3 [Qualifications and Credit Framework, QCF, is a national certificate in care work]. We have workshops and training sessions on dementia on how to communicate and to explain why people do what they do. If I went to the management and asked for extra training they would always put it on. For moving and handling and fire we have external trainers come in". Another staff member told us, "The training is very good. We have the quality care manager who walks around and does spot checks and trains people if they're not doing things correctly. We have external people come in and in supervisions we are asked what training we would like. I asked for moving and handling training to be a trainer and was sent on a five day course to be a trainer in moving and handling."

Staff told us they had the training they needed when they started working at the home. The registered manager had ensured that all staff had received a comprehensive training programme and that training was kept up to date with regular updated courses. There was a full induction programme in place. Induction workbooks were comprehensive and showed signing off of sections on different dates and by different senior staff, showing they were used actively and reflectively. The checks included observed practice of catheter care, meals practice, personal care, and theory in areas such as, policies, mental capacity and safeguarding. Supervision records for staff included one to one and group supervisions. For example, there was a meeting for senior staff on Elizabeth unit that considered a response to a person's weight loss. This group supervision led to learning around improvements for weight recording procedures and malnutrition assessments for all residents.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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). The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe. Records showed that the service had made appropriate referrals for DoLS and were using the principles of the MCA to protect people. For example people who required the use of bed rails and lap straps to keep them safe had appropriate referrals made to the local DoLS team. Where people had applications to deprive them of their liberty authorised

these were updated and any changes to the person's condition was reported to the relevant people.

People appeared to enjoy mealtimes and have access to the food and drink they liked. One person told us, "I don't like red meat they know that so if I want something other than what on the menu they will make me an omelette or a jacket potato." Another person told us, "They know I don't like fancy food; they know that and will accommodate me. I have no complaints." We observed mealtimes over the course of our two day inspection. We observed that people had assistance where they required it. Staff members were sitting appropriately and focussed on the task. Some people were actively helped with choices and some made use of printed menus on each table. Staff encouraged some conversation but only where people wanted to speak. The food was well presented and hot, with prompt service. Some people had wine with their meal and a choice of desserts was available and encouraged. A person having finished their meal asked for a cup of tea, which was provided quickly. We observed that service to people dining in their bedrooms appeared well organised.

People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes and the kitchen was organised and clean. The staff were aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. People with special diets had their needs well documented in their care plans. Nutritional risk assessments were in place which provided guidance to staff on how to mitigate the risk of choking, such as providing a soft diet and thickened fluids. People at risk of choking had input from a speech and language therapist (SALT). Some people were at risk of malnutrition and required their weight to be monitored regularly and the completion of food and fluid charts. The registered provider was using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese.

People had access to health and social care professionals to meet their health and social care needs. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People had a health action plan which described the support they needed to stay healthy. Temple Grove cared for people with very complex health needs and were considered to be highly specialised in this regard by a health care professional we spoke with. We spoke with a care manager from the NHS Continuing Health Care (CHC) team. Continuing healthcare is free care for outside of hospital that is arranged and funded by the NHS. The CHC care manager told us, "We feel Temple Grove is a centre of excellence for complex clients. Some clients we refer here we wouldn't dream of putting in another nursing home. This home is the first port of call for us. We have lots of clients in hospital with tracheotomies and we cannot place them in other nursing homes [A tracheotomy is a medical incision in the windpipe made to relieve an obstruction to breathing]. The [registered] manager has got the training and the equipment in place so we can refer safely." The CHC manager described cases where outstanding care had been given to people and their families, such as one person who had a terminal condition and the service had arranged meetings with specialist doctors to enable the family to come to terms with the reality of their loved ones' condition. The family were supported sensitively by the service through this process and after the death of their loved one.

Another person had been admitted to the service with advanced cancer. The person had an extremely complex set of medical conditions, and had been told that their life expectancy was a matter of weeks. The person had full mental capacity and was scared of dying in hospital. The person's extended family had been visiting the hospital every day for their six month stay and this had taken an immense toll on the person and their family. The person's family was welcomed in to the service and at times were offered accommodation at the service when they stayed late or travelled long distances. The person passed away peacefully with

their family around them. The outcome for the person was that they were able to die at the service with their family around them in an environment that was calm, tranquil and serene.
Another person was admitted to Temple Grove with a complex medical history. The person had previously undergone surgery and had a complicated recovery. They had been transferred to a specialist hospital for intense rehabilitation and whilst there, their diabetes became very unstable with hypoglycaemia (low blood sugar) attacks occurring very regularly. There was an added complication that the person was unaware they were having the attacks. On admission to Temple Grove the person was diagnosed as at risk from six other conditions, some of which were life threatening, and some of which were having a severe impact on the person's morale. This included continence care that required highly specialist care and daily reviews. The team at Temple Grove were able to assess the situation and monitor the person's continence care. The registered manager told us, "Within the first four weeks the team here, because of their specialist knowledge in bowel care, were able to assess X and decided to commence X on bowel training. This has been an immense success, so much so that the person has now managed to gain independence with their continence care, and this has had an impact psychologically on their mental health and emotional well-being and the impact it will have on a care package and bowel management in the community when he returns home." In addition to this the care staff had been provided with training to be able to record blood sugars and recognise the symptoms of hypoglycaemia and could therefore notify the nurse if an attack was imminent. The registered manager told us, "Due to this skill, the team have identified the hypoglycaemia before medical or emergency intervention was required. The team have liaised with the GP and diabetic specialist to modify his insulin regime to prevent further hypoglycaemic attacks." The service was implementing plans to support the person to carry out and record their own blood sugars and to be able to independently administer their own insulin when they returned home. The registered manager commented, "This will enable X to have a less limiting care package at home, and enable greater autonomy in their own care and independence." Without this specialist care from the service the person would have had to stay in hospital but is now looking to be discharged to the community with a level of independence in managing their own complex health conditions.

The CHC care manager told us, "The improvements in the service are startling. The competencies of staff: they are so highly trained. They buy in specialist help when needed and have increased their staffing levels. No other provider in the area can look after complex cases and as such people are being left in hospital. Temple Grove have the skills to look after complex clients and despite tight budgetary pressures we have managed to significantly increase the fees we pay to reflect the level of care provided here. We increased the fees because no other nursing home would touch the people we refer here and they were just staying in hospital." One relative told us, "This home is just fantastic. I used to teach health and social care and I dug my heels in and insisted that my husband was bought here. It's like a home from home. The staff are excellent; always smiling, compassionate and happy to talk to me or my husband." When we asked what made this service stand out we were told, "They liaise very well with the specialist Parkinson nurse and consult me over any changes to medicines. They work well with OT's and provide equipment and assessments when we need them. The staff spend so much time talking to my husband and asking him what he wants. The local reputation of this place is fantastic and well deserved: that's why I was prepared to wait weeks in a hospice to place my husband here.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "I am very, very lucky I've been here just over a year and I am very happy: I couldn't be more looked after, my family are so pleased that I am happy." Another person told us, "When I have been out I know that when I come back they will look after me: it gives me confidence." A relative told us, "Mum was very pale and underweight when she came in here, look at her now she has put on weight and looks very well." Another person commented, "I am bed bound, but I am very happy here the staff know me well. I love it to bits, it's the happy atmosphere, they are like my surrogate family." Another person told us, "They all know I like to be called [name] (not the person's given name)." People received care and support from staff members who had got to know them well. The relationships between staff members and people receiving support demonstrated dignity and respect at all times. We observed a team leader who was supporting a person back to their room having accompanied them to watch a performance given by a visiting singer. The person was non-verbal and had given the team leader a 'lovely cuddle' as they came up together in the lift. The team leader told us, "That sort of thing really makes my job worthwhile."

On the day of our inspection we observed very open, familiar relationships between people and their staff and these were apparent throughout the inspection. We observed domestic staff chatting to people in their rooms. One carer asked a person if they were cold and if they wanted a blanket. There was lots of interaction between staff and people through talking, laughing and joking. We observed visitors entering the service and being known to the receptionist and spending time to chat to them. The service felt like a calm and tranquil place: it was bright and had nice wide corridors; we saw that there were plenty of staff available to meet people's needs and requests. A range of people told us that they were happy at the service. One staff member told us, "The staff stay on the same units here and they build up relationships with people and their relatives. The staff really care and nothing is too much trouble. It's nice when you go in to someone's room and they say 'oh it's you, you've been off for a few days how are you?'". Another staff member told us, "This is peoples' homes and we get to know people and their families. I spend time just chatting to people. Some male residents prefer male carers so we sometimes change carers up just to have new conversations with people and let men have their 'male chats'". Staff members described how they looked in regularly on people who stayed in their rooms and our observations confirmed that this happened. One staff member told us, "The activities girls are good with that [reducing social isolation]. We know who is at risk of isolation and the girls will do a one to one session or a game. We've got time in the afternoons or weekends and evenings. For example, some ladies like their nails painted and we do that whilst we sit and chat. A lot of the time people who don't like activities like a chat or a walk outside. One person doesn't like activities but has a computer, Wi-Fi, and a pet cat."

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. One person told us, "I don't like to be organised by them [staff] I like to stay in my room it's my choice. I have everything I need here and my visitors can come and go as they please." One person used a wheelchair to mobilise and had informed staff members that they did not want to use the lap belt. Staff members had established that the person had capacity to make the decision and examined other measures to keep the person safe. In a risk assessment the person had been offered alternative belts to use

but had made their choice clear that they did not wish to use one. The same person liked to have a cup of tea whilst they smoked a cigarette outside. However, the risk assessment identified that the person was at risk of scalds and burns. Staff consulted with the person and the person agreed that staff members could carry out the cup of tea in a beaker with a lid and the person would wear a heat resistant protector over their lap in case of spillages. This meant that the person did not have to change their important routine. Another person told us, "They [staff] always knock and say who they are when they come in, they ask me if all's fine. I get all the drinks I want and when I need them to change my position in bed, that's done on time like we've agreed." The person told us they felt "completely involved" in their care plan and that they felt they were enabled to be as independent as possible.

People's privacy and dignity was respected by staff. One persons' care plan instructed staff members to 'knock on the person's door, gain their agreement to enter, and gain their verbal consent to all interventions. Staff are to ensure the call bell is available'. This type of entry was typical of the care plans we reviewed and our observations during our inspection showed that staff respected people's privacy and upheld their dignity. One staff member told us, "We have pictures on people's doors and do not disturb signs. When entering a room and after personal care we close the door, speak to the person, close the curtains, and cover the person with a towel if we are washing them. If there are any concerns these get reported to the nurse discreetly," Another staff member commented, "We reassure people with continence needs. People can get embarrassed, especially people with capacity, but we gently reassure all people and we work closely with the continence team." One person told us, "They are very caring when they have to turn me to prevent bed sores."

Staff knew people's individual communication skills, abilities and preferences. Care plans contained a detailed section on communication. One person who had suffered brain damage had a level of communication that could change from day to day. This was explained in their care plan and staff were given clear instructions on how to best communicate, "Speak with X slowly and clearly. If they become upset keep your voice low as this may help calm them. Always talk to X about what you are doing and what she is to expect next. Encourage X to meet with other residents and support X to communicate with them. Use their objects of identity such as photographs and interests to encourage them to talk." We observed that staff members followed these guidelines and supported the person to communicate.

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One person told us, "They [the service] arranged for me to go to Germany with a carer so I could see my brother for one last time." Staff had arranged for the person, who was 95 years old and German, to fly out to Germany to visit their brother for one final time. Another person told us, "They have helped me to lose some weight and go back to swimming which I hadn't done for years." The service had supported the person to go swimming, which was now a regular occurrence, and had involved the physiotherapist to ensure this was done safely. One staff member told us, "It's all about the person and what they want: it's about the individual and how they like things carried out. One lady has a shower every morning at 09.00 and has her own routine. She doesn't like breakfast early or in bed; she likes having it when others are having their coffee morning. She loves having The Beatles on in the background when showering and she chooses the staff to do this with."

The service had a positive and pro-active approach to care planning. People's needs were assessed before they came to live at the home to ensure that their care and support needs could be met there. One person had a detailed pre-admission assessment completed by the care quality manager which was clearly based on extensive time spent with the person as well as with reference to their clinical notes. The assessment identified the persons' wish for continued use of bed rails and their level of understanding of and active involvement in pressure relief, which had been an historical problem. The assessment identified pressure relieving equipment required by the service. A personal history was taken of emotional and mood issues and noted that these meant the person was guarded about new relationships and they needed time to build up trust. A discussion had been recorded to establish the person's wishes for their daily routines and how to maximise their sense of control, for example in maintaining some independence in their personal care. This process enabled staff to deliver responsive care and support.

Following the pre-admission assessment, individualised care plans were devised. The care plan showed that the findings of the pre-admission assessment had been carried though into the care plan. The care plan had different sections such as communication, continence, emotional support, medicines support, mental capacity, mobility and night care. The aim of the care plan was for the staff team to work consistently in their approach and to provide a safe environment and to work towards improving the quality of life for the individual. Each of these sections were expanded upon in detail. People's wishes and preferences were tracked through in detail in these sections. For example, one person's night care plan stated that the person, "…doesn't want hourly checks, and wants their door shut. X agrees three hourly turns [for skin viability]." There was also guidance for staff to provide a hot drink before sleep and oral care. "When things are explained X is very accommodating." This example was representative of the care plans we reviewed and they contained good, clear objectives to guide staff members on how care and support was to be provided in the way that people want.

People were supported to follow their interests and take part in social activities. The service employed two activity co-ordinators; both had obtained a level two diploma. The welfare worker managed activities and was the primary provider of one to one work and the build-up of life history information, but all three staff members supported people with one to one sessions. There was a coffee morning most days. This was a

planned but informal session, which also provided a venue for people to have a late breakfast. People were provided with newspapers and puzzle books, and their conversations were facilitated when required. There was the use of a minibus for monthly trips out; this year had included a tea party, a trip to Eastbourne pier, a pantomime show, and a concert. Ideas for trips were canvassed through residents' activity meetings of which there were six a year. Records showed these meetings took place and considered what had gone well and what people would like to be done differently so that the next eight week plan could be decided.

We observed a music session and people told us they enjoyed the activities on offer. One person told us, "Music means a lot to me and we have a lot, it draws people together." Another person told us, "I decide what activities to do. I like to join in with the bingo and quizzes we go out occasionally, next week we are going to a garden centre." We asked about the activity meetings and were told, "They're very good, several people come and we do influence what happens." The person told us that they missed going out but said they used the garden most days and liked to use the minibus trips when possible. People chose whether to stay for a cup of tea in dining/lounge area after the music entertainer had finished, or whether they wanted to return to their rooms or elsewhere. We observed that people were comfortable; that they were free to choose where to be in their own home. The activity staff promoted choices and conversation, and there was a lot of meaningful contact between residents, and between staff and residents. One activity co-ordinator told us that she went to each unit every day and this meant she saw all residents 1-1 each week. The activities co-ordinator showed us how all interactions were recorded on individual's records. Examples seen showed care staff also recorded when they had spent significant time individually with people. There was a section of the care plan entitled 'work & play' which detailed people's interests and preferences. Staff used this section to record their interactions with people so it was possible to track how people spent their time and how staff supported them; and also when staff offered people interaction but it was refused.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service records all complaints in a complaints log and there had been eight complaints recorded in 2016. There was a complaints policy that set out the procedure for responding to complaints and timeframes for replying to complainants. All complaints had been dealt with in line with the registered provider's complaints policy. We reviewed a sample of complaints and found that the registered manager had ensured that learning was put in place from any shortfalls in service and issues were resolved. For example, one person's partner had complained about the way a GP had spoken to them. The service had liaised with the GP practice manager and the person had met with the services' own GP instead. This had been resolved and the complainant had received a written response. Another person had complained that their mother did not have lunch the day before they visited her. This matter was investigated and it was found that the person had no lunch as there was no gravy or sauce made available to the person. The person was being supported by a new member of staff who did not know the person required a soft diet, and that cheese sauce was in fact available. The learning outcome from the complaint was for staff to know the people they are supporting and for the chef to clearly record people's preferences. This matter was bought up in the food committee meeting as a learning exercise. A letter apologising, explaining the investigations' findings and the learning outcomes was sent to the complainant and the matter was recorded as resolved.

Good

Is the service well-led?

Our findings

The registered manager and the management team provided leadership to the service. One person told us, "The new management team are much better." Another person told us, "I feel comfortable talking with the manager she is very open." One staff member told us, "I think [registered manager] is wonderful: the best boss I've ever had. She's so good, she's got an eye for things and makes suggestions and we all think 'yes, why didn't I think of that'. For example we have regular meetings but were doing group supervision when we can so she suggested combining it and formalising it in the diary and it works. She's always here for you and she knows the staff and residents well. She knows what's going on." Another staff member told us, "We have a really good structure and regular meetings with [registered manager]. I can go and speak to her for anything, even if it's just a personal catch up. It [management] has improved so much since the bad times here: a group of us stayed and it now feels like the reward."

At our last inspection on 24 and 26 September 2015 we found that there was no registered manager in post and that quality monitoring systems had not had time to be embedded. At this inspection we found that there was a registered manager had been in post since August 2016 and that improvements had been made. The management team were actively involved in raising standards and making improvements such as overhauling the quality monitoring systems and implementing a safe environmental risk assessment. One relative told us, "I think they [management] understand people's needs as they are nurses, They're quite attentive to training needs and getting the right balance of staff and mix on the floors and they are receptive and listen and they have residents meetings and you can make any comments. I think the cleaning there is very good."

The registered manager had created a new post, the care quality manager, as they felt that a deputy manager role would not suit the service due to its' size. Initially the registered manager and nominated individual worked in each other's roles but they found they were not working to their strengths so agreed with the owners to swap roles. The registered manager felt this has led to their success. The registered manager told us, "We do monthly audits; we looked at clinical profiles and saw four main risks: malnutrition, wound care, accidents and incidents, and infections. As monthly audits were too large we go through the four risk profiles with the lead nurse on each unit every week. This is done by the registered manager, the quality care manager, and the senior nurse for the unit as a whole. On each unit we go through the whole monthly audit and from this we can set up training or focus on any issues." The registered manager explained how this system led to swift responsive improvements. For example, one unit had an issue with recurrent urinary tract infections (UTI's). The registered manager put catheter care training in place for staff, viewed personal care to ensure best practice was being followed, looked at people's medicines to see what antibiotics people were being prescribed and reviewed fluid charts. This resulted in improvements to staff practice and a request to the GP to try a different antibiotic.

The service promoted a positive culture that is person-centred, open, inclusive and empowering. Professionals and relatives were encouraged to visit at any time. One relative told us, "The staff are friendly and when you walk in the home is fresh and clean and warm and doesn't smell. It has a nice ambience. The staff all know me and speak to me when I go in." The registered manager told us, "There is a strong

management presence and when something goes wrong we learn and act on it. One person choked at the dining table when they took a deep breath and swallowed food. Help was called via the emergency bell and nurses dislodged the food and called the ambulance. We reviewed the incident and looked at what went well and what could be improved upon and have put in place choking assessments for carers to use with people and different flow charts for nurses referencing the resuscitation council. The staff were happy to talk and not get told off, but learn."

There was opportunity for staff members to make suggestions to improve the service and where possible these improvements had been implemented. The registered manager had recently completed all 94 staff members' appraisals and told us, "It was very important for me to do all the appraisals personally as I learned so many things. The housekeeper assistant said, 'there's no sign on the bath to say don't enter in use' we hadn't thought about that: it was a great idea so we changed it. The kitchen assistant suggested having new cups and trolleys so there's always drinks available when we take the old trolley away to clean the cups, and we went out and bought new trolleys and cups. The kitchen assistant wants to develop their career and become a chef so they're doing an NVQ [National Vocational Qualification is a nationally recognised work based training programme]. We have nearly 70% of our workforce NVQ or QCF qualified." The registered manager described how they had signed with Public Health England for notifications around infectious diseases so they can be prepared if there is an outbreak of, e.g. norovirus, in the local area. The registered manager told us, "We are also signed up with the health and safety executive, QCF, we use NICE guidelines in our training. We have our own safeguarding policy but we use the local authority policy to make sure it's all up to date." The registered manager ensured they were up to date with their own training and was supervised by the clinical commissioning group lead. The registered manager informed us that they also have a monthly meeting with the owner of the business to conduct a monthly quality review.

The registered manager had a clear vision for the service and relatives were empowered to contribute to improve the service. The registered manager told us, "We sent letters out to all people and their relatives asking how often they wanted their care to be reviewed. Some people chose to have monthly reviews which they can be a part of. If people don't want to be involved we still review their care monthly. There's no restriction on visiting times and people are free to come and visit at any time." Records for residents' meetings showed that people have a high level of involvement in the running of their own home. In one meeting people had raised the issue that call bells did not work in the garden and requested hand bells. We saw that this had been actioned and hand bells were available for people to call for assistance in the garden. People were involved in activities meetings and had made suggestions about themed coffee mornings to raise money for local charities. We could see that this had been actioned and people were in control of the activities group and could direct which activities they wanted to try. The registered manager told us that there was a closed social media group for the service that only two staff members could approve posts to, but that is used to update information about the service and is helpful for some people and for relatives. The registered manager described the values of the service as, "We want to be the best so we review our practice and make changes quickly so we can be responsive to changes. We want residents to feel safe and talk to us; to live and enjoy their autumn years here. We run workshops in the afternoons as this is what staff have told us they want. If I don't look after my staff, they won't be able to look after our residents."

The registered manager had ensured that the service had strong links with local and national organisations in order to achieve clinical excellence. The Registered manager informed us that the service will be joining the spinal injury association which is supported by Stoke Mandeville Hospital. This would enable the nurses to access highly specialised training to complement their care of complex needs patients. There was an external advisor employed by the service to oversee and review bowel evacuations and moving and handling procedures for spinal injury patients. This enabled clinical and care staff to provide specialist care

to people who could not be supported in other nursing homes due to their complex conditions and who would otherwise be in hospitals with social limited lives.
The management team had ensured that strong partnership links with other services had supported people to engage socially. One person with a complex spinal injury, who was previously socially isolated, told us that they trusted the staff team to enable him to live happily in a residential environment which previously he had shunned. The person told us they had begun their placement thinking it might be a stage to return to independent living but they now saw their future in the service and they had been given time to work this out for themselves. This would not have been possible without the strong partnership links set in place by the registered manager with the specialist tissue viability nurse, physiotherapist, Stoke Mandeville hospital and the visiting GP. Another person had been admitted to the service for end of life care and the registered manager ensured that nurses, the GP, the team leader and care staff on the unit worked together to form a network to support the person and their family. Great care was taken to ensure the family understood the reasons why certain interventions were recommended. The GP was at hand to change the doses of medicines based on the observations made by the registered nurses. Plans were in progress to arrange for a room to be made available for the family to use to allow them to get some rest. The networks that the management team put in place enabled this care to be delivered to allow the person to die with dignity and their family to be supported sensitively.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.