The Council of St Monica Trust

The Garden House

Inspection report

Cote Lane
Westbury-on-Trym
Bristol
BS9 3TW

Tel: 01179494017
Website: www.stmonicatrust.org.uk

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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

The Garden House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Garden House provides accommodation with nursing and personal care for up to 102 people. At the time of our inspection 98 people were living in the home. The care home has four separate areas. The Oaks, Maples and Cedars provide general nursing and personal care. Sundials provides nursing and personal care for people living with dementia.

At the last inspection on 21 February 2017 the service was rated Requires Improvement. We found breaches in two regulations relating to consent to care and Deprivation of Liberty Safeguards (DoLS). Following this inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 27 and 28 March 2018. At this inspection, we found improvements had been made and the legal requirements had been met.

The service has improved to Good.

There was a registered manager in post. 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.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was monitored. Staff received supervision and training to ensure they could meet people's needs.

Medicines were safely managed. Risk assessments and risk management plans were in place. Incidents and accidents were recorded and the records showed that actions were taken to minimise future occurrences.

Staff demonstrated a good understanding of safeguarding and whistleblowing and knew how to report concerns.

Appropriate health and safety checks were undertaken to reduce risks to people. The home was clean and staff followed the homes infection control policy and procedures.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Improvements had been made and people were helped to exercise choice and control over their lives

wherever possible. Where people lacked capacity to consent to care and make decisions, the principles of the Mental Capacity Act (MCA) 2005 had been followed. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

People received a service that was based on their personal needs and wishes. Changes in people's needs were identified and care was reviewed to meet their needs. People who used the service felt able to make requests and express their opinions and views. People were helped to exercise choices and control.

A range of activities were offered and provided people with entertainment both in and out of the home.

People benefitted from a service that was well-led. Systems were in place for monitoring quality and safety. Improvements were made when shortfalls were identified.

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 has improved to good.

Improvements had been made in the management of medicines. Where shortfalls were identified the provider took prompt action.

People were protected from abuse because staff had received training and knew how to identify and act on concerns.

Staff were safely recruited and staffing levels were sufficient to meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences. Risk assessments were completed and risk management plans were in place.

The home was safely maintained and appropriate health and safety checks were completed. The home was clean and infection prevention and control measures were in place.

Is the service effective?

Good

The service has improved to good.

The service complied with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).People were asked for consent before care was provided. Where people were unable to provide consent, appropriate best interest decisions were made in line with legal requirements.

People were provided with a healthy diet which promoted their health and well-being and took into account their nutritional needs and preferences. Systems were in place to monitor and act on changes to people's intake.

Staff received training and support to enable them to meet people's needs.

People had access to a GP and other health care professionals.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service has improved to good.

A registered manager was in post. They provided consistent leadership. People who used the service were given opportunities to provide feedback which was acted on to make improvements.

Staff were supported and able to express their views and opinions at staff meetings and through surveys. Actions were taken in response.

Systems were in place to assess, monitor and mitigate risks and make improvements to the quality of the service offered to people. A range of audits were completed on a regular basis and actions promptly taken when shortfalls were identified.

The registered manager recognised their responsibilities with regard to notifications they were legally required to send to the Commission.

The Garden House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of The Garden House on 27 and 28 March 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by three inspectors, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A CQC graduate analyst shadowed the inspection as part of their work experience.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 29 people who lived at the home and 8 visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the representative for the provider, the registered manager and 18 staff including registered nurses, care staff, maintenance, housekeeping, laundry, activity and catering staff. We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at nine people's care records in detail and checked other care records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the care home.

Good

Is the service safe?

Our findings

The service had improved to Good. When we visited in February 2017, although the legal requirements were being met, improvements were needed with regard to the management of some people's medicines. At this visit, improvements had been made and people's medicines were safely managed.

Medicines were given safely and in accordance with people's individual needs and preferences. One person commented, "I get my medication on time which is important. It is a relief because I don't have to worry." Another person's records stated they were, 'short sighted and liked the nurse to tell her which tablets she is taking.' Staff signed the records to confirm when people had taken their medicines. Checks were in place to make sure all medicine administration records (MARs) and topical MARs, for creams applied to people's skin, were fully completed. A system was in place to follow up and check for any gaps in record keeping. Actions were taken promptly when such gaps were identified.

MAR charts contained up to date photographs of people. This meant people could be easily identified if unfamiliar staff, such as agency nurses administered their medicines. Some people were self-administering some of their medicines. Staff had assessed their ability to do this safely and this was recorded.

Where people were prescribed medicines on an as required basis (PRN) there were clear protocols in place to inform staff when and why people might need these. For example, some people were unable to communicate when they were in pain, or were prescribed medicines for anxiety. Protocols detailed the signs people displayed and what staff should look out for. Two people did not have protocols in place. We brought this to the attention of the registered nurse at the time, and they took prompt action. This was to ensure that signs and symptoms people may display were recognised and they would receive these medicines when needed.

Some people were having their medicines administered covertly. This meant they did not know they were being given medicines, which were disguised in food or drink. Clear protocols were in place and detailed records were completed. People had been assessed as lacking the capacity to consent and best interest decisions had been made with input from relatives, care home staff, the GP and the pharmacist.

Medicines were stored and disposed of safely. Systems were in place to make sure medicines that required cool storage or extra security were safely stored. This all meant people could be confident their medicines were safely managed.

People and relatives told us they felt safe in the home. Comments included "My room is on the ground floor but night staff are walking up and down checking the security," "I am completely safe. I am lucky to be here. I have to be hoisted and I don't have any problems" and, "I don't have any worries regarding my relative's safety. She is not mobile and they take such good care of her."

People and staff were protected by the homes policy for entering the home. The front door was secure and visitors had to ring a bell to gain entry. All visitors were required to sign a book and state the reason for their

visit and who they had come to see. Health and social care professionals were asked to show an official form of identification before entering the premises. A staff member asked us for identification when we arrived.

People were protected from the risk of abuse. Staff had received training and were able to give examples of signs and types of abuse and discuss actions they would take, including how to report concerns. A member of staff told us, "It's all about protecting people from harm. I would report any concerns to the manager." The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. A member of staff said, "If I saw any bad practice I would let the manager know. If nothing was done I would take it to safeguarding and even further, to CQC."

Risks to people's health and well-being were assessed and risk management plans were in place. These included risks associated with skin condition, choking, use of bed rails, falls, moving and handling, nutrition and dehydration. For example for one person at high risk of falls, their plan included the use of a sensor mat to alert staff if they moved out of bed during the night. For another person their plan reminded staff to make sure their mobility aid and call bell were kept close to them, and to keep their room as 'free from clutter' as possible.

Where people were assessed as at risk of developing skin damage or who had pressure ulcers, pressure relieving chair cushions and mattresses were used in addition to supporting people to reposition on a regular basis. We checked at random, and found most mattresses were set correctly. We noted two pressure relief mattresses where the pressure setting according to the person's weight were not set correctly. This meant people may not be receiving the level of pressure relief support they had been assessed as needing. We brought this to the attention of the registered manager who took corrective action before the end of our visit. In addition, they confirmed to us in writing after our visit they had introduced a more robust checking system to monitor the use of pressure relieving equipment and details of how this was communicated to staff. This showed the provider's commitment to making improvements when they were needed.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. Four of the people we spoke with told us they had fallen in recent months. They all spoke positively about the prompt staff response and actions taken at the time. For one person, they were transferred to hospital for further tests. The records showed that relatives, where appropriate, were informed. The registered manager showed us the monthly analysis they completed. They told us how they looked for patterns or trends to make sure actions were taken where needed. For example, one person had fallen on more than one occasion and usually at a specific time of day. The advice of a specialist nurse was sought and a medicines review had been planned.

Staffing levels were sufficient at the time of our visit. People and relatives told us there were enough staff most of the time and staff responded to calls for help and support in a timely manner. There were staff vacancies and a recruitment programme was in place. Agency staff were used to cover shortfalls if permanent staff were unable to work additional shifts. One relative commented, "Most of the staff are regular, but we have been visiting when there are agency staff who introduce themselves and tell us they know our loved one who seems quite at ease with them." Staff told us how they moved to different areas of the home when needed if there were shortfalls in a specific area. A member of staff commented, "I think we have enough staff. If people's needs change and we think we need more staff we tell the manager and we get more staff."

Staff were safely recruited. Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional

checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council. The provider included people who used the service, in the staff interview process. This was to make sure people's views were taken into account when staff were recruited to work in the home.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans were recorded for each person. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required. A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency situation such as severe weather conditions or loss of heating. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

People were cared for in a clean, hygienic environment. During our visit, we looked in people's rooms, communal areas, bathrooms and toilets. People told us they felt the service was clean and well maintained. Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves was readily available and we saw staff used PPE appropriately during our visit. The registered manager told us that infection prevention and control training was mandatory for staff, and records we saw supported this. There were policies, procedures and systems in place for staff to follow in the event of an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that waste was stored and disposed of safely.

Good

Is the service effective?

Our findings

When we visited in February 2017, we found shortfalls in mental capacity assessments and best interest decision making. This meant people's rights were not fully protected in accordance with the MCA. This was a breach of the legal requirements. The provider wrote to us and told us how they were addressing the identified shortfalls.

The service had improved to Good. 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.

At this visit we found sufficient actions had been taken and people's rights were protected in accordance with the MCA. This was evident in all areas of the home and specifically in Sundials where people using the service were living with dementia. We saw that people were supported to make decisions and that staff checked with people to obtain consent and agreement to care whenever possible. One example of the many times we saw people being asked before care was provided was a member of staff knocking on a person's door, waiting for a response and then asking, "Hello lovely lady, what would you like me to do for you?"

Staff told us they had received, 'lots of training,' to help them understand the importance of acting in accordance with the requirements of the MCA. As one member of staff told us, "I don't assume people don't have capacity. I let them make their own decisions if they can, even if it might be an unwise one."

The supporting records showed that decision-specific mental capacity assessments were completed. Where people did not have capacity to consent meetings were held with people's relatives to agree where best interest decisions were needed, and these were fully recorded.

When we visited in February 2017, we found shortfalls that amounted to a breach of the regulation relating to the requirements of DoLS. Full consideration had not always been given to least restrictive options, for example, before using sensor mats and door alarms, or administering medicines covertly to people. The provider wrote to us and told us how they would address the shortfalls we identified.

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

At this visit, we found sufficient actions had been taken and the legal requirements were being met. Detailed records provided evidence that, where practices that could be seen as restrictive, such as use of bed rails, sensor mats or giving medicines covertly, other less restrictive options had been fully considered. The use of

restrictive options were discussed with relatives, GP's and other health care professionals where appropriate to agree what was needed and in each person's best interests. Where restrictions were assessed as being required, applications were submitted to the local authority responsible for the authorisation of DoLS and accompanying conditions. At the time of our visit, 30 DoLS applications had been submitted and five people had authorised DoLS in place. We checked and found where conditions were stated, these were being met. For example, for one person it was required that a record was kept of opportunities they were given to take part in engagement and activity provision. For another person, their level of objection to staying in the home was recorded. The registered manager completed regular audits to check how DoLS conditions were being met and made recommendations when further actions were needed.

People and relatives told us they felt staff were knowledgeable and understood their needs. Comments included, "Staff are good at their job. They know what they are doing and have a way of dealing with my relative who can be difficult" and, "Staff are good. They do everything I need."

Staff had received training that included safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the home and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. A member of staff told us, "I had three or maybe it was four days as an extra and then worked in pairs with other staff until I felt confident and got used to people and their needs."

Staff received training specific to peoples' needs, for example around the care of people living with dementia and those at the end of their life. Staff told us that training was encouraged and as one member of staff said, "Training's very good. Trainers are very good as well. Quite proud to be working here, it's lovely". Staff told us they were provided with regular updates and refresher training for topics such as fire safety, moving and handling, mental capacity act and safeguarding. They also completed further training specific to the needs of their role, such as venepuncture and catheterisation that was undertaken by registered nurses.

The registered manager and staff told us about systems of staff development including one to one supervision meetings and annual appraisals. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. The registered manager told us one of their aims was to make supervisions more effective for staff and they were just introducing new documentation so supervisions included more spontaneous 'seize the moment' meetings, to encourage staff and supervisors to make the meetings more meaningful.

People were supported to eat and drink. Nutritional assessments were completed when people moved into the home and their dietary needs and preferences were recorded. We spoke with senior catering staff who told us how they were informed and kept updated with each person's individual needs, choices and preferences which were recorded on 'special requirement' forms.

Menu choices were displayed and people could also select alternatives if they so wished. We observed lunch in each of the areas of the home and to those people in their rooms. There were choices of two main meals, a vegetarian option and salads. The meals were well presented and looked appetising.

Most people spoke positively with comments such as, "Food is first class, there is always a choice. It is hot and well presented" and, "Food is scrumptious, especially the puddings. I have put on weight since being here." We did receive other comments and suggestions that the food 'could be better.' People were provided with opportunities to provide feedback, at three monthly 'resident forums'. In addition, feedback was obtained from other meetings and directly after meal service. We saw recent improvements had been

made in response to feedback given. This included the braising of some meat after feedback that the meat was not tender enough. In addition, some people who ate meals in their rooms provided feedback about the temperature of meals, and often meals were not served 'hot enough'. A portable hot trolley had just been purchased at the time of our visit to make sure people did receive meals at the optimum temperature.

Staff were attentive and provided support when it was needed. For example, a member of staff saw that one person was struggling to eat their meat, and asked, "Do you want help cutting up the pork or will you be ok?" then, "I'll do it for you now."

In Sundials, where people were not always able to fully describe their experiences, we carried out a lunch-time observation using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot tell us. Staff sat alongside people, telling them what they were eating, holding simple conversations and letting the people set the pace, such as for when staff should offer more food.

Where people needed to have their food or fluid intake recorded, we saw records were fully completed. When needed specialist support and advice was sought, for example, from speech and language therapists (SALT) and nutritional teams. Recommendations were clearly recorded. We saw for one person the position they needed to be in when they were being supported with food, was clearly recorded and staff were aware of the person's individual needs.

Staff supported people to access healthcare appointments if needed and, liaised with health and social care professionals involved in their care if their health or support needs changed. People's care records showed that people had been referred to and seen, for example, by GP's, the mental health team, specialist nurses and physiotherapists.

Communication systems were in place to help promote effective discussions between staff so that they were aware of any changes for people in their care. This included shift handovers, written '24-hour nursing reports' and daily entries into care records.

The care home was decorated and equipped to meet people's needs. For example, for people who need support to move, ceiling tracking hoists were provided in many of the bedrooms. All bedrooms had en-suite toilet, sink and shower facilities. There was a range of communal lounge and dining areas. We saw that work was in progress to enhance the facilities for people living in Sundials, which was located over two floors. The corridors had been painted, and works were in progress to further develop a dedicated reminiscence area.

Good

Is the service caring?

Our findings

The service remained caring. We received many positive comments and feedback from people using the service and from relatives. These included "Staff are so friendly, tactful and thoughtful. I struck gold when I came here. They don't bother me unless I call for them. It's such a relief to know they're there," "Everyone is lovely, everyone is very kind to me, they do everything for me, I love them," and, "They treat her so well, she is not always easy, but they understand her and are very patient."

We spent time in various parts of the home, including communal areas and individual bedrooms so that we could observe the care, attention and support that staff provided for people. During our visits we saw staff demonstrating acts of patience and kindness. People were asked if they were ready to receive personal care. People were supported with things that were important to them prior to moving in to the home. This included preferred style of clothes that were clean and ironed, shaving, jewellery, make-up, hairstyling and manicures.

Throughout the two days of our visit, we observed people being treated in kind, caring and respectful ways. Staff were helpful, warm and friendly and people looked relaxed and comfortable in their presence. Everyday conversations took place and staff stopped to speak with people as they walked past rooms or communal areas. One member of staff chatted to two people about a holiday they were planning. A member of staff spoke with a person about helping them out into the garden for some fresh air when the rain stopped. Another member of staff reminded a person about visitors that were due to visit, and then had a brief chat and asked the person about their family. It was clear that staff had got to know people well.

Staff were able to describe people's likes, dislikes, interests and preferences. Staff told us they got to know people well. Each person had an allocated key worker. This role was described to us by staff. They told us they, "Simply go and have a chat, take residents for a walk, one of the best parts of the job" and, "Tidy their rooms, water their plants, paint their nails, take them to the shop." Staff did comment about recent changes in staff allocation, which meant some staff were in the process of getting to know people living in different areas of the home. The registered manager confirmed to us the changes had been planned, and a new improved rota system had just been introduced.

Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We were told that staff always knocked before entering rooms. We observed this happening on most occasions, but did notice three occasions during the two days when this did not happen in the Sundials area. We reported this to the nurse in charge at the time.

Privacy was maintained when personal care was being provided, and we saw doors were shut, and engaged signs were displayed on the doors. Staff were sensitive to people's needs and one person told us, "I have no problems with personal care. I found it difficult at first, but staff are so respectful and ask first."

People's equality and diversity was recognised and respected. We heard staff referring to people by their preferred names and communicating in ways that were meaningful to people. Staff were available on duty

who could speak the language of a person whose first language was not English. A person with sight loss was supported to recognise their call bell because a raised dot had been placed on it so they could feel where to press when they needed help.
People's rights to a family life were respected. Visitors, sometimes arriving with family pets, were made welcome at any time. Where relatives chose to have meals with people on a regular basis this was encouraged. During our visit, one person celebrated a birthday with visiting relatives who had brought in champagne and a birthday cake. Catering staff had also baked a cake and lit candles before singing happy birthday, much to the delight of the person and their relatives.

People's confidential information was protected. Care records were stored electronically and accessible to staff when needed. One member of staff told us, "Everything is confidential here and nothing gets discussed off the unit, not even with our family."

We read recent compliment cards and letters received in the home. An extract from one read, 'Since December 2016 you have cared for my relative with continuous and consistent devotion and love. You have shown sensitivity and respect throughout, particularly during the last few days of her life. My relative had a long and enjoyable life, and we are so grateful that during the last year of it she felt safe, secure and happy in her new home, receiving nursing and medical care of the highest standard'.

Good

Is the service responsive?

Our findings

The service remained responsive to their individual needs. Before new people moved into the home they were assessed by the registered manager or senior staff to make sure care needs were known and could be met. People were able to call for help and support when needed and were provided with call bells and pendants. We were told staff responded promptly on most occasions and acknowledged that during 'busy times' they may have to wait a little longer. Comments included, "When I ring the response time is good," and, "When the bell goes you are put in a queue and wait your turn. It is not instant, but not long."

Care plans were written that provided details of people's physical, mental, emotional and social needs. People and relatives where appropriate were involved in care planning. One relative said, "We were involved in the original care plan which was very long and detailed and the manager asked, 'How can we make sure [name of person] is looked after as she would like?' She also compiled a life story."

Most of the care records were personalised and accurately reflected people's care and treatment needs. They contained information about peoples' backgrounds, where people had lived, significant events and relationships that were important. Details of how people wanted to be supported was recorded, including preferences for gender of care staff to provide personal care, and details such as whether they liked baths or showers.

Where people had complex care needs, their care plans were detailed and provided clear guidance about the treatment and support they needed. For example, one person had a percutaneous endoscopic gastrostomy (PEG) tube. This is a tube directly into a person's stomach, when they are unable to take sufficient or any intake by mouth. The records provided clear guidance and instruction about how the equipment was to be used and the nutritional feeding regime in place.

We did see examples where records were not accurate which we brought to the attention of senior staff and the registered manager. For example, use of non-specific comments that could be seen as judgemental for one person described as being 'on the bell at lot' without any further record about how often and why the person may have been calling frequently. Another person was receiving treatment for a pressure ulcer. The records were not clear in that the wound description was not accurate on one occasion and there was no reason specified for the types of wound dressings being changed on three occasions. When we brought this to the attention of the registered manager they took immediate action which they later confirmed in writing to us.

People told us their preferences and choices were respected. They gave examples such as choosing where to spend the day, what activities to participate in, what and when they ate and when they got up and went to bed. As one person said, "I enjoy my own company and prefer to stay in my room and read or watch TV. I talk to my family by phone every day and am quite content. I am informed of the activities and asked if I would like to join in, but am not pressurised to do anything." Another person's comment included, "I have made friends here and joined clubs. There is plenty on offer, but you are not forced."

We saw a range of activities were provided. Most of the group activities took place in the Cedars, Maples and Oaks areas of the home with everyone in the home invited to attend. People were visited in their rooms and given copies of the weekly activity programme. The activities included coffee mornings, music and movement, 'sherry and stretch' 'Alive' guided reminiscence, 'songs from the shows' and classical recitals from professional musicians. There were links with the local nursery and children visited on a regular basis, with a local high school whose pupils also visited regularly. We spoke with one of the activity coordinators who told us about the regular trips they organised using the mini bus, with a dedicated driver, to places of local interest.

Most people spoke positively about the range of activities provided in the week and commented there was not so much to do at weekends or on bank holidays, unless care staff organised a film showing or organised a craft activity.

Although we were told by staff that people living in the Sundials area of the home were invited to the group events that took place we did not see many people from this area actually participating. We saw staff spent time engaging with people, often on a one to one basis, such as and taking people out in the garden for walks. Staff told us they were looking for ways to enhance the opportunities for 'meaningful engagement' with people.

A complaints procedure was in place that was readily available to people and relatives. In addition, leaflets were displayed in the reception area. Everyone we spoke with told us they would feel comfortable to raise concerns if needed. We spoke with one person who had raised a concern a couple of days before our visit. Before we had chance to speak with, and ask the registered manager for an update, the concern was addressed and the equipment the person had concerns about, was back in full working order. A relative told us, "We raise concerns as they happen and they are dealt with immediately." We also looked at the complaints file and saw that complaints were managed in accordance with the provider's policy.

Records showed that staff had discussed end of life plans and recorded what people wanted to happen if they became very ill. Spiritual needs had been considered and where people had expressed specific support they may need, this was recorded. Relatives were involved in discussions about circumstances in which people may wish to be transferred to hospital or stay in the home, and when DNACPR's had been agreed. This is a way of recording a decision not to resuscitate a person in the event of a sudden cardiac collapse. We spoke with relatives of a person who was receiving end of life care. They told us the person was being kept pain free and was being cared for by 'lovely staff who could not do more.'

Good

Is the service well-led?

Our findings

People now benefitted from a service that was well-led. When we last visited the home in February 2017 the provider's quality assurance systems had not identified shortfalls such as those we had identified with regard to consent to care and DoLs.

At this visit, as we have reported on in the effective section of the report, sufficient actions have been taken and improvements made, and the legal requirements were being met.

When we last visited the home we received mixed feedback about the management of the service. At this visit, most of the feedback we received was positive. People told us they saw the registered manager as they walked around the home and 'if and when they needed to'. Relatives told us they were able to see the registered manager at any time and they were described as, 'approachable' 'understanding' 'good communicator' and there was an 'open and honest culture' in the home.

The registered manager acknowledged in discussions with us during our visit, that one of their on-going challenges was to constantly look at ways of increasing their 'visibility and presence' given the size and layout of the home. They completed a 'Managers Daily Walk Around' that included talking with people using the service, and with staff.

We found there were numerous ways for people to provide feedback and to be involved with the running of the service. Surveys were completed and resident and relative meetings were held regularly. A meeting took place on the second day of our visit. Actions had been taken in response to previous feedback received. For example, changes had been made to enhance peoples dining experience and opportunities for more evening outings were being explored. This meant people could be confident their views and opinions would be listened to and acted upon.

A range of auditing and monitoring systems were in place. These included care records, infection control, medicines management, pressure ulcer audits, falls audits and call bell response times. Audits were completed by the registered manager, senior staff in the home, and representatives for the provider and external consultants. Where shortfalls were identified, improvement actions were taken.

The registered manager showed us the monthly call bell auditing system which they used to help assess staffing levels throughout the home. In January 2018, the auditing had showed the time taken for staff to answer people's call bells had increased. This was specific to one area of the home, and during one specific time period. The registered manager took action and increased the staffing levels in that area. In response to the shortfall we identified in the management of one person's pressure ulcer, the registered manager took immediate action and they amended their audit document. This all showed that quality assurance systems were used to identify and make continuous improvements to the service.

Staff had the opportunity to express their views at staff meetings. Minutes were recorded and circulated. In addition, 'Colleague opinion surveys' were completed. We read the feedback from the most recent survey,

completed in November 2017. One of the issues raised by staff related to their working patterns. Changes had been made and a six week 'rolling rota' was introduced to improve consistency. Staff had also commented about their terms and conditions. The registered manager told us how they had since introduced incentives for staff. This included a monthly 'spotlight' award to reward staff who had been nominated for 'Doing what matters.' Changes had been made to the documentation for staff supervision and staff told us they had been asked for their views and contributed to the changes that had been made.

An 'Our values' booklet was available with copies for people who used the service and staff. The booklet contained quotes from the chief executive, volunteers, staff and people who used the service. Examples of how the values were put into practice were given. The staff we spoke with understood the provider's values and were proud to work for St Monica's Trust. Whilst we heard some 'grumbles' from staff about recent rota changes, staff said The Garden House was a good place to work and, as one member of staff said, "This is a very supportive environment to work in. We all help each other."

The registered manager is a registered nurse. They told us how they kept up to date with current practice. They attended the provider's mandatory update days, local care provider forums, clinical conferences, including a recent End of Life conference. They subscribed to care journals and worked with, and received support from, the provider's clinical governance staff.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.