Countrywide Care Homes (2) Limited

Mary Chapman Court

Inspection report

Mary Chapman Close
Dussindale
Norwich
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Tel: 01603701188

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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 19 September 2017 and was unannounced.

Mary Chapman Court provides care for up to 34 people. There were 27 people living in the home on the day of our inspection. The home supported people who were over 65 years of age, some of whom were living with dementia. The building offered accommodation over two floors.

On the ground floor were a communal lounge, separate dining room and conservatory, where people could socialise and eat their meals if they wished. On the first floor were an additional two lounge's and hairdressing area. The service provided transport for access to the community.

It is a condition of the provider's registration that a registered manager is in post at this location. The registered manager had left the service in August 2017. The provider had a nursing home, next door to Mary Chapman Court; the registered manager for that location has submitted an application to register with the Commission. Meaning they intend to have a dual management role supporting both locations. 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 of the Health and Social Care Act 2008 and associated regulations. There was an acting deputy manager in post who was supported by senior staff.

At the last inspection on 14 and 15 June 2016 the service was rated 'Requires Improvement'. The report was' published in August 2016. At the last inspection we found there was an insufficient number of staff to keep people safe and meet people's needs. We identified the service had not monitored peoples weight for some time so did not take timely actions to protect people from the risks of unplanned weight loss. The service was not following their procedures in the safe administration of medication. Consequently we found the manager had not completed robust and sufficient audits. Following the inspection the provider sent us a detailed action plan telling us how they would address the concerns we identified. At this inspection we found sufficient improvements in all of these areas. The service had continued to develop and had further strengthened their very caring approach. People received exceptional care that was personalised to them, taking account of their individual needs and wishes.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People who were able to said they felt safe at the home.

People's care records showed risks to their safety were assessed and the action needed to mitigate those risks. These assessments and care plans were reviewed and updated at regular intervals to ensure people's changing needs were met. Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

There were sufficient staff in place to meet people's needs. The manager used a dependency tool to assess staffing levels and to ensure they were based on people's needs, were up to date and reviewed monthly. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

Staff received an induction into the service and senior staff checked competencies in a range of areas. Staff had received a range of training and many had achieved or were working towards a National Vocational Qualification (NVQ) or more recently Health and Social Care Diplomas (HSCD). Staff received formal supervision and annual appraisals from their managers.

People were supported by staff who understood and effectively applied the principles of the Mental Capacity Act, 2005 and the Deprivation of Liberty Safeguards. Staff confidently applied the MCA to make sure that people were involved in decisions about their care so that their human and legal rights were protected. People were supported to have maximum choice and control of their lives and staff assisted them in the least restrictive way possible.

People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. Observations of meal times showed these to be a positive experience, with people being supported to eat a meal of their choice and where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Nutritional assessments were in place and special dietary needs were catered for.

People's health care needs were assessed monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Exceptionally caring relationships had been built between people and staff. Staff working in the home were predominantly caring and compassionate. Staff knew the needs and preferences of the people they cared for and people were given reassurance and encouragement when they needed it. Where people needed support in order to make their own day to day decisions this was provided by staff. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's stories. People's rights to privacy, dignity and independence were taken into account by staff in the way they cared for them. People receiving end of life care were treated with outstanding care and compassion.

People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. Staff were always visible to interact or sit with people. Staff said it was important they were also involved in ensuring people had something to do or someone to talk with. People were offered a wide range of both group and individual activities that were meaningful to them and which had a positive impact on their lives. Each person's needs were assessed and this included obtaining a background history of people. Care plans and assessments were comprehensive and showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences.

The home had been decorated and arranged in a way that supported people living with dementia. The service was brightly decorated and stimulating for the people living there. The communal areas of the service were clean and well-furnished with a homely feel. People's rooms were individualised, with personal items such as ornaments, photos and furniture. The outside area was accessible with paths and benches.

Complaints were listened to and managed in line with the provider's policy. Relatives told us that they felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

People and their relatives were involved in developing the service through meetings. People, relatives, healthcare professionals connected to the service and staff were asked for their feedback in annual surveys. All responses were positive from the recent quality assurance questionnaire. Their views were valued and they were able to have meaningful input into the running of the home, such as activities they would like to do, which mattered to them.

Staff felt the manager was supportive and said there was an open door policy. Relatives spoke positively about the care their family members received. There were effective quality assurance processes in place to monitor care and plan on-going improvements. A quality and compliance manager visited the home on a weekly basis supported the manager.

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 had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

Sufficient numbers of staff were provided to meet people's needs. Safe recruitment systems were in place.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training as required to ensure they were able to meet people's needs effectively. Staff received supervision and appraisal.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

Is the service caring?

Outstanding

The service was outstandingly caring.

Staff were extremely kind and compassionate. People's rights to independence, privacy and dignity were valued and respected; by staff who took time to speak and listen to people.

The service was inclusive of people's family, wider circles of

support and the community.

Equality and diversity were managed well and people were supported to follow their own religious and cultural preferences and beliefs.

People were involved with and included in making decisions about their care and how they wanted this to be delivered.

The home provided outstanding end of life care. People experienced a dignified death in line with their wishes.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

People were able to take part in meaningful activities of their choice.

People were aware of the complaints procedure and knew what to do if they were dissatisfied with the care they received.

Is the service well-led?

Good

The service was well-led.

There was an honest and open culture within the very stable staff team who felt well supported.

People benefited from a well organised home with clear lines of accountability and responsibility within the management team.

Staff told us that the manager was approachable and that they were encouraged to discuss any issues or concerns. The provider encouraged people and their relatives to express their views about the service and the provider was open to suggestions for improvement.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

Mary Chapman Court

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 19 September 2017 and was unannounced. The inspection team consisted of one inspector and one specialist nurse advisor.

Before the inspection, we received 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

We spoke with six people who lived at the service, four relatives, the quality and compliance manager, acting manager and administrator. We spoke to three care staff, the chef and the home's activity co-ordinator. We also spoke with one visiting district nurse and General Practitioner (GP).

We looked at the care plans and associated records for six people. We looked at six people's medication records and six people's weight records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

At the previous inspection of 14 and 15 June 2016, we found there was an insufficient number of staff to keep people safe and meet people's needs. At this inspection we found improvements had been made. Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although staffing levels remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw that people received care and support in a timely manner. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the lounge and staff discreetly assisted them, ensuring they were comfortable in a quieter environment and enjoying the garden views, as staff knew they liked gardening. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice.

The rotas reflected each day that at least four care staff and one senior carer were on duty from 8am to 2pm. In the afternoons, there were at least three care staff and one senior carer on 2pm to 8pm. At night time two care staff and one senior carer were on duty 8pm to 8am. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed. In addition to the care staff, the service had a team of domestic staff, a chef and kitchen assistant, one activity coordinator and gardener. This enabled the care staff to attend to people and their needs.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.

At the previous inspection of 14 and 15 June 2016, we identified the service had not monitored peoples weight for some time. At this inspection we found improvements had been made. Records demonstrated weights were being recorded monthly or weekly if required. Observations of the weight and nutritional input charts evidenced that unless unwell, people had records of steady weight recordings and that the forms gave evidence of nutritional and fluid intake. Where unintentional weight loss had been identified, there was an increase of monitoring and actions taken by staff to ensure people did not lose further weight.

People who were able to told us they felt safe and our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were firstly checked to see if they were in pain or needed assistance, which we observed.

Six peoples care records included risk assessments regarding nutrition, possible falls, mobility, activities and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. For example, one person's care records described the hazards and measures to control risks

regarding going out, preventing falls, moving and handling procedures and nutrition. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff. The risk assessments were reviewed and updated regularly and as needs changed. For example, we were told about people who had dysphagia. This is the medical term used for people who have difficulty swallowing. People with dysphagia need support when eating or drinking to reduce the risk of choking. One person's care records confirmed they had this condition and detailed measures staff should take to reduce the risk of choking. They needed a pureed diet and thickened fluids. Our observations at lunchtime confirmed that consistency of food was given to people in line with their assessed need and as detailed in people's care plans.

Moving and handling assessments gave staff clear guidance on how to support people when moving them. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable. Risks regarding falls and developing pressure areas on skin due to prolonged immobility were completed. Appropriate referrals had been made to health care services. These included referrals for assessment by the tissue vitality service regarding pressure area care, and physiotherapy services where people were at risk of falls.

People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas developing on their skin. One person had a record to show they were repositioned at regular intervals to relieve the pressure on their skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

At the previous inspection of 14 and 15 June 2016, we identified the service was not following their own procedures in the safe administration of medication. At this inspection we found improvements had been made. People's medicines were safely managed. There were policies and procedures for the safe handling of medicines. Medicines were administered by trained staff. Records demonstrated arrangements had been made for all trained staff to be competency assessed annually. This is an observation of staff regarding how they safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.'

The senior carer was observed administrating medication on the day of the inspection. We observed medication administered safely and the MAR chart was seen to be signed and dated. We found no gaps in these records. The senior carer was observed explaining to residents what she was doing, gaining their consent and explaining what the medicine included. The senior carer ensured that the medication was given in accordance with the wishes of the person and that it was given safely and that the person was comfortable. We observed that unused medication was discarded safely and in accordance with the administration of medication policy. Stocks of medicines showed people received their medicines as

prescribed. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

The acting manager demonstrated understanding of her responsibilities to protect people from abuse and to provide safe care. We asked the manager about the systems and processes in place to ensure appropriate action was taken when incidents and safeguarding situations occurred to reduce risks to people. The manager explained that all individual incident and accident reports were seen by her, that she then compiled a monthly report, which was reviewed by the quality and compliance manager. This was shared with senior management, and a trend analysis completed. We spoke with staff about the safeguarding of people and each staff member had a good awareness of the principles of safeguarding procedures and who to report any concerns to. Records showed staff were trained in safeguarding procedures and this was included in the induction for newly appointed staff. The manager said they had also attended safeguarding training which was provided by the local authority.

Good

Is the service effective?

Our findings

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Induction was followed by a minimum of four shadow shifts. New staff shadowed more experienced colleagues and did not work on their own until they were competent and confident to do so.

The provider maintained a spreadsheet record of training in courses completed by staff, which were considered mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people and the Mental Capacity Act (MCA.) Additional training was available to staff in specific conditions such as end of life care, sensory deprivation, dementia and diabetes. Records confirmed all staff who had finished their induction, had received this training. Staff confirmed they received training which they said was of a good standard and that they were able to suggest relevant training courses which were then provided.

Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard.

Not all staff had received supervision sessions in line with the provider's policy, which stated staff should receive supervision four supervisions annually. Six staff files showed that the staff had only received two supervisions in the last year. However, staff told us they felt supported by the team and manager. We spoke with the manager about their plans for supervisions. The manager showed us their audit tool, which demonstrated that supervisions were not being carried out as regularly as they should. The action plan was in place to ensure staff supervision was arranged and the manager had completed this. Staff told us, although they did not receive frequent supervision they felt supported and information shared was through handovers during the day, staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the manager had an open door policy where they could talk to them anytime they needed to.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People and their relatives said staff consulted people and gained their consent when providing care where this was possible. We observed staff gained people's consent before supporting them using their assessed communication method. One staff member told us, "I ask questions and then rephrase the questions to ensure that they have understood, simpler questions, not just yes or no questions." Our observations confirmed people were able to make choices and were in control as much as they could be in the day to day decisions being made. For example what people wanted to wear, where they wanted to sit, what activity they wanted to do and what level of interaction they wanted with staff. Records confirmed that staff had completed training in the MCA and had a good understanding of this topic.

Appropriate DoLS applications had been made and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. We talked with the chef and the kitchen assistant who explained how they catered for people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. We observed good communication between kitchen staff and care staff, who advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and speech and language therapists. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

We observed the lunchtime meal in the dining room. The atmosphere was calm and relaxed and there was music playing which people told us they enjoyed. Tables were nicely laid with condiments and sauces. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Staff assisted people who required support with eating their meal in a discreet and unhurried way. We observed four people state their meal was, "Lovely", "It's lovely", "Very tasty," and "Very nice". People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse or optician. If needed, staff would support people to attend their hospital appointments. Each person had a transfer to hospital file which provided information that would be

required if the person needed to be admitted. This helped to make sure that other professionals would have information about people's general health, how they communicated and any specific wishes regarding their healthcare.

The colours and décor of the home supported people living with dementia to orient themselves in their surroundings. For example, there were objects placed around the home for people to pick up and engage with. We observed people walking around with various items that were of interest to them, such as knitted items, which some people enjoyed holding and putting on. There were handrails along the corridors for people to steady themselves and rest if needed.

Outstanding ☆

Is the service caring?

Our findings

Without exception people could not speak highly enough of the caring and compassionate nature of the service, staff and management team. They told us that every member of staff demonstrated this approach consistently and without fail. They told us of the exceptionally high standard of care they received and how this made them feel. From speaking with people, we understood that a very person centred approach came naturally to the staff that worked at May Chapman Court. This meant that everyone we spoke with during the inspection was able to give us examples of how the service and staff had made people feel valued, important and special.

One person who used the service told us, "Every single staff member I have met cares about me. Genuinely cares about my wellbeing. When they come on shift and before they leave shift, they will check in with me and spend time with me. They are never rushing to get away." Another person told us, "All of them are hardworking and caring. I enjoy each day because of them. They make sure all of my needs are met, nothing is too much." Another person told us, "It is caring, they [staff] are excellent. I get a smile every day. They are very sensitive to how I am feeling. They know by my face when I may be low. They come and chat to me and ask me what's the matter."

The relatives we spoke with talked prodigiously of the distinctive and positively far reaching effects of the manner in which the service and staff cared for their family members. Relatives consistently told us they valued their relationships with the staff team and felt that they often went the 'extra mile' for them, which made them feel as though they really mattered. Throughout our visit there was a strong emphasis on family. People, their relatives and the care staff described the home as an extended family that they all felt an important part of.

One relative told us of the care provided, "I can sleep at night knowing [person] is safe and being well cared for. More than well cared for, they are having a better quality of life now than they had in years. It has changed our lives. I am welcome here anytime and we take [person] out on a weekly basis with no time restrictions." Another relative explained the creative lengths the service had gone to improve the quality of life for their family member who lived with dementia. They told us that gardening had been a real interest for them and that the service had used this knowledge to create a separate space for the person to spend time in. The relative told us that the service planted a number of flowers in this area and created a vegetable patch that staff supported their family member to care and nurture. The relative told us that staff assisted their family member to this area when they felt upset or distressed and that it helped them to remain calm and content. The person's relative told us that this gave them a sense of purpose and self-esteem. Another relative told us, "The staff are very caring, I have not met any of them [staff] that differ. They are all very friendly, helpful and encouraging. All of them." For five people, their passion was musical theatre shows. The service organised a special event where the five people could enjoy their passion at a theatre show locally. One of the person's relatives told us, "They [people] loved this! [Person] hasn't done anything like that in years. She hasn't stopped talking about it. Nothing is too much for the staff here. If they know a person is fond of something or has a particular interest they go above and beyond to introduce it."

We saw that genuine and meaningful relationships had developed between people living at the home, their relatives and staff. This extended clearly to the manager, administrator and quality and compliance manager who were all very visible around the home during our visit. The manager and administrator brought their dogs into the home during our inspection to meet people and spent time going round to see individuals. We saw a number of people's faces lit up at the sight of the dogs. People's families were welcome at the service and relatives told us they felt like they mattered. We saw relatives arrive to be warmly greeted and in some cases receive reciprocated hugs from staff. Relatives told us they were able to be as involved in the person's care as much as the person wished them to be. One relative told us, "We no longer attend formal reviews. We don't need to because we discuss [persons] needs on a daily basis. Staff listen to all of my views, they are acknowledged in the care plans and consequently [person] is very happy." Two other relatives told us how staff extended their care for their family member to the relative themselves. They described how staff checked how they were getting home every time after visiting their loved one. One relative explained that if needed staff arranged transport to ensure they went home safely. Both relatives explained that staff would stay on after their shifts had finished to spend time with them and talk to them. One relative told us, "The staff here ensure [person] is well cared for, is well loved and that's how they have made me feel as well."

The staff we spoke with demonstrated commitment and motivation in offering a person centred service that was dedicated, gracious and of a high quality. Staff spoke of delivering care and support that was arranged by the needs, preferences and wishes of those people who used it. People were at the core of the actions other staff and they spoke of them in affectionate, respectful and caring terms. The senior carer, carer and activity lead all stated "I love working here. I love the interaction with the residents."

People sat with staff who talked to them about their known interests. Staff were laughing and telling jokes to people. People responded well and appeared happy and entertained. We observed a staff member adjusting someone's glasses so they were comfortable. Staff showed a caring approach to people. They gave people positive reinforcement when they engaged with them. Interactions between people and staff were good and it was clear staff knew people, and people knew staff. A person showed us how their nails had been done that morning and indicated the care worker had helped them to do it in the way they wanted.

On the day of the inspection there were several people living with Dementia, there was no evidence of challenging behaviour or distress as staff were observed to interact with people with kindness, gentleness and warmth. Two staff described how they gave people choice, by explaining what they are doing by employing simple questions. Both staff told us they rephrased questions to ensure people have understood the question and then are able to make an informed choice.

People were involved in planning their admission to the home and if they could not do this their relatives were involved and spoke on their behalf. People were able to bring in personal items to the home which helped them personalise their bedrooms and we saw in some cases this extended to furniture and pictures for the walls. Relatives told us they felt involved and had been asked about their family member's likes and dislikes, and personal history in order that staff could provide their relative with appropriate care. One relative told us, "When the manager assessed my [person] it was clear they were going to struggle in such a new unfamiliar environment. The provider went above my expectations by arranging for key furniture items that meant a lot to [person] to be transferred from [persons] home to their room. We know it gave [person] comfort in being able to be in a room filled with those furniture items that meant so much to them. Items that connected [person] to memories of her husband, my dad."

People's abilities to express their views and make decisions about their care varied. To ensure that all staff

were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. We found care plans detailed how people would like to be supported to vote and how they would like to receive their mail. The records stated 'I would like my family to assist me'. 'I would like my post to be delivered to me and for the staff to assist me in opening my post'. One care plan stated the person liked to have a clean nightdress on every day. Records confirmed this happened. The senior carer told us, "I ask what time they [people] would like to get up and make sure that they have a choice for meals and ask them what they would like to wear. If they want to stay in bed a bit longer then I will come back later."

Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed to help give people a normal life. People told us that staff knew them well and understood the way they wanted to live their lives at May Chapman Court. One person who used the service told us, "I am fiercely independent. Staff know this, they respect this and encourage this. I tidy my own room, I like to clean and I know my limitations." Another person told us 20 years before living at Mary Chapman Court they had given up knitting. However over a period of four months of daily encouragement from staff, they had been supported to take up this hobby again. The person told us, "They [staff] bend over backwards for me. I didn't knit for 20 years due to an injury and the girls [staff] bought me some wool and needles. They never gave up on me. For four months they sat with me and encouraged me. Stitch by stitch I got there and am now knitting on a daily basis. That is down to them. They helped me, encouraged me and I love that." The person showed us the multiple blankets they had made and told us how she was encouraged to sell them at local events. The person told us, "I love selling them, people love my blankets."

Family meetings were held. Staff created a safe space for relatives to share ideas and explore their feelings in relation to the care their relative was receiving. The staff explained relatives often experienced a range of emotions resulting from the person moving into a care home in the first place but also following a decline or even death of a family member. Relatives met regularly and set the agenda for their meetings. Relatives were encouraged to participate in events and activities within the service and relatives were consulted regularly about the care provided. Relatives gave us positive feedback about the service. A recent meeting had resulted in a change in the menu as people had requested a wider variety. Relatives told us the change in menu had led to meals such as chilli con carne and meatballs and this had received positive feedback from people.

Equality and diversity were managed well and people were supported to follow their own religious and cultural preferences and beliefs. People's choices about who they wanted to support them with certain tasks and activities were respected. For example, one person had requested a particular staff member to help them with their sewing and knitting because this was a shared interest. We found that this had been put in place. People were able to attend Church. One person told us, "I visit the local Church once a month. Staff take me. This means so much to me to have that personal time at my Church that I have attended for years." Records showed that a member of clergy visited the home weekly to provide spiritual support and communion to people who were unable to physically attend Church. One person told us, "I really enjoy this. I am glad the home arranges for this to happen. Its important part of my life. The staff understand and respect this." We found individual spiritual needs were being supported. Records showed that the staff were aware of and recording the wishes of each person.

The staff induction included instructions for staff in treating people with dignity, maintaining people's independence and treating people as individuals, which we observed in practice. The senior carer told us, "I always make sure that I take two towels in for giving personal care to ensure that residents dignity is maintained at all times and to ensure that they feel safe. I use one towel to cover their intimate areas. I encourage people to do as much as they can for themselves so they feel as they have some control."

Each person had a person centred care plan which was personalised to reflect people's preferred routines and choices in how they spent their day and how they wished to be helped. People who were able told us they were able to choose how they spent their time. Care plans also included details of how staff should support people with emotional needs. Staff told us care was provided based on what the individual needed and that choices were available to people.

At lunch the staff provided support to people who needed it. They responded when people wanted a different meal according to their choice. Staff made sure they carefully wiped people's mouths after eating and drinking to protect their dignity. Staff spoke to people warmly and interacted well with those who needed help. The staff made eye contact with people and crouched down so people could see them when they spoke to them rather than standing over them. A person was eating their meal independently, a care worker made sure they did not eat too much food each time to ensure they could swallow safely. Staff took care to treat people in a way which made people feel they mattered.

All those we spoke with told us they were treated with utmost respect and that their dignity and privacy was maintained. One relative told us how staff always explained what they were doing when assisting their family member to mobilise. During our inspection we observed this consistently. We saw that staff asked people's permission before assisting them to mobilise and that they gave them time to understand what was about to happen. We saw staff comfort, reassure and explain to people throughout this process. We observed staff ensure bedroom doors were closed before giving personal care. We saw that a screen was also used to protect people's dignity when the use of moving and handling equipment was required.

When a person was approaching the end of their life we saw evidence of awareness of the needs and preferences of people. The home had an end of life champion whose role it was to focus on end of life care and the experiences of people. They were also responsible for providing information and guidance for other staff members. This included implementing guidance from NICE (National Institute for Health and Care Excellence) Quality Standards for End of Life Care. The guidance aims to improve end of life care for adults in their last days of life by communicating respectfully and involving them, and the people important to them, in decisions and by maintaining their comfort and dignity. It includes recommendations on how to manage common symptoms without causing unacceptable side effects and maintain hydration in the last days of life. Staff understood the importance of having conversations around this aspect of care with people and those that were important to them, but at a time that was right for people.

The guidance from NICE had been embedded through the end of life care plans which were very detailed, person-centred and had the person and their relatives at the heart of their support. This was in order to record people's wishes, choices and preferences for their end of life care. We saw that people's physical, emotional, spiritual, cultural and social needs had been taken into account. Wherever people had appointed others to make decisions on their behalf, we saw that official copies of these documents were on file. A person receiving end of life care had a record that 'I would like to wear my blue nightie on the hanger in the wardrobe and want the window left open.' The carer told us that all the staff were aware of the persons wishes.

When a person was approaching the end of their life, the manager told us that staffing levels were adjusted to ensure their needs were fully met and that they were never alone. Family and friends were encouraged to stay at Mary Chapman Court during these times. A relative of a person receiving End of Life care described the staff as "Fantastic, they [staff] do everything for my [relative]. They have looked after her brilliantly." Another relative of a person receiving End of Life care told us, "staff are providing for all of my [persons] needs. They [staff] are wonderful." Another relative told us. "They [staff] stay with [person] when they don't have too. Even when their shifts have ended they will stay through the night, so [person] is never on her own.

The care has been top notch."

For two people who were nearing the end of their life, the service had worked collaboratively with other healthcare professionals to ensure the person experienced a comfortable, dignified and pain-free death. This included ensuring appropriate equipment, medicines, healthcare treatment and spiritual support was in place. The District Nurse told us, "I think this is one of the best care homes we visit. The staff always follow advice and guidance. Palliative care is excellent. The staff are very caring."

Good

Is the service responsive?

Our findings

We observed people and staff together in the communal areas. They chatted and joked with each other continuously. Staff responded well to those who gestured for help because they did not have verbal communication. There was laughter and free communication between staff and people. Each person had a communication care plan, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, angry or in pain and how staff should respond. Care workers and the manager communicated with people in an appropriate way according to their understanding.

People's needs were comprehensively assessed at the time they were admitted to the service. This included communication needs, personal care, continence, mobility and nutrition. Further assessments were carried out regarding moving and handling and any risks to people. They were legible and securely stored. They were person centred and people's choices and preferences were consistently documented. The care plans we looked at contained meaningful information about people's social and personal histories. It was possible to 'see the person' in these documents.

Each person's care plan contained detailed information about people's care needs and actions required in order to provide safe and effective care. Some people had diabetes. Their care plan's contained clear and concise information for staff concerning the management of this. For example, we noted people were assessed as being at risk of developing a pressure sore due to immobility. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration. They had been placed on an air mattress, the pressures of which were calibrated and regularly checked. The District Nurse told us there was no one with pressure sores greater than grade 2 (superficial) and that the staff "follow all instructions and turn people regularly". This was confirmed by a relative who told us the staff "turn my [person] regularly, they do everything, they make sure that she has mouth care as well." Care plans and risk assessments were reviewed at regular intervals and were updated to show changing needs were addressed.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way, for example, in relation to chiropody, eye care or GP. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

Most people were able to be directly involved in their care planning and relatives confirmed they were able to be involved if they wished. Three relatives we met said they did not need to be involved as they were able to chat to staff or the manager at any time. However, the opportunity was there. People had consent forms in their care plans, which asked when people would want their loved ones to be contacted. People who used the service had monthly meetings where they discussed topics that were relevant to them and the

service such as social activities and meals.

The activity coordinator managed a mixture of external and internal activities for people including word and puzzle games and regular visits from companies offering entertainment. There was a full timetable available with dates and times of what activities were available and when. On the day of the inspection, we observed people looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. We observed one person asking to watch a film that they had missed at the weekend. We observed the activity coordinator set up the film for the person to watch. People who had a particular interest in gardening had an allocated area in the garden where they could grow fruit and vegetables. A hairdresser visited the home each week. People told us they enjoyed engaging with the hairdresser.

Records demonstrated that people attended a wide variety of activities, for example Church, bingo and musical events. Some records reviewed had daily activity charts completed and daily records recorded activities that people had participated in that day.

Due to people choosing to spend most of the day in the communal areas, they were able to interact with staff and watch what was going on, so there was a low risk of isolation. The small number of individuals who chose to remain in their bedrooms received 1:1 time with the activity coordinator. Activity records demonstrated they chose to relax in their rooms, listening and watching their preferred radio station and television programmes. Activities such as art, exercises and memory games, were also supported in people's bedrooms. This ensured the risk of people being socially isolated was minimised.

The manager and her team had made every effort to ensure that the environment was as conducive as possible to supporting people who lived with dementia in having a structured, meaningful day. The first floor lounge was well thought out. It had lots of interesting objects that could be picked up by people and interacted with. We also observed seating areas along the hallways where people could rest and where dementia friendly activities were placed for people to engage in.

The complaints policy included clear guidelines on how and by when issues should be resolved. It contained details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The provider responded to complaints effectively and in line with their complaints procedure. There was an accessible complaints procedure in place and on display in the communal areas. People knew who to speak with if they had any concerns or complaints. People confirmed they could talk to staff and felt listened to. Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was discussed with the person as part of their monthly resident meetings in a format the person was able to understand.

We noted the provider had received a number of compliments, in the form of cards, letters and e-mails, from people and their relatives since our last visit. All expressed a high degree of satisfaction with the care provided.

Good

Is the service well-led?

Our findings

It is a condition of the provider's registration that a registered manager is in post at this location. The registered manager had left the service in August 2017. The provider had a nursing home, next door to Mary Chapman Court; the registered manager for that location has submitted an application to register with the Commission. Meaning they intend to have a dual management role supporting both locations. There was an acting deputy manager in post with a tier of senior staff.

We asked staff about the vision and values of the service. One staff member said, "Our aim is to provide a safe service and for the needs of people to be met in an individualised way." Another staff member said, "It's to offer reassurance to families and be able to provide a real quality of life to people." Staff demonstrated the importance of offering each person a personalised service and each person being highly valued.

Staff said that they felt fully supported and that the manager was approachable. Staff confirmed that the manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence.

The manager completed a range of quality monitoring audits. These included medicines, accidents, incidents, safeguarding, pressure wounds, complaints and health and safety. In addition to these, the compliance manager completed quarterly quality audits. On the audit form there were details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details, outcome i.e. closed, on-going, no further action. The form also included a section for recording any details of any trends developing and noted actions taken. Records demonstrated that information from the audits was used to improve the service and information recorded used to reduce risk of untoward events occurring.

An audit to review compliance with CQC standards and regulations was completed in September 2017 by the quality and compliance manager and manager. This was carried out as part of the home's internal quality monitoring programme. At the previous assessment during August 2017 five areas were recommended for improvement. These included a health and safety meeting to be arranged, implement a checklist evidencing staff were trained to use fire equipment and for the first aid box to be checked weekly. All recommendations had been addressed by the manager. Therefore quality assurance measures had been implemented effectively to ensure the service continuously improved and addressed concerns in a timely way.

Staff told us they attended staff meetings where they could discuss the care of individuals and any updates to policies and procedures. Staff said they felt supported and said there was a culture where they could ask for support and training to enhance the standard of care they provided.

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose, the last CQC report and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent people and their relatives annually with the last being in 2016. We noted all expressed a high degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.