Norse Care (Services) Limited

Mayflower Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 04 June 2018 and was unannounced.

Mayflower Court is registered to provide care for up to 80 people. The home supports older people all of whom were living with different forms of dementia. The accommodation comprised of a new purpose built building over two floors. Mayflower Court is part of the Bowthorpe Village. This includes a 'housing with care scheme' The Meadows. This is part of the Bowthorpe Village and was inspected separately and was not part of this inspection. There were 80 people living in the service at the time of our inspection visit.

Mayflower Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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. The registered manager shared that they would soon be leaving their employment with Norse Care (Services) Limited. The registered manager told us, a manager from another Norse Care Home would be transferring to Mayflower Court on a permanent basis and would be making an application to register with the Commission in due course.

At the last inspection on 16 and 17 March 2017 the service was rated 'Requires Improvement.' The report was published in June 2017. At that inspection we identified three regulatory breaches' of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was due to the registered manager failing to ensure that people's emotional and social needs were met by staff. People were not always treated with dignity and respect. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. We also found the service was in breach of one regulation of the Care Quality Commission (Registration) Regulations 2009. This was due to the service failing to notify us of significant incidents in a timely way.

Since our last inspection, we have continued to engage with the registered manager. We required the registered manager to complete an action plan to show what they would do and by when to improve the key questions is the service safe, effective, caring, responsive and well-led to at least good.

At this inspection, we confirmed that the registered manager and provider had taken sufficient action to address previous concerns and comply with required standards. As a result, at this inspection we found significant improvements had been made and maintained, resulting in the overall rating and each key question being changed to, 'Good'.

There were systems, processes and practices to safeguard people from situations in which they may

experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff had been appointed.

Overall medicines were managed safely and staff had a good knowledge of the medicine systems and procedures in place to support this.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Training was provided to staff to meet the needs of people. Staff received regular supervision and appraisal and told us they felt supported in their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

People's nutrition and hydration needs were catered for. A choice of meals were available three times a day and drinks and snacks were made readily available throughout the day.

In addition, people had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

There was an extremely positive caring culture within the service and we observed people were treated with dignity and respect. Dignity was embedded in the services' values and culture.

People's wider support needs were catered for through the provision of daily activities provided by activity coordinator, care staff and visiting entertainers.
They were also supported to express their views and be actively involved in making decisions about their care as far as possible. Confidential information was kept private.

People received personalised care that was responsive to their needs. Care staff had promoted positive outcomes for people who lived with dementia including occasions on which they became distressed.

There was a complaints policy and procedure made available to people who received a service and their relatives. All complaints were acknowledged and responded to quickly and efficiently. In addition, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met.

There was a range of quality audits in place completed by the management team. These were up-to-date and completed on a regular basis.

All of the people we spoke with told us they felt the service was well-led; they felt listened to and could approach management with concerns. Staff told us they enjoyed working at the service and enjoyed their jobs.

The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. In addition, the management team worked in partnership with other agencies to support the development of joined-up care.

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.

Care staff knew how to keep people safe from the risk of abuse.

People had been supported to avoid preventable accidents and untoward events.

Overall medicines were safely managed.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were employed to support people.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

People enjoyed their meals and were helped to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Positive outcomes were promoted for people who lived with dementia.

People told us that they were offered the opportunity to take part in a range of social activities.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well led.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Mayflower 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 checked 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.

We visited the service on 04 June 2018 and the inspection was unannounced. The inspection team consisted of three inspectors and one specialist nurse advisor. There was also two experts by experience. An expert by experience is a person who has personal experience of using this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, 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.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. 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 breakfast and lunchtime meal, medicines administration and activities.

We spoke with 16 people who lived in the service and with six relatives. We spoke with the registered manager and deputy manager. We spoke with two team leaders, six members of care staff, one domestic employee, one activity co-ordinator and the chef. During our visit we were able to speak with two visiting healthcare professionals who gave us permission to share their views in this report.

We looked at the care plans and associated records for nine people, including medicine 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 staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

At the last inspection in March 2017 we rated this key question as 'Requires Improvement'. We found that people's medicines were not always managed in a safe way. We concluded that improvements needed to be made to ensure people received their medicines safely and as the prescriber intended.

At this inspection, we found improvements had been made and maintained, resulting in the rating being changed to, 'Good'.

Overall at this inspection we found that the necessary arrangements had been made to ensure the proper and safe use of medicines. In May 2018 the provider had reported to us and to the local safeguarding authority that six people had not been administered their evening medication as prescribed. This had been identified the following day and we found this to be an isolated incident. The registered manager referred the incident to the GP who visited the six individuals the same day and concluded there had been no medical impact for the six individuals affected. The registered manager arranged for an immediate investigation and found it to be a staffing error. Consequently the staff involved were suspended from administering any further medication until they had been retrained and assessed as competent. We saw a system available for reporting and investigating medicine incidents or errors, to help prevent them from happening again.

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. However we found the temperature records were not always complete. We found this had not had an impact on the safety of medicines but was a recording issue. We fed this back to the registered manager who provided assurances this would be included in the medication audit in the future.

We found the storage of medication was in a room shared with medication belonging to other people in another service on the same site, for the same provider. This meant staff from both Mayflower Court and from the other service had shared access. We concluded this was a security risk and fed this back to the registered manager. The registered manager was receptive to our feedback and took immediate action while we were on site. The registered manager ensured the door had a key system and changed the existing code for access. This meant staff not employed to work at Mayflower Court no longer would be able to access the medication storage room. The registered manager removed the small amount of medication not belonging to people in Mayflower Court and transferred it to the people it was prescribed to in the other service. We concluded the security risk had been adequately addressed and was no longer a risk.

There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and allocated care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that

people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. 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.

One person told us, "My instinct tells me I'm safe here. I know if I get poorly I'll be looked after." Another person told us, "It's good here. I feel safe here, it's very nice."

A relative told us, "[Person] is very ill; she does spend a lot of time in bed. I hope that changes but she is safe. She's at risk of falling out of bed and I asked if they could put rails up. They haven't but they've lowered the bed and put soft mats down so if she does fall she shouldn't hurt herself."

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 checked to see if they were in pain or needed assistance, which we observed.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls.

We viewed nine people's care records which included risk assessments regarding nutrition, possible falls, diabetes, choking and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff.

Moving and handling assessments gave staff clear guidance on how to support people when moving them. We observed people were safely moved from chairs to wheelchairs and to sit at the dining table. We observed staff communicating with people during transfers to check people felt safe and comfortable. 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.

We found risks regarding 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 viability service for pressure area care. People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas. Three people 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 viewed records of when people were repositioned which were also being audited daily to ensure people were being safely supported as instructed in their care plan.

Risks regarding falls were completed. Appropriate referrals had been made for physiotherapy services where people were at risk of falls. Each person had a falls diary that was analysed monthly. Results from this analysis demonstrated falls had reduced from 01 April 2018 to 01 June 2018. The impact of this meant people's mobility were being safely and effectively supported.

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. An environmental risk assessment was in place which identified risks to people, staff and visitors. Weekly, monthly and quarterly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

The registered manager told us that suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. We saw that the registered manager had established how many care staff needed to be on duty at each time of the day based upon an assessment of the care each person required. This was reviewed as a minimum monthly. We were told that there were always 12 carers and two team leaders in the building from 8am to 8pm. Rotas we sampled reflected what we had been told.

Changes had been made to staffing levels recently to take into account the needs of people using the service. The registered manager had introduced an additional member of staff on each floor known as a floater. Their role was to work on either floor supporting staff as and when needed. The team leaders also stated they were on the floor either supporting to deliver care or carrying out audits of the care provided and liaising with relatives and other health care professionals.

The registered manager told us if agency staff were needed, they were allocated from an approved list. To ensure people were supported safely, we were told, they requested specific agency staff who knew the home to cover shifts and records confirmed this. Records confirmed that agency staff received an induction when first working at the home and given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking.

We were provided with information about how the company performance managed staff and they had a robust system of staff support in place. Sickness was closely monitored and staff attended back to work interviews. We were provided with figures, which showed sickness levels amongst staff were reducing, and had gone from 12% to 4% in four months from November 2017 to February 2018. The use of permanent agency staff had also decreased, as most agency usage was to cover staff sickness.

In addition to the care staff, the service had a team of domestic staff on shift each day. The service had one chef each day and one activity coordinator who worked Monday to Friday. This enabled the care staff to attend to people and their needs. The activity coordinator told us, they helped supervise and manage a team of volunteers and a befriender who visited people.

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.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

There were suitable systems to protect people by the prevention and control of infection. Records showed that the management team had assessed, reviewed and monitored what provision needed to be made to ensure that good standards of hygiene were maintained in the service. We found that the accommodation was clean and had a fresh atmosphere. We also noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean. In addition, we noted that soft furnishings, beds and bed linen had been kept in a hygienic condition.

Overall we saw that care staff recognised the importance of preventing cross infection. They were wearing clean uniforms, had access to antibacterial soap and regularly washed their hands.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the need to refer people to specialist healthcare professionals who focus on helping people to avoid falls. They also included practical measures such as when using agency staff they are always paired with an experienced carer who was employed by the service.

Good

Is the service effective?

Our findings

At the last inspection in March 2017 we rated this key question as 'Requires Improvement'. We found the staff team did not consistently have the skills and knowledge to support people who were living with dementia. We also found some people's needs with eating and drinking were not always managed in an effective way.

At this inspection, we found improvements had been made and maintained, resulting in the rating being changed to, 'Good'.

One person told us, "I really like it here, everyone's so nice and friendly, I can't fault it, they [staff] know what they are doing."

A relative told us, that the staff were skilled to do the role they did and told us, "it means I am able to relax."

The registered manager maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the registered manager to monitor when this training needed to be updated. These courses included food hygiene, fire safety, first aid, health and safety, infection control, moving and handling, equality and diversity and medication. Additional training was available to staff in specific conditions such as mental health, end of life care and diabetes. Staff also received on-going refresher training to keep their knowledge and skills up to date.

All staff had training in dementia care. Staff told us they had become a dementia friend. This was delivered through the Alzheimer's association and is a scheme, which provides training about dementia and the impact this has on individuals, families and the wider community. The Alzheimer's association provide training and resources but in return expect people who have received the training to deliver the training to others to increase awareness and knowledge of the prevalence and effects of living with dementia.

We found that care staff knew how to care for people in the right way. An example of this was care staff knowing how to provide clinical care for people who lived with particular medical conditions. Other examples were care staff knowing how to correctly assist people who experienced reduced mobility or who needed help to promote their continence.

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.

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. These 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.

Without exception all of the staff we spoke with, told us teamwork among the care staff was positive and that morale was good. Staff received monthly supervisions with the registered manager or deputy manager and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

We found records demonstrating other ways staff were supported. This was through staff monthly meetings. Minutes of these discussions demonstrated staff discussed people's needs, activities, changing policies and procedures, safeguarding and training needs.

Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

Some staff had a lead role within the service. This meant they had oversight of this area of practice and specific duties in relation to their lead role, including keeping up to date with any key changes of legislative practice. They also ensured staff were aware of their responsibilities and were complying with the company's policy and any other legislation. For example, we spoke with the infection control lead. They told us about the auditing schedule they had developed and how they encouraged all staff to take responsibility for good infection control practices and use of personal protective equipment. They said they carried out observations of staff practice, which helped them assess if staff were conforming to policy. They said they would explain to staff the reasons for things being in place to help staff understand why they must comply. In addition to an infection control lead, there were other champions for another sixteen areas of health care and related regulated activity.

One person told us, "The food is very good, I have no complaints at all about it." Another person told us, "The food is good and there's plenty of it."

We were present at lunch time and we noted that the meal time was mostly a relaxed and pleasant occasion. The dining tables were neatly laid, people were offered a choice of dishes and the meals were attractively presented. The service had a pictorial menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow.

Stocks of food included fresh vegetables and fruit and the chef told us dishes were homemade from fresh ingredients. 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.

People's nutritional needs were assessed and care plans recorded where people needed support with eating and drinking. Where people had problems with eating and drinking, referrals were made to the GP, dietician or Speech and Language Therapist (SALT). Copies of SALT reports were included in people's care records so staff knew the type of support people needed. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed

these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Some people's food and fluid intake was monitored, which was recorded and showed people had sufficient to eat and drink. People's weight was monitored and recorded. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed them receiving.

We found that robust arrangement s were in place to assess people's needs and abilities before they used the service. This involved meeting with the person and completing a needs assessment, by gathering information from them and any relevant health and social care professionals. We looked at recent records which showed a wide-ranging needs and preferences assessment had been carried out, including the person's capacity to make their own decisions. It was apparent the person had been involved with the process and had signed in agreement with the outcomes of the assessment. People were encouraged to visit the service, for meals, activities and short stays. This was to actively support the ongoing assessment process and provide people with the opportunity to experience the service before moving in.

The service had policies and procedures to support the principles of equality and human rights. This meant consideration was given to protected characteristics including: race, sexual orientation and religion or belief. Records also showed that the registered manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care. One relative told us, "I have seen no evidence of any discrimination."

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.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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.

Staff had received training of the MCA and DoLS and as part of their dementia training. Our observations confirmed staff promoted choice and acted in accordance with people's wishes.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff readily having to hand over important information about a persons' care so that this could be given to ambulance staff if someone needed to be admitted to hospital.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

Two visiting healthcare professionals stated the service and care delivered had improved a lot since the previous inspection in March 2017. They told us, the service had now established a system whereby a form is filled in at 10am every morning, based on hand over notes regarding any health issues that have been raised. The team leader then enters this into a paper diary and gathers the information for the visiting professionals. The list of issues or concerns for each person are then triaged by visiting healthcare professionals. Every two to three months a review takes place, with the person, their relatives, the team leader and healthcare professionals, to review any actions and discuss outcomes.

We were shown evidence that this established system had resulted in improved pressure sore grades. People who had been identified as being at risk of developing pressure sores had risk assessments which included contributory factors, such as mobility, continence, nutrition and hydration and their diabetic state. Pressure sores are graded between one and four, one being the mildest form. One healthcare professional told us, "They [staff] are now on the ball."

Mayflower Court also had clinical multi-disciplinary health meetings (MDT) which were held weekly where the registered manager or deputy manager, team leader, GP and other healthcare professionals would attend, to discuss people's health needs. One of the healthcare professionals who attended these meetings told us, the care of people identified as at risk of choking is now mainly managed in house, under the guidance of the SALT team. They explained that now the care team 'nip in the bud' any potential issues and refer to the MDT weekly meeting's.

One healthcare professional told us, "We have a really good relationship with the staff at Mayflower Court. The staff know the residents very well and they often only need reassurance from the nursing team. They [staff] have some real poorly people who are still able to walk and are hard to manage, they are amazing with them."

One person told us, "I like my room, I've got it the way I want it and it's comfortable." We noticed one person had a bookcase full with books, the person told us, "I read a lot, I really like to and because I have Alzheimer's it's important I keep mentally active. There's a library here too, a small one but it's good." Another person told us, "I'm only here for a few weeks. I will be going home but I was told if I wanted to have some of my photos and pictures up then I could."

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. There was sufficient communal space in the dining room and in the lounges. In addition, there was enough signage around the accommodation to help people find their way around. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Good

Is the service caring?

Our findings

At the last inspection in March 2017 we rated this key question as 'Requires Improvement'. We found one breach of regulation. We observed staff not interacting or acknowledging people. We saw staff walk past people when they were clearly distressed. At these times staff did not stop and offer support or assistance.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and the regulation was now met, resulting in the rating being changed to, 'Good'.

One person told us, "I am very happy here, I think the staff are wonderful." Another person told us, "The staff are very friendly. The staff know me as a person and they know what I like and don't like." Another person told us, "I think they [staff] know me quite well as a person." A fourth person told us, "I would describe my relationship with the staff as pretty cordial." A fifth person told us, "The staff are nice and I have no problems with them at all."

More people we spoke to told us, "They're [staff] all very good, very kind. Even people who aren't carers like the cleaners and kitchen staff, they are lovely." "I'm pleased I came here, the care is very good."

One relative told us they visited every day and that they were "happy for [person] to be here." They had observed their loved one to be relaxed in the environment, putting their feet up and smiling. The relative told us the person understood their living environment and they had told them they were happy. Another relative told us, "They [staff] have been great. All my requests have been granted, such as moving [person] upstairs as they found down stairs a bit noisy." The relative told us, they visit four times a week and had a very good relationship with the staff. Another relative told us, "I've seen them [staff] talking with other residents and they hold their hands and are very loving towards them." A fourth relative told us, they visited whenever they wanted which can be late in the evening. The relative told us, no one is "too busy to have a conversation with anyone" and "[Person] feels this is now home."

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

Records indicated there were a number of people with a diagnosis of dementia, we observed staff interacting effectively with people with in a calm, friendly manner. Throughout the inspection the atmosphere was relaxed and there was no evidence of people experiencing distress.

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed

positive conversations that promoted people's wellbeing. Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms. We observed staff kneeling to speak with people, stroking their arms and backs and calling them by their names.

We asked whether people could make choices about the way they were living. One person told us, "I generally like to stay in my room reading and studying. I'm doing an Open University course in Art." Another person told us, "I can go out if I want to but someone needs to come with me." We asked if the person minded that and they said "No, I don't really know it round here so I might get lost." Another person told us, "I decide when to get up and go to bed. They [staff] might come in and suggest it's bedtime but they don't make me go to bed, if I want to stay up a bit longer I do."

Records demonstrated that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night. People were asked if they would prefer a bath or shower. Whether people wanted to be supported with having a wet or electric shave. Records demonstrated that choices were being met and documented.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Care plans included people's preferences around clothes and gender of care staff they wished to be supported by.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. People had the opportunity to attend church services within the service. Staff told us holy communion was held and different religions were known and respected. We asked for an example of how this was put into practice and staff said they could do an alternative Christmas for anyone who did not celebrate Christmas.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

We found that people could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.

Good

Is the service responsive?

Our findings

At the last inspection in March 2017 we rated this key question as 'Requires Improvement'. We found one breach of regulation. The service had failed to ensure that people's emotional and social needs were met by staff.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and the regulation was now met, resulting in the rating being changed to, 'Good'.

The service employed an activity coordinator to plan and organise activities. They also managed a group of volunteers and a befriender. The activity coordinator worked 37 hours per week and had two part time staff and eight volunteers who helped deliver activities.

There was an activity schedule, which was widely available across the service and showed planned activities from Monday to Sunday. Planned activities were appropriate to people's needs and offered the opportunity for both group and one to one activity. Staff were flexible in their approach depending on the needs and wishes of people on the day. Activities included music, movie nights, sensory stimulation, (sensory boxes, and touch boards) flower arranging, card games and comedy. Coffee mornings were held which were extended to families. Trips out were planned every other week. Examples given of recent activity included bowling and a trip to the zoo.

The activity coordinator told us there was also support from the local community including projects involving school children, the brownies/rainbow group who had won an award for their intergenerational work.

The service had introduced golden tickets. This was a record of any spontaneous activity initiated by staff or people using the service. For example, if a staff member supported a person for a walk into the garden, to the café for a drink or spent time with them across the day this was recorded on the golden ticket. These were displayed around the service and demonstrated how staff were regularly engaging with people and enhancing their well-being. This approach encouraged a personalised approach to care where all staff took responsibility for ensuring people had opportunity for meaningful engagement and activity.

Other initiatives included a 'resident' of the day, where staff presented the person with flowers for females and toiletries or other gifts for men and a trip to the café. There was a wishing well where once a month the provider would grant a person their special wish. We discussed this with the registered manager as this demonstrated good practice but needed to be extended to help ensure people routinely had their wishes met.

During our inspection we observed staff engaging appropriately with people and enhancing their well-being. Within the complex of Mayflower Court, there was a library, hair dressers and general shop. There was also a restaurant and café. Families could come as they pleased and meet their relatives at the service and go for

coffee/ lunch.

There was information around the service showing what was planned including activities, forthcoming events, planned meetings and photographs of different things people had participated in. There was information about 'resident' of the day and people's birthdays. Relatives when coming in could see what had been happening or was planned helping to keep them informed.

People had detailed social histories which staff were aware of and helped them to provide greater personalisation around people's individual needs. The social histories/profiles gave staff an insight in to the person's life experiences and what was important to them. We saw photographs and emphasis on what people had achieved in their lives. The service continued to support people to achieve and pursue their own interests.

People told us, staff had carefully consulted with them about how they wanted their personal care delivered. Overall care plans were being reviewed monthly to make sure that they accurately reflected people's changing needs and wishes. Other records confirmed that people were receiving the personal care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing, changing position safely and promoting their continence.

We saw that care staff were able to promote positive outcomes for people who lived with dementia. The management team had made appropriate referrals to the Dementia and Intensive Support Team (DIST) when required. The DIST team offer assessment and interventions for adults with age related needs suffering from mental health problems including anxiety, depression, confusion and dementia.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home.

Good

Is the service well-led?

Our findings

At the last inspection in March 2017 we rated this key question as 'Requires Improvement'. We found two breaches of regulation. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. The service failed to notify us of significant incidents in a timely way.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and both the regulations were now met, resulting in the rating being changed to, 'Good'.

The registered manager had a clear understanding of the important events that they must notify, by law, the Care Quality Commission (CQC) about. The records we hold about the service confirmed this.

The management team in place included the registered manager, two deputy managers, supported by the area manager and provider. The staff rota had been arranged to ensure there was always a manger/team leader on duty to provide leadership and direction. There was an administrator providing additional management support. We found the managers had an 'open door' policy that supported ongoing communication, discussion and openness.

The service's philosophy of care, vision and values was reflected within the written material including, the guide to the service, staff induction and policies and procedures. There were displays at the service which promoted dignity and dementia awareness. Some staff had been given 'lead roles' on specific work themes, such as 'dignity champion,' 'infection control champion' and a 'dementia friend.'

There was a welcoming and friendly atmosphere at the service. We observed numerous positive interactions between people who used the service, staff and managers. Staff spoken with expressed an understanding of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions and a code of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates.

We noted that each shift was led by a team leader. These members of staff shared an office and worked closely together. We heard them discussing the personal care needed that day by each person who lived in the service. We then noted that this discussion was reflected in the tasks we saw care staff being asked to complete. In addition, we were present when the care staff met to hand over information from one shift to the next. We noted the meeting to be well organised so that detailed information could be reviewed in relation to the current care needs of each person.

Quality assurance systems were in place that included audits by the registered manager and deputy manager. We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. Systems included: finances, medicines management, accidents, activities, housekeeping, health and safety, falls, infection

prevention and control and care plans. We noted examples where shortfalls had been identified and addressed. The registered manager had introduced 'spot checks' to ensure people were receiving safe and effective care. The area manager carried out compliance visits on behalf of the provider; this involved ensuring the audits were completed and actioned.

One relative told us, "[Registered manager] is approachable and always has time to speak to me." Another relative told us, "The manager has always been available to meet with us when needed. The care home is well led. I can see staff are well supported, because they are always smiling. I think its evident when a team of staff are not being supported because it will show in their work. The staff are lovely."

We found that the registered manager understood and managed risks and complied with regulatory requirements. Records showed that the registered manager had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all of the key questions we ask when assessing the quality of the care people receive. Furthermore, we saw that the registered manager had suitably displayed the quality ratings we gave to the service at our last inspection.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend joint residents' and relatives' meetings at which they had been supported to suggest ideas about how the service could be improved. We noted a number of examples of suggested improvements being put into effect. An example of this was changes that had been made to the menu so that it better reflected people's changing preferences.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in October 2017. We noted all expressed a 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.

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

Care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. They told us they were sure that any concerns they raised would be taken seriously by the registered manager so that action could quickly be taken to keep people safe.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the provider recognised the importance of ensuring that people received 'joined-up' care. One of these involved the provider's membership of a county-wide association that worked to identify how commissioners and service providers could better develop a cross sector approach to delivering high quality care.