The Royal British Legion

Mais House

Inspection report

18 Hastings Road
Bexhill On Sea
East Sussex
TN40 2HH

Tel: 01424215871
Website: www.britishlegion.org.uk

Date of inspection visit:
10 August 2017
15 August 2017
22 August 2017

Date of publication:
19 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Mais House on the 10 and 15 August 2017. We also visited on the 22 August 2017 to feedback about the inspection and its findings to the registered manager as she was on annual leave during the second day of the inspection.

Mais House provides accommodation, personal and nursing care for up to 54 older people living with a range of physical health problems, such as Parkinson's disease, diabetes, strokes and cancer. There were also people who were now living with early stages of dementia and those who were receiving end of life care. There were 46 people living at the home at the time of our inspection. Accommodation is arranged over two floors on the residential wing and three floors on the nursing wing. Each person had their own bedroom. The home is divided into two units, nursing and residential with communal areas shared by both units. Access to each floor is gained by a lift, making all areas of the home accessible to people. The outside areas are safe and attractive with areas for people to enjoy. The garden areas were accessible for those who required assistance.

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

At a comprehensive inspection in 28 and 30 October and 02 November 2015, the overall rating for this service was Inadequate and it was placed into special measures by the Care Quality Commission (CQC). Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by May 2016. During our inspection on 22 and 24 June 2016, we looked to see if improvements had been made. We found that the breaches of regulation had been met but needed time to be embedded in to everyday care delivery and Mais House therefore was rated as requires improvement.

This unannounced comprehensive inspection was carried out on 10 and 15 August 2017 to see if the improvements had been sustained. We found that whilst improvements had been sustained there were areas that still required further improvement.

People's health needs were monitored but not all were effectively managed and followed up in timely manner. When peoples' blood sugars were higher than the normal range, action had not been taken. There was also no recorded timely follow up to see if the blood sugar level had reduced to the normal range. A quality assurance system was in place. However some areas of documentation such as wound care and medicines administration records needed more oversight to ensure they were completed consistently, correctly and information was appropriately recorded.

Care plans were reflective of people's assessed level of care needs. Risk assessments included those for falls, skin damage, nutritional risks and moving and handling risks. For example, cushions were in place for those

that were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and epilepsy. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. Staff had received training in end of life care supported by the local hospice team. There were systems in place for the management of medicines and people received their medicines in a safe way.

Nurses were involved in writing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The manager said care staff were being supported to do this and additional training was on-going. Food and fluid charts were completed and showed people were supported to have a nutritious diet.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. People were seen in communal lounges for activities, meetings and meal times and were seen to enjoy the atmosphere and stimulation. A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the whole day, seven days a week and was in line with people's preferences and interests.

Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service and relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people moved into the home. The provider had made training and updates mandatory for all staff, including safeguarding people, moving and handling, management of challenging behaviour, pressure area care, falls prevention and dementia care. Staff said the training was very good and helped them to understand people's needs. All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC.

Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, registered manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff said the management was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and, they would be happy to talk to them if they had any concerns.

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

Mais House was safe. There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Requires Improvement

Mais House was not consistently effective. People's health needs were monitored but not all were effectively managed and followed up in timely manner.

Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).

Staff received training which was appropriate to their job role. This was continually updated so staff had the knowledge to effectively meet people's needs. They had regular supervisions with their registered manager, and formal personal development plans, such as annual appraisals.

People received a nutritious and varied diet. People were provided with menu choices and the cook catered for people's dietary needs. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

Mais House was caring. was caring. Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were

treated with respect and dignity.

Each person's care plan was individualised. They included information about what was important to the individual and their preferences for staff support.

Staff interacted positively with people. Staff had built a good rapport with people and they responded well to this.

Is the service responsive?

Good

Mais House was responsive. Care plans demonstrated how they responded to people's individual needs. Some people told us that they were supported to make everyday choices, such as where they spent their time.

There were activities for people to participate in as groups or individually to meet their social and welfare needs. This was confirmed by discussions with people.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.

Is the service well-led?

Requires Improvement

Mais House was not consistently well led. Whilst we saw improvements had been made, there were areas that still needed to be embedded in practice to ensure that improvements were consistently sustained.

A quality assurance system was in place. However, some areas of documentation needed oversight to ensure they were completed consistently and information was appropriately recorded.

The registered manager and staff in the service were approachable and supportive.

There had been a number of positive changes made to the day to day running of Mais House and there was a clear programme in place for continual improvement.

Mais House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on the10 and 15 August 2017 and was unannounced. We also visited on the 22 August 2017 to feedback about the inspection and its findings to the registered manager as she was on annual leave during the second day of the inspection.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with 12 people who lived at the home, five visiting relatives, eight care staff, three registered nurses, two cleaners, the area manager, the registered manager and the activity co-ordinator. We also contacted external health professionals, such as the paramedic practitioner, GP and speech and language therapists to gain their views of the service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at four care plans from the nursing floor, one respite care plan and three care plans from the residential wing. We also looked at risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Mais House this is when we looked at people's care documentation in depth and obtained their views on how they found living at Mais House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People told us they felt safe living at Mais House. One person told us, I feel very secure living here." Another person said, "I have no concerns, I'm happy and safe here." Relatives said, "All the staff are very good, they know how to keep people safe." Another relative told us their family member was safe and settled and they did not worry about their safety. Staff expressed a strong commitment to providing care in a safe and secure environment.

Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. There were risk assessments for health related, social and environmental needs, such as skin integrity, nutrition, falls and mobility in and out of the premises. Risk assessments and care plans demonstrated how people's health and well-being was being protected and promoted. For example, continence care was identified and a plan of action for staff to follow such as regular visits to the bathrooms and application of topical creams was in place. Care plans contained information to guide staff on how to maintain people's skin integrity and prevent pressure ulcers.

People were supported to move safely. We observed people being supported to move from a wheelchair to armchair with the support of appropriate equipment. We saw staff were mindful of the person's safety and well-being throughout. Staff offered support and reassurance and people told us they felt safe whilst being moved by staff. One person said, "I trust them to keep me safe." People's care documentation and risk assessments reflected the lifting equipment and size of sling to be used. People had their own personal sling which reduced the risk of cross infection.

A system was in place to record accidents/incidents with actions taken to prevent them as far as possible. Accidents were recorded with information about what had happened, such as an unwitnessed fall in a person's bedroom or in the communal areas. The information recorded included action taken to prevent a further accident, such as increased checks and a sensor mat. Audits were carried out for the accident/incident forms to ensure sufficient information was recorded. Accidents were reported to the local authority in line with safeguarding policies.

Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts indicated that medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered correctly. People confirmed they received their medicines on time. One person told us, "I get all my medicines when I need them." There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. People's medicines were securely stored in a clinical room and they were administered by registered nurses and senior care staff who had received appropriate training. We observed two separate medicine administration times and saw that medicines were given safely and that staff signed the MAR after medicines had been taken. The clinical room was well organised and all medicines were stored correctly and at the correct temperature. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

Staff had an understanding of abuse and what action they would take if they had any concerns. They identified the correct safeguarding and whistleblowing procedures should they suspect abuse had taken place, in line with the provider's policy. They were aware that a referral to an agency, such as the local authority, could be made. One staff member told us, "I would always tell the manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know." Another staff member said, "I would not hesitate to report anything that wasn't right." Staff confirmed the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The registered manager said all concerns were reported to the local authority, they then waited for a response before they took any action and records were in place to support this. This meant people were protected as far as possible from abuse.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Staff arrangements included separate staffing on a daily basis for each floor. This was based on the skills and competency of staff and the individual needs of people. For example, each shift on the residential unit required a senior carer with competency in medicines. The nursing unit had two registered nurses to oversee and monitor the clinical care provided. People told us there were enough staff to respond to their needs although they were often 'busy.' We were told, "Really lovely staff, always a smile, they sometimes seem very busy but they always give first rate care." Another person said, "Some days staff seem to be under the pressure but I have never had a worry about there not being enough staff."

We observed people received care in a timely manner and call bells were answered promptly. The registered manager undertook random audits on call bell response times. Staff told us that they worked hard to ensure an immediate response and felt the number of staff on duty allowed them to do so. Staffing levels allowed for staff to support people and to take people into the garden for fresh air. We also saw that staff sat with people in the communal areas chatting and engaging them with different activities whilst other people started to join them.

Recruitment processes were safe. We found staff records included application forms, confirmation of identity and of the person's right to work. The recruitment process included a thorough interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider. These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, fire fighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. Staff had received regular fire training and evacuation training. Staff told us they felt confident they would be able to manage an emergency situation and talked of the organisational on call systems in place.

Requires Improvement

Is the service effective?

Our findings

People and relatives had confidence in the skills and abilities of the staff employed at Mais House. One person told us, "They look after us well, they seem well trained," another person said, "Knowledgeable" and one visitor said, "The staff are all very good, they all know exactly how to respond to X and get the best results." Feedback from visiting health care professionals was positive about the skills and competence of the staff and their willingness to learn. People were complimentary about the food and how they were provided with choice and variety.

People commented they regularly saw the GP and relatives felt staff were effective in responding to people's changing needs. Staff recognised people's health needs could change rapidly and some people may not be able to communicate if they felt unwell. One staff member told us, "We look for little signs, changes in behaviour, strong smelling urine and facial expressions which may indicate something is wrong." To help monitor health needs staff monitored people's vital signs, such as oxygen saturation levels, random blood sugars and blood pressures. However we found that when abnormalities were documented such as a high blood sugar, or a low oxygen level, staff had not followed them up or referred them on to the GP for investigation. The rationale of what staff were monitoring for, for individual people was not documented and therefore care staff would not know when to report a potential health problem to the registered nurse. For example one persons' blood sugar was significantly high and. another persons' oxygen levels were low. These had not reported to the GP or further action taken by the staff team. The impact on people was mitigated as staff took this forward immediately for further investigation. Another person had been seen by an eye specialist and suggestions to assist their reading had not been followed up in a timely and effective way. This was an area that requires improvement.

Staff understood the principles of the Mental Capacity Act (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff undertook a mental capacity assessment on people admitted to the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example, we heard the registered nurse say, "Are you ready for your medicine now, and have you any discomfort." Care staff asked people, "Shall I help you to the bathroom," and "Would you like another cup of tea." Staff were able to tell us that they know people's mental capacity can change quickly and so it was always important to approach people and ask for their consent.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). During the inspection, we saw that the registered manager had sought appropriate advice in respect of these changes in legislation and how they may affect the service. The manager knew how to make an application for consideration to deprive a person of their liberty, such as locked doors and had submitted applications where they were deemed necessary. We looked at the applications and saw that the reasons for applications were person specific and included a rationale.

The management team organised all staff training and worked with staff regularly to underpin what was needed in the training sessions. These sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff received training in safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. Staff also received additional training specific to peoples' needs, for example care of catheters percutaneous endoscopic gastrostomy (PEG), dementia care and end of life care provided by the local hospice. Additionally, there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One member of staff said, "All the staff get training. I have completed a National Vocational Qualification in Care -Level 2 and 3. We all complete mandatory training." From talking with staff we found that they were committed to learning and wanted to develop their skills further. One staff member said, "We are encouraged to learn, and we can put forward training, ideas and the manager will source it."

We saw staff used their training to assist them in their roles within the home. For example, we observed staff assisting people with their meals in a way that ensured they were maximizing their independence, but assisting discretely. We also observed people moving people safely throughout the inspections in hoists and wheelchairs. We saw staff communicated with people by using different techniques displaying empathy and patience.

Staff received on-going support and professional development to assist them to develop in their roles. Supervision schedules and staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns. Feedback from staff and the manager confirmed that formal systems of staff development, including an annual appraisal was undertaken. The registered manager told us, "It's important to develop all staff as it keeps them up to date, committed and interested." Staff told us that they felt supported and enjoyed the training they received. Comments included, "Interesting", "Valuable" and, "The RN (registered nurse) works with us on the floor to make sure we do things correctly."

People told us they had access to chiropodists, dentists, dieticians, opticians and psychologists. People were also supported with attending appointments. Records and discussion with staff confirmed that staff had developed links to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, specialist tissue viability nurses were contacted and involved in planning and reviewing of care for people who had skin damage. Specialist advice was also sought from dementia care specialists who supported staff in providing tailored support to people who could exhibit behaviour that may challenge staff and other people. Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

People told us the food was good and we saw staff asked them what they wanted at mealtimes and offered drinks in between. One person said, "The food is good, lots of choice, we can have seconds." People had an initial nutritional assessment completed on admission and their dietary needs and preferences were recorded. People told us that their favourite foods were always available, "They know what I like and don't like and there is always a choice." A nurse told us, "People have a nutritional assessment when they arrive and we monitor monthly."

People's weight was regularly monitored and documented in their care plan. Some people didn't wish to be weighed and this was respected, and staff said, "We use different ways to monitor their weight such as clothing if they don't want to be weighed." The registered manager said, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT)

and GP." The staff we spoke with understood people's dietary requirements and how to support them to stay healthy. Staff kept the kitchen informed of any changes to peoples' dietary needs and who needed their food fortified. Guidance was readily available in people's care plans about any special dietary requirements such as a soft or pureed diet. One person's care plan had a report which identified they required a 'soft, moist diet'. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this. Staff told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, the chef as well."

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded positively when staff approached them in a kind and respectful way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Wonderful, kind and patient" and, "Always cheerful and ready with a smile." One person told us staff didn't try and rush them to get everything done. One staff member said, "I feel that our staff team is really focussed on caring, we have all learnt and really want to do our best."

People were treated with kindness and respect, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Morning (name)" and, "How are you today." We saw several lovely interactions, staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. We also saw a care staff member sit with a person during a late breakfast and encourage them with eating independently with gentle prompting, "Can I help or are you managing ok ?" and, "Let me help you with that." This enabled the person to retain their dignity whilst accepting help.

The SOFI told us that staff and people engaged positively using verbal and non-verbal communication. During the meal service staff sat alongside people and maintained eye contact whilst assisting people. The pace that staff assisted people was set by the person and not the staff member, which meant that the person was not rushed and enjoyed their meal.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. A relative told us, "They ask us for suggestions and keep us well informed." Staff supported people and encouraged them where they were able to be as independent as possible. Another relative said, "The staff are very caring." The registered manager told us, "People are supported to do what they want when they want."

People told us that staff encouraged and supported them to make everyday decisions and lead a lifestyle of their choice. One person had returned from a trip abroad and had another one planned. They told us, "It's a great relief to be supported by the staff to fulfil my dreams." Another told of us that staff always listened and helped to make decisions if they asked for assistance. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, it's nearly lunchtime." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be as long as they are safe. We give them space and respect their independence" and, "We let people make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." Some people were able to confirm that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the dining area. Staff always ask me." Another person said, "Due to my health I spend a lot of time in bed, but staff do what they

can to relieve my frustration, they pop in all the time and ask me if there is anything I need."

People's preferences were recorded in the care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different; they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and read, rather than participate in activities, were supported to do so.

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private. We would not like everyone to know that we had had an accident and our clothes were wet and needed changing. We just need to imagine how we would feel if it was us or a relative." This showed staff understood the importance of privacy and dignity when providing support and care.
There were people at Mais House who were receiving end of life care. End of life care is when people had been seen by a doctor who agreed to withdraw active treatment due to their frailty and according to their care plan, were to receive 'tender loving care' (TLC). TLC is used in care to describe considerate and solicitous care. Documentation to support this decision was in place and followed NICE guidance. NICE guidelines are evidence-based recommendations for health and care in England. This meant that this care pathway had been discussed, documented and agreed by families and health professionals involved in their care. We also saw that care plans for end of life care delivery included personal care, mouth care and detailed pain control management. Staff had received training in end of life care and the management of pain medicines. We found staff had a good understanding of how to monitor and manage pain relief at this stage of people's life.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "I know that I can express myself and staff will support me." Another person liked to look smart and told us staff ensured that their clothes were clean and pressed, we were also told "I like to wear make-up especially if I am going out, I can't do it myself but staff help me."

Staff said relatives and friends could visit at any time and relatives told us they were always made to feel very welcome. One relative told us, "We are always welcomed and feel at home, tea is always offered. We know all of the staff."

There were various communal areas, these included lounges and dining areas and they were comfortable and provided the feel of being at home. Books, videos and DVDs were displayed for people to use at any time. People were seen enjoying spending time in different areas with family and friends. Outside areas were available and assessable for everyone. There were areas for people to be involved in growing vegetables and flowers and to sit and enjoy the fresh air.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus and activities. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

People liked their rooms and had individualised them to suit themselves with memorabilia, photographs and personal possessions with the assistance of relatives and friends. Relatives said they were involved in discussions about and the planning of people's care and felt able to talk to the staff about this at any time. One relative said, "I know there is a care plan and I get asked regularly for my input." Another relative said, "I am informed of any changes and if my relative is unwell the staff ring me." People commented they were well looked after by care staff and that the service listened to them. One person said, "There are regular meetings, we are encouraged to be involved in what happens in the home."

People commented they felt able to make their own decisions and those decisions were respected by staff. However one person felt that staff had over protected them in respect of their freedom to mobilise and this had impacted on their well-being and had made them feel isolated in their room. The person had been told not to mobilise without staff with them and to ring for assistance. The person felt that this was a restriction and that they should be allowed to make their own decision even if they may be unsteady at times, "I can make my own mistakes." On discussion with staff they acknowledged that they had managed this person's mobility to ensure they were safe and not fully acknowledged the person's right to make their own decisions. Following the discussion they had a meeting with the person and came to a decision that pleased everyone concerned. Staff reflected on the situation and came up with an immediate plan to hold meetings with people to discuss individual and positive and effective risk enablement.

Before people moved into the service a senior staff member carried out an assessment to make sure staff could provide them with the care and support they needed. Following this assessment the possible admission is discussed by the senior staff in the service to ensure a suitable placement and that the admission process is managed appropriately. For example ensuring all appropriate equipment was available before admission. Where people were less able to express themselves verbally or they wanted less involvement people's next of kin or representative were involved in the assessment process. This meant people's views and choices were taken into account when care was planned. One person told us "My daughter was involved and was able to contribute, it's such a big decision to come into a care home."

The assessment took account of people's beliefs and cultural choices this included wishes surrounding people's death. Care plans were written following admission and updated as people's needs changed and on a monthly basis. One day a month was allocated to one person for a full review which was completed in consultation with all staff. Relatives all told us they were kept fully informed of any changes in care and felt they were included and involved as their relatives would want. Care plans gave guidelines to staff on how to meet people's needs while promoting an individual approach. The organisation and senior staff were aware that care plans needed further attention and were progressing this. The registered manager said, "The organisation are looking at changing the care plan system, we are being asked to look at different systems." Following the inspection we were told that Mais House were to trial a new computer system.

Staff had a good understanding of people's specific care needs and responded to them appropriately. For example, one staff member told us "A person had diabetes and staff were in contact with the GP to ensure

the care plan reflected clearly what action to take in response to regular blood test monitoring." Care plans also had specific guidelines to care for people who were at risk from falling or were unable to use their call bells with records confirming hourly checks to be undertaken. Staff were regularly updated about changes in people's needs at handover and throughout the day. During the inspection we saw staff communicating regularly with each other. Staff listened to each other and shared information provided by visiting professionals with care plans updated accordingly.

The service employed specific staff to organise and facilitate activities and entertainment and they worked as part of the team. They knew people well and were attentive to people's individuality and differing needs and abilities. There was a strong respect for the British Armed Forces and the staff incorporated this in to people's life histories and ensured special dates were remembered. Special events were planned to commemorate these. The activity person was available and gave support to people in the group sessions as they needed. Specific people had been encouraged to help organise certain things within the service, for example taking responsibility for ordering and organising newspapers, looking after the fish and organising some military memorabilia to display in the home. These people were proud of being able to contribute to the running of the service. One person said, "I couldn't imagine living anywhere else."

There was a full activity programme that reflected people's interests. This included quiz times, visits out and external entertainers and pet visits. During the inspection we saw people petting dogs which were thoroughly enjoyed by all, including those who remained in bed or in their room. We also saw people being taken in to the gardens to enjoy the sunshine. Outings for people were arranged and people talked of trips out. The bar area had been refurbished and this continued to be a popular meeting place for people to meet before meals and socialise.

There were celebrations and events held in the home which were enjoyed by the people living in Mais House. Photographs of people enjoying events both inside the service and at external venues were also displayed around the home.

Regular staff and resident/family meetings are now being held and we saw that times of meetings were displayed details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the chef.

A complaints procedure was displayed in the reception area of the home and in other communal areas. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log was kept and monitored by the head office of The British Legion. There was also a file of complimentary letters and cards received which were shared with all staff.

Requires Improvement

Is the service well-led?

Our findings

From our discussions with relatives, staff, the registered manager, the provider and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people who lived at Mais House needed and wanted. Relatives and staff said the registered manager was available and they could talk to them at any time. We observed the registered manager greeting and sitting with people and talking to them at various times throughout our inspection. Relatives said the management of the home was good and all staff were always very helpful. One relative said, "The home is very well led, nice atmosphere and calm." People told us, "Its well-led, they listen to us and we are given opportunities to contribute to how the home is run."

Quality monitoring systems had been developed over the past year. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Areas for improvement were on-going such as care documentation. The registered manager said it was an area that they wanted to continuously improve their recording and a new care plan system was on its way.

Whilst there was a quality assurance framework used there were areas that needed improvement. Care plan audits had been undertaken however identified shortfalls from the audit were not always followed up. Wound care records were not clear. We found some old records in the care plans that were dated 2013 and not completed to show the wound had healed or archived. Photographs of wounds did not follow NICE guidance as they were not labelled or measured to evidence healing or deterioration. Some photographs were unidentifiable. We found errors in medicine administration records that had not been identified. For example one medicine a laxative had been written in twice by different staff, staff had only given the medicine once but signed both entries. Another medicine had been signed for as out of stock but had actually been discontinued by the GP. This told us that further improvements were needed to the quality assurance systems used to evaluate the service and drive improvement. This was an area that requires improvement.

All care plans were up to date and reflective of people's needs. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned. Such as laundry service and menu choices. Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence.

There was a new management team which had been working consistently to develop the support and care provided at the home. The manager said, "Whilst we feel we have really improved, we want to continue to improve to deliver really outstanding care." Staff were proud of the improvements they had made, the morale of staff was strong and they worked as a team.

Systems for communication for management purposes were established and included a daily meeting with the senior staff. These were used to update senior staff on all care issues and management messages. For

example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The manager is open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are encouraged to be involved in developing the service here." "I think the management is strong and approachable" and, "I feel sure that if I speak to the manager about anything, something will be done about it. I don't just mean complaints suggestions are encouraged as well and they listen to us."

The service worked in partnership with other key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff are knowledgeable about the people they care for and want to get it right" and, "They listen, take advice and act on the advice."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

The service had notified us of all significant events which had occurred in line with their legal obligations.