Barchester Healthcare Homes Limited

St Thomas

Inspection report

St Thomas Close
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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 was unannounced and took place on the 17 and 18 July 2017.

St Thomas (to be referred to as the home throughout this report) is a nursing home which provides nursing and residential care for up to 72 people who have a range of needs, including those living with epilepsy, diabetes, cancer, sensory conditions such as hearing and slight loss as well as people receiving end of life care. The home provides specialist support to those living with dementia. At the time of the inspection 59 people were using the service.

The home comprises a large two storey building which is set around a central courtyard and garden area which offers seating and shaded areas for people, relatives, visitors and staff to enjoy. It also provides areas of interest such as a pond with ornate metalwork to keep the pond safely enclosed and planting areas with flowers and trees for people to cultivate and enjoy. On the ground floor the home has living accommodation with communal areas including lounges and dining rooms. The ground floor is linked by adjoining corridors which are open to allow people to move freely around the home and the courtyard is accessible to all. The first floor comprises of living accommodation and a hairdresser and barbers area. The first floor is accessible by a lift allowing people access. 69 bedrooms have ensuite toilet and handwashing facilities and three rooms have ensuite shower rooms. Communal bathrooms and accessible toilets are available on both floors. On the ground floor a chapel provided people with the means to meet their spiritual needs and a linked coffee shop area enabled the chapel to also be used as a meeting point for people and their visitors.

The home did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The current general manager had been employed at the home in May 2017 and was in the process of becoming registered with the CQC.

People using the service told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people. People's safety was promoted because risks that may cause them harm had been identified and guidance provided to staff to help manage these appropriately.

People were supported by sufficient numbers of staff to meet their needs. The provider was able to adapt their staffing levels appropriately when required in order to meet changes in people's needs.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely; nurses were responsible for managing medicines and had received

the appropriate training to enable them to complete their role safely. Medicines were stored, administered, disposed of and documented appropriately.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire or flood which may result in the loss of living accommodation. These were accessible to staff and emergency personnel such as the fire service, if required to ensure people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable.

People were supported by staff who received appropriate training enabling them to meet people's individual needs. Staff received regular supervision to ensure they were supported in their role.

People, where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. Records clearly documented that where people lacked the capacity to make specific decisions for themselves that actions taken on their behalf were always in their best interests. Staff sought people's consent before delivering their care and support.

People were supported to eat and drink safely whilst maintaining their dignity and independence. We saw that people were able to choose their meals and were offered alternative meal choices where required. People's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

People's health needs were met as the staff and manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which apply to care homes. The manager showed an understanding of what constituted a deprivation of a person's liberty by the correct submission of relevant applications to ensure people were not deprived of their liberty without legal authority.

People told us that care was delivered by kind and caring staff who sought to meet their needs and ensure they were happy. We saw that people had friendly and relaxed relationships with staff who would stop and speak with them as they moved around the home.

Care plans and risk assessments contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements and promoted their dignity. People were encouraged and supported by staff to make choices about their care including how they spent their day in the home.

People's care plans and risk assessments were reviewed monthly or sooner when required to ensure they remained accurate to enable staff to effectively meet people's needs.

People living with specific health conditions such as epilepsy for example were supported to manage these conditions safely. Guidance regarding the management and monitoring of people's blood glucose levels was available and we saw this guidance was followed in practice.

People knew how to complain and told us they would do so if required. Procedures were in place for the manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the

manager.

The provider's values were communicated to staff. Staff understood these and relatives told us these standards were evidenced in the way care was delivered.

The manager and staff promoted a culture which focused on providing care to people in the way that staff would wish their family members to receive. The manager provided strong positive leadership and fulfilled the requirements which would be associated with their role as a manager.

The manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe. Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff who were encouraged to raise concerns with the manager.

The quality of the service provided was reviewed regularly by means of effective quality control audits. These were completed to identify areas where the quality of the service provided could be improved. We could see action had been taken to address where any shortfalls in the service provision had been identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from the risk of abuse. Staff were trained in safeguarding, understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified. Recorded guidance was provided for staff and reviewed monthly to ensure people's needs were managed safely

People were supported by sufficient numbers of staff to meet their needs in a timely fashion. There was a robust recruitment process in place to ensure staff had undergone thorough and relevant pre-employment checks prior to commencing their role.

Medicines were administered safely by nurses who received training appropriate to their role to ensure medicines were stored, administered, documented and disposed of safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who completed a nationally recognised induction process to ensure they had the skills and knowledge required to meet people's needs in an effective way.

People were supported by staff who were able to discuss the principles of the MCA and demonstrated a detailed awareness of how to enable and support people to make choices in their daily lives. Care provided in people's best interests was documented appropriately and relevant parties involved in those discussions.

People were encouraged to participate fully in mealtimes to ensure they ate and drank sufficiently to maintain their health and wellbeing.

People were supported to seek healthcare professional advice where required in order to monitor, manage and treat their changing health needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach with people, supporting them in a kind and sensitive manner.

Staff had a well-developed understanding of people and had developed companionable and friendly relationships with them.

Where possible people were encouraged to assist in creating their own personal care plans to ensure their individual needs and preferences were known and provided by staff.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed and updated people's care plans and risk assessments on a regular basis with additional reviews held when people's needs changed.

People were encouraged to make choices about their care which included their participation in home activities and how they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner in accordance with the provider's complaints policy.

Is the service well-led?

Good

The service was well led.

The manager promoted a culture which placed the emphasis on people receiving quality care from staff who treated people as if they were their own family.

The manager provided strong leadership and fulfilled the requirements of being a registered manager by informing the Care Quality Commission about important and significant events.

Staff were aware of their role and felt supported by the manager.

They told us they were able to raise concerns and felt the manager provided good leadership.

The provider and manager regularly monitored the quality of the service provided so that continual improvements could be made.

St Thomas

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 function. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 17 and 18 July 2017 and was unannounced. The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family members who had received care. The Expert by Experience spoke with people using the service, their relatives and staff.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We had not asked the provider to complete a Provider Information Return (PIR) before the inspection. A PIR 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 reviewed this information during the inspection.

During the inspection we spoke with five people, three relatives, two nurses, four members of care staff, the chef, the activities co-ordinator, the deputy manager and the home's manager. We looked at ten care plans, six staff recruitment files, staff training records and 20 medication administration records. We also looked at staff rotas for the period 19 June 2017 to 17 July 2017, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. Not all the people living at the home could share their experiences during the inspection we spent time observing staff interactions with people including during activities and lunch time sittings.

The home was previously inspected 19 July 2016 where no concerns were identified.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home, one person told us, "I feel alright here". This was a view confirmed by relatives, one relative told us, "There's always plenty of staff about. I like the openness here (family member) has a walker so she can walk around here safely".

People were protected from the risk of suffering abuse as staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe physical and emotional symptoms people suffering from abuse could exhibit if they were unable to verbally express their concerns. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns and felt confident to report any concerns. This included to the manager, the provider and external agencies such as the local authority and Care Quality Commission if required.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, people's moving and handling needs, their identified falls risk and any individualised risks identified such as risk of choking whilst eating. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. These also included the use of equipment aids such as hoists and slings which were required to support people safely. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Moving and handling equipment used to support people such as hoists and wheelchairs were available for staff to use. These were regularly serviced to ensure they remained safe to use. Risks to people's care were identified, documented and staff knew how to meet people's needs safely.

When accidents or incidents occurred these were documented fully and audited to enable the manager to identify if there were any actions which could be taken to prevent a reoccurrence. Staff completed the provider's accident, incident and near miss forms when an incident, accident or when the potential scenario for an incident could occur. These detailed when and where the incident occurred, any witnesses, immediate action taken to manage the situation, steps taken to prevent the incident from re-occurring and were signed by the home's clinical lead or manager to ensure all appropriate action was completed.

There were robust contingency plans in place in the event of an untoward event such as fire, flood, catering disruptions and accommodation loss. Each person was assessed for their level of mobility and guidance provided for emergency services, such as the fire or police service, to identify the level of support people required to be evacuated from the home. If rooms were no longer suitable for habitation then people would be moved to the provider's other homes within the county to ensure continuity of care. These plans allowed for people to continue receiving the care they required in emergency situations.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who

were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Professional registration documents for nurses were available and updated to show they remained registered in order to provide nursing care. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Relatives and staff we spoke with felt there were sufficient numbers of staff deployed in order to meet people's needs. One member of staff told us, "I don't feel I have to rush and there is time to spend with the residents". Another member of staff told us, "Yes, at the moment, yes the staff level is very good". Staff told us if someone was unable to work due to last minute reported sickness they would work as a team in order to ensure all people's needs were met. Staff also said the manager would assist if required in order to support the existing staff team with tasks such as assisting people at mealtimes.

The manager identified the minimum staffing levels consisted of three nurses and twelve members of staff throughout the day and two nurses and four members of staff working during the night. There was no reduction in staffing levels at weekends and staff were supported by administrative, housekeeping, activity, maintenance and kitchen staff on duty. Records and observations during the inspection showed sufficient numbers of staff were deployed to meet people's needs safely. Where shortfalls in the rotas had been identified these had been filled by the staff team offering to complete these shifts as overtime and the use of agency staff. Where agency staff were used the same staff were requested and returned to the home which ensured they had detailed knowledge of the people living in the home and their individual needs. Staffing levels were reviewed by the manager when it was identified there had been a change in the level of people's needs in order to ensure their needs were met. For example when it has been identified people required additional staff to support people to manage some behaviours they were exhibiting we could see and additional staff were deployed.

People living at the home received their medicines safely. Nurses received additional training from external training providers in relation to medicines management. People's medicines administration records (MARs) were correctly completed to identify people received their medicines as prescribed. Nurses were also subject to competency assessments to ensure medicines were managed and administered safely. Nurses ensured the administration and management of medicines followed guidance provided by the Royal Pharmaceutical Society.

We noted that medicines given on an 'as needed' basis (known as PRN) were managed in a safe and effective way. PRN protocols were in place for each person taking medicines in this way; they outlined how, when and why they should be taken and included maximum doses over a 24 hour period. We also noted that 'time-critical' medicines were given at the appropriate time such as those given for Parkinsons and Diabetes. When people were unable to verbally communicate their levels of pain, staff used an assessment tool to measure the level of pain people were suffering. These were used to gauge the appropriate level of pain relief needed. There were also regular recordings of blood glucose levels in MAR charts for those living with diabetes.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective, in line with the provider's policy. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for on topical MAR charts when administered and safely

stored. Other medications were safely stored in locked cupboards. Medicines requiring refrigeration were stored in a lockable fridge which was not used for any other purpose. The temperature of the fridge and the room in which it was housed were monitored regularly to ensure the safety of medicines. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. We saw appropriate action had been taken to ensure these were stored, documented and audited appropriately.

Good

Is the service effective?

Our findings

People spoke positively of the food they received, one person told us, "It's quite good actually". Relatives were confident that staff were able to meet people's health and wellbeing needs when required, one relative told us, "The staff call in the GP".

People were assisted by staff who received a thorough and effective induction into their role at St Thomas. This induction included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. New staff were required to complete an induction which was based on the Care Certificate. This is a structured induction programme which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support.

The provider had identified training which they felt was essential for staff to complete to enable them to provide care and training refreshers were completed when required. Staff spoke positively of the training provided, one member of staff told us, "I love the training, I just find it interesting and I really do love the dementia side of this care". Another member of staff said, "Training has been very good and it's very, very helpful". As a mandatory package staff had undergone training in areas including infection control, health and safety, moving and handling people, fire awareness, safeguarding adults, first aid and food hygiene.

Staff were also supported to complete training in the following areas, the Mental Capacity Act 2005 (MCA), medicines management, the care of people with dementia, the care of people with dysphagia (difficulty in swallowing), customer care including duty of candour and skin integrity.

Nurses were also supported to undertake training in specific areas which enabled them to maintain their professional registration. One nurse told us, "I've done more training in the few months since the new manager came in than the two years previously, I've done suprapubic catheter training and wound management and I've more to come". Suprapubic catheterisation is the processes for managing people's continence concerns. There were processes in place to guide nursing staff through the process of revalidation. This is an ongoing process by which registered nurses must demonstrate their fitness to practice to their professional body.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop their skills and abilities. The manager had also introduced a new system moving forward where heads of departments would be responsible for supervising their own staff.

Supervision and appraisal records were detailed and individualised. During these processes issues of importance to both the supervisor and member of staff were discussed. Staff told us they were able to speak to the nurses and deputy manager at any time and felt supported as a result. One member of staff told us of their supervisions, "Yes, yes, they are (useful), supervisions they do many times, (and they ask) is everything alright". Processes were in place so that staff received the support to enable them to conduct their role

effectively.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager showed an understanding of DoLS which was evidenced through appropriately submitted applications and authorisations. Staff were able to identify the principles of the MCA, one member of staff told us, "If someone has mental capacity and they want to take risks, in the end it's up to them". People told us and staff demonstrated that they complied effectively with the MCA by offering people choices with their day to day care. Staff spoken with understood why DoLS were required.

When people had been assessed as not having the capacity to make key decisions about their care, the provider had documented that actions taken were in people's best interests. Best interests decisions are made in conjunction with people close to the person the decision is being made on behalf of to ensure their needs are met fairly and any action taken is for the benefit of the person. This included the use of bed rails for those who were being nursed in bed which had been signed by people and or their family member with a legal authority to agree to their use. Applications made to deprive people of their liberty had always been discussed with relevant persons and documented fully as being in their best interests.

We saw people enjoyed the meals which were provided and were supported by staff who were patient and attentive to their needs. Staff were flexible in their approach when supporting people to ensure they were offered every opportunity to enjoy their meals. Lunch was not rushed and there was a relaxed atmosphere in the dining rooms. We saw staff sat alongside people supporting them to eat, they were patient and gentle in their approach and gave people time to eat what was provided. People who ate in their rooms were supported by staff in a caring way. One person continued to refuse to eat however the staff encouraged them to drink as it was a hot day and we saw this person was provided with sufficient drink in order to meet their hydration needs. People had drinks readily available to them and fruit, crisps and biscuits were regularly offered to support people who may not always be willing to eat a main meal. Snacks such as sandwiches, fruits and yoghurts were available to people day and night in the event they wished to have something additional to eat.

The chef working at the home during the inspection was a temporary bank member of staff. They were able to evidence they knew who had specific dietary needs such as those who required a diabetic, pureed, fortified or soft diet. Adaptive cutlery and plates were available to people to enable them to maintain their independence whilst eating. The home provided yellow plates to those people living with dementia who had an identified need to increase their food intake. People living with dementia can experience difficulties with their sight and perception and may not be able to recognise and distinguish food when served on white plates. By offering contrasting colour yellow plates on the home's blue tablecloth this assisted people living with dementia to distinguish between objects making it easier to identify when food has been provided.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of illness could be identified. Some people living at

the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Records showed minimal variations in weight suggesting people were supported to eat and drink sufficient amounts to maintain a healthy weight. Professional health care advice was sought and followed by staff which was evidenced during the interactions with the staff. For example some people living at the home could exhibit behaviour which could challenge others, this placed them, staff and other people living at the home of risk of injury or distress. We could see staff appropriately sought professional support and guidance from other professionals such as the older persons mental health team when situations arose. This was sought to identify whether or not there was any additional action the home could take to meet people's needs. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to support staff on how to manage people living with certain conditions, such as epilepsy. Care plans detailed what the triggers and physical symptoms of these conditions were, what action should be taken and which health and social care professionals should be made aware. Records showed that staff were aware and knowledgeable on what action to take in response to people's conditions and were documenting these accordingly.

The home had been decorated in a way to support those people living with dementia to live as independently as possible. For example; to increase people's ability to move independently around the home, handrails were painted contrasting colours to the walls to provide a focal point to enable people to walk safely within the home. There were also pictorial signs to assist people in identifying the different areas of the home such as communal areas including dining rooms and private areas such as bathrooms and toilets.

Good

Is the service caring?

Our findings

People were supported by staff who were gentle in their approach and provided support in a caring manner. People and relatives confirmed that support was delivered by caring staff. One person we spoke with told us, "They're (staff) all very nice here… they're lovely". Another person said, "The staff are very good, they are very kind". Another person told us about the staff, "The staff – they're very good, very caring". This view was shared by relatives we spoke with, one relative told us, "Some of the carers are superb and go the extra mile…They are lovely staff, so sweet".

Caring, supportive and friendly relationships had been developed by staff with people. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans were written in a way which showed affection for the people they were discussing. They contained personal information to assist staff to know about them as individuals, describing both their care and support needs along with the positive personality traits they wanted staff to acknowledge. These allowed staff to have a greater understanding of people's needs and the care they required.

Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people as they moved around the home which included speaking with people who were nursed in their rooms. This was confirmed by relatives we spoke with, one told us, "They (staff) come in and say hello when they pass".

Where people required one to one care whilst living at the home we could see this support was provided in a non-intrusive and respectful way. One to one care is provided where peoples support and care needs are such that they are a risk to themselves or others living at the home. On these occasions people are supported on an individual basis by a member of staff whilst they are awake. People were allowed to move freely around their home and were not restricted by the staff that supported them.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress and offered reassurance when required. During a lunch time sitting we saw staff took quick action when people dropped cutlery items or food on the tablecloths and exhibited signs they were distressed. Staff were quick to offer verbal reassurance and ensure people were comforted by promptly tidying and collecting items required.

The home used a screening tool for identifying those who may suffer with depression as part of their dementia symptoms. This objective tool allowed staff to identify changes in people's mood, such as becoming anxious, behaviour symptoms such as becoming agitated or physical signs such as appetite loss which could indicate someone was beginning to exhibit signs of depression. This screening tool was reviewed monthly to ensure signs in people's overall wellbeing could be quickly identified. For those living with depression guidance was provided in their care plans on how staff could approach them in a positive way to ensure their mental wellbeing was supported. This included offering people verbal reassurance, providing items which provided physical comfort such as stuffed toys or dolls for example. Staff were aware,

and took positive action to promote people's mental wellbeing minimising the risk of them suffering emotional distress.
Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch to interact with people to engage with them. When communicating staff would often gently place a hand on people's arms to communicate that they were being spoken with. We saw that people were comfortable and actively sought this physical contact with staff. Friendly conversations were held whilst staff and people chatted and held hands whilst they moved around the home.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day. Care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in the nurses office on the ground floor to protect confidentiality. During the inspection staff were responsive, respectful, kind and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included making sure people were suitably clothed and had their modesty protected when they were assisted with their personal care. People were provided with personal care with the doors shut and curtains drawn to protect their privacy. During the inspection we saw staff deal sensitively with people's continence issues protecting their dignity.

People were also respected by having their appearance maintained. Attention to appearance was important to people and noted in care plans. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked. We saw staff supported people to maintain their appearance and ensured they were appropriately dressed. Staff were able to recognise people's wish to be smart and well-dressed and ensured they offered support in a unobtrusive and caring way.

People had been supported to ensure their wishes about their end of life care had been respected and documented accordingly. Care plans provided personalised information for people regarding the support they required and their wishes about where they wanted to be. These included the family members they wished to be made aware and present when their health deteriorated.

People had their spiritual needs met. A Christian chaplain regularly visited the home to carry out services in the homes chapel. In addition staff were able to show us how they met individual needs of people with a range of religious beliefs. This included supporting people of other religious faiths to attend religious services outside of the home in order to ensure their spiritual needs were met.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plan. People not able or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided. Relatives were informed when changes in planned care were due to occur, one relative said "Staff will phone me (if there are changes to care)…they always keep me up to date". Another relative told us, "They (staff) always ring. (Family member) had a couple of falls, they rang me and updated me". The provider sought to provide a range of activities for people to participate in. One relative told us their family member attended the activities they enjoyed, "There is always something going on, it's a personal choice".

People's care needs had been assessed and documented by senior staff before they started receiving care. These pre-admission assessments were undertaken to identify people's support needs and care plans developed outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. Care plans were also reviewed when people's individual needs changed. For example, when there had been a change in people's health needs care plans were updated to reflect the change of care which was required. People, staff and relatives were encouraged to be involved in reviews to ensure people received personalised care.

For people living with pressure sores we saw the home took appropriate action to respond to these appropriately. Pressure sores are usually caused by unrelieved pressure on a persons' skin and can be suffered more by those persons being nursed in bed. We noted risk assessments for people's skin integrity included possible contributory factors such as people's lack of mobility, continence issues and concern regarding people's nutrition and hydration. Nursing staff had responded appropriately to people's assessed needs ensuring air mattresses were in place, which can relieve pressure on a person's body, and the pressure settings were regularly checked to ensure they remained effective. Body maps had been completed showing the site of pressure sores with regular photographs taken to enable nursing staff to see improvement or decline in any such areas. Nursing staff were responsible for monitoring changes in people's needs and ensured all appropriate action was taken to maintain people's health and wellbeing.

The provider sought to engage people in meaningful activities. Care plans detailed people's hobbies and previous interests to help staff to encourage people to participate in as broad a range of social activities as possible. Care plans detailed people's particular social interaction needs and the need for activities to be completed with people on a daily basis. For some people living at the home their care plans detailed that they enjoyed listening to particular genres of music. During the inspection we saw these people's favourite types of music were playing which was something they were known to enjoy. People, including those nursed in bed were also encouraged to participate in a number of sensory activities, these included hand massage, aromatherapy and light sensory items.

The home had two activities coordinators which enabled people to participate in three activities a day. The main activities coordinator promoted the use of homely activities such as baking, dusting, tidying, preparing and making tea and sandwiches. These types of activities can help a person living with dementia feel connected to their life before receiving care and can maximise their choice and control. Some activities such

as those involving reminiscence can help people seek an emotional connection with others.

Staff were aware it was not only the activities staffs responsibility to ensure people were engaged in activities in order to maintain a fulfilled and enjoyable life. During the inspection we saw staff engaged in participating in aromatherapy sessions and show an awareness of where people would enjoy spending their time. We saw a member of staff acknowledge that a person would not enjoy sitting in one of the quieter lounges and supported them to participate in activities which were ongoing elsewhere in the home.
A typical week activities rota was viewed and included activities such as board games, arts and crafts, bingo, exercise classes along with activities outside the home such as a gardening club. The home had its own mini bus which meant they were able to support people to visit the local community to participate in shopping and banking when they required,

External agencies were also encouraged to visit the home to encourage people to experience new and different situations. The main activities coordinator was also keen to expand activities to include dementia friendly swimming classes for those who were able to attend. Dementia friendly swimming occurs in quieter environments to minimise the amount of external noise and groups of people which can sometimes be distressing for those living with dementia.

The home also held summer fetes and invited people, family, friends and the local community to the home to participate in events with stalls, tombola and raffles. The proceeds of which were then used to support a local charity and to assist residents to take part in additional activities. People and relatives spoke positively of the summer fete which was held shortly before the inspection. One person told us, "That was good" and a relative said, "We came to the summer fete, it was good weather and a lot of people turned up".

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the manager to address any concerns. The provider's policy offered advice and guidance to people, relatives and visitors to the home regarding how they would be able to raise a complaint, the timescales for any response to such a complaint and how to raise complaints with the local authority and the Care Quality Commission.

The staff members we spoke with were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures, which were on display in communal areas.

Complaints were recorded on the home's computer system so they were accessible to review to identify trends or repeated incidents involving people or staff. Four formal complaints had been received since the last inspection. We could see the complaints had been investigated by the previous registered and current manager with steps taken to address the causes of the complaints. These had been responded to by both the manager and previous manager in line with the provider's policy.

Good

Is the service well-led?

Our findings

The manager sought to achieve a culture which placed people at the heart of care delivery which included involving friends, family and representative person. People and relatives recognised and knew who the manager was and spoke positively of their ability to manage the home, one relative told us, "The new manager is great. The atmosphere is great now. I wasn't happy before but things are much improved". Another relative said, "I've been very impressed so far". People and relatives told us they were happy with the quality of the service provided. One relative wrote to the home to express their thanks for the care delivered, 'I am writing to you to congratulate the nursing team at St Thomas's Care Home in Basingstoke for the care of my brother at the end of his life. All the carers seemed different and much happier in their work and more motivated so the nursing care has been outstanding".

The manager was keen to encourage an open, friendly and person centred culture between all people living at the home, staff and relatives. In order to achieve this manager sought to engage and involve people, staff and family members in regular contact, which staff and relatives confirmed. One relative told us, "The new manager is more approachable. I've noticed a difference...very approachable. Another relative said, "The deputy and the manager are both very approachable". The manager was available to people and staff to offer guidance and support whenever they were required. Staff confirmed the manager was open to their requests for assistance, operating an 'open door' policy and was supportive in her actions. A member of staff told us, " Definitely (open) now, 100%, it's a good team here. I would feel comfortable going to (manager) or (deputy manager) I can feel I can go to any of the management and express my concerns here". Another member of staff said, "Yes, (I feel) supported, I think we have always had nice team work here…when (manager) started it's different, she's very open when you talk to her whatever you want to say you can talk to her".

The manager was keen to promote an atmosphere where people felt they were receiving care in a friendly and relaxed environment. Relatives we spoke with told us they felt the home provided a homely environment for their loved ones, one relative told us, "When you come in it's a nice relaxing atmosphere". The home had a mission statement which explained the standards of care that people should expect to receive whilst living in the home. Positiveness, honesty and empowering people were identified as key words which were integral to the delivery and the receipt of care people received.

Whilst staff were not always able to immediately identify the provider's values we observed they demonstrated these values in the way they delivered care. Staff were able to identify the how the manager wished them to provide care. This included treating people as if they were members of their own family living in their own homes, empowering people to make decisions and promoting their independence where possible. One member of staff told us, "Make sure (people) feel it's their home and the relatives as well, it's their home as well". Another member of staff said, "To treat people as family I don't know how to do the other way, I just do like I used to do with my…it's just like my family".

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. We use this information to monitor the service and

ensure they responded appropriately to keep people safe. The manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance. We asked staff if they thought the home was well-led by a strong manager. One staff member told us, "I think the new manager has made a big difference. She thinks like we do; she's very caring. Firm but fair, that's what I would say". Another staff member said, "I would rate the home as good. The manager has been very supportive and I can talk to her at any time. It's not like that everywhere".

The quality of the service people experienced was monitored through regular care plan reviews, residents meetings, relatives meetings, monthly Memory Café meetings with relatives where speakers were invited to come and talk with people as well as annually completed surveys. The last residents meeting had occurred on 5 July 2017 and during this meeting people were asked to share any worries or concerns they had about the home, their care and the activities available to them. People responded positively during the meeting saying staff were friendly, kind and caring, they were really happy with the food. People had also said they would like to go out more. As a result the activities coordinator was organising a coach trip to a beach which would also involve relatives so they could enjoy time at the coast. Plans were in place to ensure regular outings were being made available to people. The last relatives meeting had occurred 4 July 2017 and during this meeting people were asked whether the food and menu met their family member's needs and preferences. Care plan reviews and the creation of family trees to support people with reminiscence activities were also discussed.

The provider sought feedback from people by the means of using an independent survey company to send out questionnaires to people and their family to ask for their feedback on the quality of the service provided. At the last survey completed in 2016, 35 people and 19 relatives responded to the questionnaire. People were asked to provide a numerical score in response to a number of questions from which all answers were collated, analysed and a percentage score out of 100 was provided. People's question included, if staff treated them with kindness, dignity and respect (97% response), if staff understood people as an individual (94%) and if the staff were capable of providing the care people needed (97%). Family and friends were asked to provide a score in response to a number of questions including, if they could be involved in decisions about their relative or friends care including end of life care (95%), if the homes facilities were suitable to meet people's needs (100%) and if the home seemed a safe and secure place to live for their family or friend (100%).

There was a robust system in place to monitor the quality of the service people received through the use of regular provider and manager audits. The manager conducted a number of audits on a monthly basis which included; unannounced site visits, housekeeping and health and safety audits. Quality checks were also completed on key areas such as the environment, care plans, activities and medicines. The provider's Regional Director or Quality Improvement Specialist also completed two monthly 'Quality First' or 'Quality Improvement' audits. These audits were based on the Care Quality Commissions inspection process and looked at whether or not the home was safe, effective, caring, responsive and well-led making recommendations for improvement where required.

The provider also invited external professionals to conduct specialist audits to ensure the quality of the home was continually reviewed. The home's dispensing chemist undertook a yearly audit of all aspects of medicines management within the home. This had last been completed on15 May 2017; no major issues of concern were highlighted.

Following these audits actions plans were put in place which detailed any actions needed and prioritised timescales for any work to be completed. For example, the last Quality First audit was completed in March 2017 identified that activities required reviewing to ensure those offered met people's specific needs.

Following the audit this area was addressed by the regional director. Staff confirmed during the inspection they had an increased budget in order to provide activities. This meant activities were more accessible to all and included more day trips and new activities equipment. We could see this action had been taken in a timely manner. The provider ensured through the use of regular monitoring areas which required improvement were identified and timely action taken to continue to improve the quality of the service people received.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home which evidenced staff were motivated to treat people as individuals and deliver care in the way people requested and required. Some of these were viewed, one relative had written, 'We wish to say a heartfelt thanks to all the wonderful staff who cared for [family member]. You showed such compassion and love to [family member] during her final couple of months. We will always be grateful for your kindness'. Another relative had written, 'You all treated [family member] with care, dignity and respect'. We saw interactions between the manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.