The Orders Of St. John Care Trust

OSJCT Hartsholme House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Outstanding
Is the service well-led?	Good

Overall summary

The inspection took place on 26 November 2015 and was unannounced.

OSJCT Hartsholme House is registered to provide accommodation and personal care for up to 44 older people or people living with dementia. There were 43 people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect

Summary of findings

them. The management and staff understood their responsibility and made appropriate referrals for assessment. No one at the time of our inspection had their freedom restricted under a DoLS authorisation. However, the registered provider had made applications to the local authority and was waiting on assessments.

People felt safe and were cared for by kind, caring and compassionate staff. People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that had the skills to do so. The registered provider ensured that there were always sufficient numbers of staff to keep people safe.

People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities. People were given a choice of nutritious and seasonal home cooked meals. There were plenty of hot and cold drinks and snacks available between meals. People had their healthcare needs identified and were able to access healthcare professionals such as their GP or dentist. Staff knew how to access specialist professional help when needed.

People and their relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect and enabled to follow their hobbies and pastimes. People were supported to make decisions about their care and treatment and maintain their independence.

People were at the centre of the caring process and staff acknowledged them as unique individuals. People were enabled by a designated activity coordinator to maintain their hobbies and interests, and build strong links with the local community.

There were systems in place to support people and their relatives to make comments about the service or raise concerns about the care they received. People and their families told us that the registered manager and staff were approachable.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. The service received recognition from other agencies for areas of good practice.

Summary of findings

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

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The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. The service received recognition from other agencies for areas of good practice.

Is the service effective?
The service was effective

Good

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff who had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

Is the service caring?
The service was caring

Good

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff respected their choices, needs and preferences.

Is the service responsive?
The service was caring

Outstanding

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff respected their choices, needs and preferences.

Is the service well-led?
The service was well-led

Good

The service had developed strong links with the local community.

The provider had completed regular quality checks to help ensure that people received appropriate and safe care.

There was an open and positive culture which focussed on people and staff, people and their relatives found the registered manager approachable.

OSJCT Hartsholme House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection took place on 26 November 2015 and was unannounced.

The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about. We also spoke with three health and social care professionals who provide support and advice to people.

During our inspection we spoke with the registered manager, the area operations manager, the head of care, four members of care staff, the cook, a housekeeper, the Admiral nurse, six people who lived at the service and four relatives. We also observed staff interacting with people in communal areas, providing care and support. The activity coordinator was on leave and we spoke with them by phone on their return.

We looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for six people and medicine administration records for seven people.

In addition, we undertook a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us that they felt safe. Three people told us that when they had raised concerns about people coming into their rooms, staff had helped them to manage their own security

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of abuse. In addition, staff knew how to share their concerns with the registered manager, senior carer on duty and the local safeguarding authority. One staff member said, "I would report it to the care leader or the person in charge." Another staff member told us, "I would report it to duty and the local authority and document it."

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as nutrition, moving and handling and falls. Care plans were in place to enable staff to reduce the risk and maintain a person's safety**.** Therefore, staff responded to people's risk of harm appropriately. For example, the family of one person told us that their relative was at risk of falls, but staff have now put a pressure mat at the side of their bed to alert staff to when the person get out of bed unaided to reduce the risk. Furthermore, risk assessments were undertaken for external activities and outings and systems were put in place to keep people safe.

There were systems in place to support staff when the registered manager was not on duty. Staff had access to a major incident folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. There was also information on safe evacuation procedures to a nearby service registered with the provider. Staff had access to on-call senior staff out of hours for support and guidance.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post.

The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift and were reviewed every month. The registered manager had recently introduced a new morning shift from 8am to 12 midday as they found this was the time of greatest need to support people and care staff. A member of staff who was working that shift explained their roll to us. They said, "It's a new shift and I assist people with their breakfast. Breakfast time is flexible and people can have their breakfast where they choose. After breakfast I take them wherever they want to go; back to their bedroom or maybe into the lounge, or to the shop to buy a newspaper and then make them a cup of tea."

People and their relatives told us that there were enough staff to look after their care needs and staff responded to their requests for assistance in a timely manner. We heard comments such as, "There is more staff than there used to be, now it's pretty good." and, "If I press the bell they come ever so quickly as they know I don't use it very often." And finally, "There seems to be quite a few staff around." We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly.

People told us that they had no concern about their medicines and always received them on time. People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. We observed a senior member of staff administer lunchtime medicines to people in the main dining room. The staff member wore a red tabard, and there was a warning sign of the medicines trolley, "medicines in progress" to alert other staff not to interrupt. This helped to reduce the risk of administration errors. We noted that appropriate safety checks were carried out and the medicine administration records (MAR) charts were completed once the person took their medicine. We saw that the staff member explained to people what their medicine was for. For example, they told one person that the doctor had prescribed their medicine to relieve their pain.

We looked at MAR charts for seven people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep.

Good

Is the service safe?

When a person was prescribed medicine through a skin patch, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of damage to the person's skin.

We spoke with the head of care and the medicines lead who were checking new medicine stock against the MAR charts. We noted that both staff signed the MAR charts to confirm that the correct medicine and quantity had been delivered. We saw where skin cream had not been labelled correctly that it was set aside to be returned to the dispensing pharmacy.

All medicines were stored in accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. All medicine incidents were reported through a formal route and the registered manager investigated them.

Good

Is the service effective?

Our findings

One person told us that they were happy with the care they received and staff's ability to carry out their roles. Another person said, "They're always training. They are pretty good with people with dementia." The registered provider took a proactive approach to training and developing staff and had their own training facility. This meant that when a training need was identified staff received that training. We looked at the training matrix and saw that staff were provided with training in areas such the care of a person living with dementia, safeguarding, and dignity. In addition, several staff were supported to work towards a nationally recognised qualification in adult social care. A staff member said, "Everything is in-house for training. They are very good for training. You couldn't get better anywhere else."

All new staff undertook a six month probationary period that included a 12 week induction programme, where they completed a workbook with the supervision of a mentor. New staff also shadowed experienced care staff before they worked on their own. One newly appointed member of care staff spoke with enthusiasm about their induction and the opportunity to learn more about the people in their care and said, "They've showed me everything; how to use a hoist and how to assist someone to eat. All the residents are different with different needs. I've seen some of the care plans. There is so much to learn. I want to learn more about dementia, I've read about it on the internet and it's really interesting." The registered manager explained that the provider was reviewing the induction training to include the new care certificate. This is a new training scheme supported by the government to give staff the skills needed to care for people. The registered manager had arranged for the learning and development coordinator, appointed by the provider to come and talk with staff about the care certificate.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and some had signed consent to reside at the service. A member of care staff said, "I always ask for their consent, try to help them understand what care I am going to give them. Make sure they are happy with it." Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

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.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves.

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. We found that the provider had followed the requirements in the DoLS and several applications had been submitted to the local authority and were waiting for assessments.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. We found that they had a do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. This ensured that their wishes were respected. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly.

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks were provided throughout the day and bowls of fruit and snacks were

available in the communal areas and we saw people helped themselves to them. People, were offered a choice of drink with their lunch and drinks were topped up throughout their meal. After breakfast we sat with a group of people who were chatting together in the lounge. They told us that the tea trolley would soon be round. One person said, "We're waiting for a cup of tea, it's all ready. The ladies will bring it; the ladies are good to us." At that moment the tea trolley appeared and people were offered a drink of their choice and biscuits and homemade cakes.

People were given a choice of where they took their meals, most choose the main dining room, eight people had their lunch in the themed traditional pub and others preferred to take their meals in the lounge or their bedroom. We found that one person who preferred to eat on their own had a small table set for lunch in one of the themed corridors that resembled a Victorian kitchen. This person also liked to eat as they walked about, so staff provided them with paper cones that they could eat finger food from. We noted that this worked well and the person took a good diet.

People and their relatives told us that they were happy with the quality and choice of food. One person said, "I can choose whatever I like and can have an alternative." Another person said, "I'll eat it. Its good portions too." Our observations supported their comments. We saw the kitchen assistant ask people mid-morning what they would like for their lunch. There were pictorial menus that people could look at to help them make their choice. After each course staff asked people if they enjoyed their food and if they wanted any more. When a person had a poor appetite staff offered them a selection of fruit and healthy snacks as an alternative. The person's food intake and weight was recorded and monitored. We looked at food intake charts for people at risk of weight loss and saw that they recorded the amount of food a person was offered and how much they actually ate.

We spoke with the cook who told us that they kept a record of people's likes and dislike and special dietary needs; such as pureed food or a reduced sugar diet. However, they added that people's tastes changed and the menus were updated. They said that a member of catering staff always attended the "residents meetings" and the feedback was always positive. In addition, people completed a feedback form. They told us that they used fresh ingredients and dishes were home-made including soups and cakes. They also fortified some dishes to support people who may be at risk of weight loss. For example, milk, butter and cream were added to potatoes and puddings.

The activity coordinator told us that they were moving away from the ritual of the drink rounds as it was institutional. Therefore, they had introduced a "fine dining" approach to drinks and snacks. China tea pots and crockery are used and cakes and biscuits are served on a cake stand. People are empowered to help themselves and their independence is promoted. The activity coordinator said, "We have found that people are eating and drinking more. The china cups are the right weight to hold."

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, speech and language therapist and district nurse. Relatives told us that staff responded when their loved one had a health problem and kept them up to date. For example one person's relative told us that their loved one needed to see their GP urgently and said, "The doctor was needed, They don't mess around in getting help." And another relative said, "They'll let me know if they have an appointment for anything. The doctor will come here."

We saw that people and their relatives were supported by three dementia leads; one of whom was also the dignity champion for the service. Furthermore, there was a relative's support group led by a specialist nurse in dementia care, called an Admiral Nurse, appointed by the provider. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. We spoke with the Admiral nurse who told us that they empowered staff to talk about the different types of dementia and the effect it can have on a person's behaviour. They also explained how they helped to support relatives. They said, "I work with relatives and residents. I support them in groups or one to one. I help families understand why their relative is behaving the way they do." We received positive feedback from relatives who attended these meetings. For example, one person's family told us, "We've been to some dementia meetings here lately which have been good." In addition, older people and people living with dementia and their families had access to information leaflets on living well in later life provided by national charities.

Before our inspection we spoke with three health and social care professionals who supported people's health

Good

Is the service effective?

and wellbeing. They told us that they worked in partnership with senior care staff and that a senior member of staff attended the multiprofessional meetings to review a person's health or social care needs.

Good

Is the service caring?

Our findings

People told us that they were cared for by kind caring and compassionate staff. One person told us that they were happy living at the service. They said, "I'm much happier here as I have company and can see my husband [also lives at service] and how he is. If all the homes were like this, there would be no problems in this country." Another person said, "They come and sit with me for a chat when they want a rest sometimes. They come to me for advice too, just like family." One person's relative told us, "He's had some falls, they're very good and look after him as well as possible. I think they are great with all of them."

People had a designated key worker who were responsible for all aspects of their care. The head of care told us that the key worker system was a success and added, "Staff develop a special relationship with residents. Some go over and above what is expected of them. There is a nice feeling, warm and friendly."

We observed that staff looked after people in a kind and sensitive manner. For example we saw one person who was living with dementia wait by the front door and each time the door opened they asked to go out. A member of staff suggested to the person that they fetch their coats and go for a walk to the local shop and buy the daily newspapers. The person readily agreed and shortly after we saw them walk arm in arm with the staff member to the shop.

People told us that they were involved in making decisions about their care and supported to maintain their independence. One person told us, "I can more or less do my own thing." One relative told how their loved one was enabled to maintain their independence and do things in their own time. They said, "They do encourage them to do what they want. They let her try to feed herself; they don't rush her with anything."

We saw that people had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. We found that relatives had confidence in the care staff provided. One person's relative told us, "We have six monthly reviews and we're as involved as we want to be. We're happy to trust their judgement." Another relative said, "I don't always come to the care meetings as they do well for [name of person]."

There were measures in place to enable people to be familiar with their surroundings. For example, the signage throughout the service was in word and pictorial format.

Some people had difficulty communicating their needs verbally and we observed staff effectively support them to express their needs. One person who was unable to talk used their eyes and facial expressions to inform staff of their needs. We watched them stare intently at the cup on their table and staff knew that that were asking for a drink. Another person who could not hear had a range of picture cards that enabled them to inform staff of how they felt or their care needs. For example, there were happy and sad faces and pictures of food and drink.

We spoke with a relative who told us that their parent's first language was not English and that they had dementia and had reverted back to speak in their mother tongue. They added that the main reason they had chosen the service for their parent was because there were staff who spoke the same language and it was reassuring that there was someone who could communicate with their parent.

Leaflets on the role of the local advocacy service were available. These provided care staff and people with information on how to access an advocate to support a person through complex decision making, such as permanently moving into the care home. We saw that one person had received support from an advocate when they first moved into the service.

People and staff were support by a dignity champion who shared their passion for their role with us and said, "Dignity is a basic human right. Some people do not have a voice and we should be the ones to stand up for them. I would take disrespectful staff aside and make them think about what they say or do." They added, "They are real people and this is their home. We must remember that we are visitors."

We observed staff treat people with dignity and respect. When staff spoke with people they called them by their preferred name. Staff knew people well and had a good rapport with them. We saw that they took a gentle and calm approach when talking with people living with dementia. We observed that before staff entered a person's bedroom or toilet they knocked on the door. Furthermore, to reduce the risk of intrusion "do not disturb" signs were displayed on the bedroom door when a person was receiving personal care or wanted quiet time.

Good

Is the service caring?

People were enabled to maintain contact with family and friends and we noted that in addition to communal lounges and bedrooms there were several quiet seating areas throughout the service where people could meet with their relatives undisturbed. One person's relative said, "We can visit anytime. There are never any restrictions." Some people had a personal mobile phone and could contact their relatives and friends at any time and those that did not were supported by their key worker to use the office phone.

We saw that a dignified approach was taken at meals times. For example, people were offered cleansing wipes to clean their hands before lunch and some people were provided with protective tabards so as their clothing would not get soiled from spills. Furthermore, some people with dexterity problems were offered their soup in a two handled bowl and were provided with adapted cutlery to eat their main course and dessert. We were told this enabled people to maintain their independence. Four people were assisted to eat their lunch by care staff that sat beside them and supported them to eat their meal at their own pace. Throughout the meal staff treated people with dignity and respect and acknowledged their achievements.

Outstanding ☆

Is the service responsive?

Our findings

We found that the service had a strong focus on person-centred care and we saw that people's diverse needs and wishes were met in a variety of ways. People spoke with enthusiasm about the activities they took part in. One person said, "Everybody enjoys it here. The bell ringers were wonderful." Another person said, "We had a sing song yesterday, we try to sing, we had a nice pianist." Relatives told us that they found the monthly activities programme useful as it helped them plan when to visit.

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. In addition, some of the public areas had recently been decorated and people had been involved in choosing the wallpaper and the fabric for new arm chairs.

We saw that the corridor walls were decorated with pictures and displays made from different textures for people to touch and pictorial decorations and photographs reflecting different themes that were meaningful to people. For example, we saw two tapestries mounted on a wall outside the bedroom of the person who had created them. Other walls reflected peoples' interest in music and travel. On the first floor there was quiet lounge for reading with a door to a secure rooftop garden that people could access when the weather permitted. There was also a tearoom upstairs called "tree tops" where people could sit with their relatives over a cup of tea and cake served in a china tea set.

There was a traditional themed pub and people and their families could access this at any time. We saw there were traditional bar games such as a dart board and a shove halfpenny board. Before lunch we observed four people in the bar having coffee and biscuits and taking part in a quiz. The member of care staff leading the activity involved everyone and praised people when they got the correct answer.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. Furthermore, people's care files and risk assessments were reviewed each month and changes to their care needs were recorded. We saw where one person was at risk of falls that they had a falls observation chart to record how they were after their fall and a falls prevention plan had been put in place. A senior member of care staff told us that six monthly reviews were a good opportunity to gain feedback from relatives and said, "Ninety percent of the feedback is positive. There will always be little things, but we can work with little things."

People's life experiences were taken into consideration and significant life events were acknowledged. For example two people had recently travelled to London to see the commemorative poppies at the Tower of London. There were photographs of their trip and their poppy on display. People had taken part in a general election campaign and invited local electoral candidates to come and talk with them. On election day people were supported to go to the local polling station to cast their vote. We were informed that these events generated discussion and reminiscence for the people who took part. There were other initiatives to help people reminisce, such as household objects from the 40s and 50s and a specially made activity board with different locks, door latches, letter box and door security chain.

We did not meet with the activity coordinator as they were on leave, but spoke with them after our inspection by phone. However, we found that a programme of activities, outings and pastimes had been arranged for people in their absence. For example, the previous day five people supported by two members of care staff met up with friends from other services at a central location. They played ball games and had a fish and chip lunch. We saw other events planned in their absence included a knit and natter group and a sing-along.

The activity coordinator told us that they worked flexible hours so as they could be present for evening and weekend activities, such as themed food nights, pub quiz and a party for people and their grandchildren.

In addition to group activities the activity coordinator supported people with one to one activities such as hand massage. They explained that some people were cared for in bed and they may also have poor communication and said, "You can tell by their body language that they are happy for me to sit and massage their hand. Some just want me to hold their hand"

Outstanding ☆

Is the service responsive?

We found that people's concerns were listened to and acted upon. For example when some people had complained about others walking into their bedroom uninvited, action was taken to provide people with a key to their bedroom door. Furthermore, the registered manager had recently introduced an early evening shift to support people living with dementia who had "sundowners syndrome", so as people who become restless and unsettled in the evenings did not disturb other people in their bedrooms. Early feedback indicated that this was successful.

We noted that a copy of the complaints, comments and accolades policy was available in the reception area and also a suggestion box for people and their relatives to leave their comments about the service. We also read several cards and letters from relatives thanking staff for the care they had given their loved one.

People and their relatives told us that they had no cause to complain, but would talk with staff or the registered manager if they were unhappy. For example, a person's relative said, "If I had a complaint I could talk to anybody. I can talk to [registered manager] or [head of care] of course." Another relative said, "She seems very happy here now. I can chat to the senior if I'm worried. I know them all well. "One person told us, "They tell me anything I want to know. I feel if I find anything wrong I can tell them, I have complete confidence in them."

Good

Is the service well-led?

Our findings

We found several examples of innovative practice where strong links had been forged with the local community to bridge the generation gap and for people to share their experiences and learn from others. For example, two students from a local school attended the service for work experience, other younger children had helped to make 32 bird boxes for the garden and two volunteer groups were doing work to redesign the garden the way people wanted it. The registered manager told us that they had a good relationship with the local community.

Following our inspection the registered manager provided us with evidence that partnerships with other organisations led to improvements in the key outcomes for people and staff. For example, the register manager was approached by the Social Sciences department at Lincoln University to provide a practical learning base for post graduate students. Fulfilling this request enhanced the supervision skills of the senior care and management teams. In addition, care staff and people living with dementia participated in a university research project that found care staff's understanding of a person's cognitive ability through images led to improvements in care plans and the delivery of person centred care.

People told us that they attended regular "residents meetings." One person said, "We have about four meetings a year. Some people moan about things, but they don't always speak out at meetings." We saw the minutes of these meetings were accessible to people. The registered manager had an open door and we saw people and their relatives were welcome to come into the office at any time and have a chat with registered manager or head of care.

The service took part in pilot scheme called "Keys to Care" on behalf the Relatives and Residents Association. This is a national association that support, informs and campaigns for older people who live in care homes and their families. Care staff were provided with training in the effective use of key cards covering 12 care topics such as daily life, dementia and privacy and choice. Ten people took part and had their quality of life assessed pre and post-trial and eight people showed signs of improvement at the end of the trial. Staff gave their feedback on their experience of using the key cards on national radio; the outcomes were positive and the scheme has now been rolled out throughout the country to improve care staff awareness of older people's needs.

The registered provider's values were on display in the main downstairs hallway. The registered manager told us about the provider's vision for the "dementia strategy". We saw this had been discussed at staff meetings. The vision was for the organisation to be a leading provider of dementia care. In addition, the service was involved with the Dementia Action Alliance to develop stronger links with the local community. Furthermore, following our inspection we were provided with additional evidence that demonstrated that people and members of staff worked together under the guidance of the registered manager to develop a "home vision". Their vision described their shared belief for the service that, "where every person living and working within it is valued and respected as an individual and where their human rights will be respected through personalised care."

Staff received supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance. Senior care staff and heads of department were empowered to undertake appraisal and supervision with their teams. Staff told us that they were well supported by the registered manager and head of care to perform their roles and all staff worked together as a team. One member of staff said, "[registered manager's name] is approachable. It is a very friendly home."

Staff meetings were held for all groups of staff and staff were encouraged to participate. A member of care staff said, "We have a staff meeting this afternoon. We have an agenda and [registered manager's name] asks all the staff if there is anything they want to bring up." We looked at the minutes from five recent meetings and saw that the topics discussed were relevant to staff roles and responsibilities. For example, medicine administration was discussed with senior carers, night time drinks with night staff and fire safety and incidents at the health and safety meeting.

On the afternoon of our inspection a care staff meeting was held in the dining room and we saw that three people had joined staff. Topics discussed included key worker duties and how to provide a high standard of personal care to people. Staff were asked to put themselves in a person's shoes and think what it would feel like not to have their teeth cleaned or their finger nails trimmed.

Good

Is the service well-led?

A staff member spoke with passion about what caring for people living with dementia meant to them, "Dementia care is very special; I get a lot of job satisfaction. Small things like their facial expressions. To put a smile on their face. To know that they feel wanted and loved means so much. We all pull together and are supported by the Admiral nurse and manager. The manager and head of care are very approachable. We are supported to do our job all the time, we all pull together. This is a happy place."

We found that the registered manager was visible, knew their staff and the people in their care. The people and their relatives that we spoke with knew who the registered manager was and knew them by name.

People and their relatives spoke highly of the quality of care they received. One person said, "I don't think I could be in a better home." One person's relative told us, "It's a wonderful place, a pretty marvellous place. Its improved leaps and bounds since she [relative] came here 10 years ago." And another relative told us, "Funnily, I recommended it this morning for a friend's mum. We've no qualms." Furthermore, people and their relatives gave their feedback through a quality assurance questionnaire organised by a national care home body and also through NHS choices website. We saw that feedback on all aspects of the service were positive and read comments such as, "we cannot fault the care" and "couldn't have chosen better."

We saw several examples where the service and individual staff had achieved recognition for delivering high quality care. For example, in 2015 the head of care had won the leader of the year award and the head cook had received the Chairman's commendation for involvements. The service had received the Earl of Gainsborough Award for infection control, medicines, care and dementia care. In addition, they had received an award from the chief admiral nurse for high standards of dementia care. Finally, the week before our inspection the activity coordinator attended London for the National Dementia Care Awards as they had been short listed for the award of activity coordinator of the year.

We found that the registered manager monitored care in the service and had undertaken a night visit on 23 November 2015 to monitor several aspects of life in the service at night. For example, the overall security of the premises, the call buzzers response time, information shared on handover and that record charts were completed as care was given and found the standard to be good.

There was a programme of regular audits that included all departments and covered key areas such as health and safety, medicines and infection control. Staff were aware that aspects of their work and the environment were audited. For example, a housekeeper told us, "I complete a daily task list and sign it and it's kept for auditing." An annual care quality audit was undertaken on behalf of the provider and the service had achieved an overall score 100%; the only service operated by the provider to achieve this. In addition, the area operations manager undertook monthly quality assurance review visits and the registered manager completed a monthly report that covered all aspects of care, such as any falls, weight losses and skin damage. The registered manager told us that the outcome of the quality audits and reports were shared with all the team at team meetings and supervision sessions, lessons were learnt and action plans were put in place.

Staff had access to policies and procedures on a range of topics relevant to their roles, For example, we saw policies on safeguarding, nutrition and tissue viability. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager, local authority and CQC. We found that previous safeguarding concerns had been investigated by the registered manager and appropriate actions had been taken.

Finally, the service was a member of NAPA; a charitable organisation interested in increasing activity opportunities for older people in care settings and also a member of the local care home association, which provided opportunities for training and networking for care home staff.