Jasmine Care Holdings Limited

Maple House

Inspection report

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Date of inspection visit: 18 and 19 August 2015
Date of publication: 21/09/2015

Ratings

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

Overall summary

The inspection took place on 18 and 19 August 2015 and was unannounced. Maple House provides residential accommodation and nursing care for up to 57 older people, including people living with dementia. At the time of our inspection 50 people were living in the home.

The home is a Victorian four storey building, with stairs and lifts providing access between floors. Some corridors were narrow and winding. There was an enclosed sensory garden with shaded seating outdoors. A sensory garden provides people with stimulation of their senses, such as smell, sight, touch and sound, through the plants and ornaments used. This can provide people with comfort and prompt reminiscence.

The home had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Summary of findings

Recruitment processes did not always evidence that people had been protected from the risks of unsuitable staff. Some checks, such as identity and criminal records checks, had been completed satisfactorily. However, the provider had not ensured that investigation into and explanation of gaps in applicants' employment history had always been recorded. Evidence of suitable conduct in previous relevant employment positions had not always been requested. The registered manager was able to provide evidence that these concerns had been satisfactorily addressed following our inspection. We have made a recommendation that the provider reviews their recruitment policy to ensure it documents all the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were protected from harm, because staff understood indicators of abuse and the process to raise concerns. Risks to people's health and wellbeing were managed because they had been identified, and actions implemented to reduce the risk of harm. For example, staff were trained in actions to take in the event of an emergency, and equipment was regularly checked and serviced.

Staffing levels were sufficient to provide people with a prompt response when they called for assistance, and to ensure their care needs were met as they wished.

People took their prescribed medicines at the same time daily. Nurses administered prescribed medicines safely, and completed medicines records appropriately. Medicines were stored and disposed of safely, in accordance with the provider's policy and NHS guidelines.

Staff completed and refreshed training to ensure they acquired and maintained the skills required to support and care for people effectively. Learning was evaluated to ensure staff retained these skills. Regular supervisory meetings and staff meetings provided opportunities to review staff needs and aspirations, and address any issues or concerns.

People were asked for their consent before care or treatment was provided. When they had been assessed as lacking the mental capacity to make specific decisions about their care, or people's liberty had been restricted to protect them from identified risks, the process of assessing their mental capacity to make specific decisions and best interest decisions had been documented. Applications for Deprivation of Liberty Safeguards had been appropriately submitted.

People were supported to maintain a diet sufficient to protect them from the risks of malnutrition and dehydration. Mealtimes were a sociable occasion, with support provided for those who required assistance to eat or drink.

People were supported to maintain their health and wellbeing. Nurses liaised with the GP and other health professionals to ensure people's health needs were managed effectively.

People told us staff were caring and respectful, and we saw this demonstrated in the care people experienced. People were encouraged to make decisions about the care and support they received through the choices they were offered. People's preferences, likes and dislikes were documented to ensure they experienced care in accordance with their wishes.

Staff were respectful of people's privacy, and valued the time they spent with people. They enjoyed helping people feel content in the home.

Staff understood people's care and support needs. They reviewed these regularly with people or their lawful representatives to ensure they received care that supported their health and welfare needs.

A range of activities were provided to participate in, and people were encouraged to join in group activities. They were supported in one to one sessions to reduce their social isolation when they chose or were unable to participate in group activities.

People and their relatives were encouraged to provide feedback on their care and wishes. The registered manager encouraged people to share minor concerns promptly, so that these could be addressed before they escalated. The provider's complaints procedure assured people that formal concerns would be addressed appropriately.

People were supported to live the life they chose. Nurses trained in palliative care ensured people were supported to die with dignity and without pain. Staff displayed the provider's values when supporting people, as they promoted their dignity and celebrated cultural

Summary of findings

differences. Staff were encouraged to make suggestions to drive improvements to people's care, and responded positively to criticism to deliver high quality care for people.

People told us the home was well managed, and staff respected the registered manager. The registered manager ensured appropriate actions were taken to drive improvements to the quality of care people experienced when issues were identified.

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?

Requires Improvement

The service was not always safe.

Documentation of staff recruitment processes had not always been sufficiently robust to evidence that all legally required checks and processes had been followed. The risk that unsuitable applicants may be employed to care for people was reduced through staff competency and monitoring checks.

People were protected from the risk of abuse, because staff understood and followed the correct procedures to identify, report and address safeguarding concerns.

People were protected against risks associated with their health needs, because staff understood how to support them safely. Environmental risks to people were managed safely through a process of checks and servicing.

Staffing levels were sufficient to meet people's needs and wishes promptly.

People were protected against the risks associated with medicines, because appropriate checks and records ensured they received their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

People were supported effectively by staff who were trained and skilled to meet their health and support needs. Additional training supported staff to develop skills to meet people's changing needs.

Staff understood and implemented the principles of the Mental Capacity Act 2005 to ensure people were supported to make informed decisions about their care. Deprivation of Liberty Safeguards were only implemented where it was appropriate to lawfully restrict people's access to promote their safety.

People were supported to maintain a nutritious diet. Staff worked effectively with health professionals to maintain and support people's health and welfare.

Is the service caring?

Good

The service was caring.

People were treated kindly by staff supporting them.

People's views were listened to, and informed the care they experienced.

Staff understood and respected people's wishes and preferences, and promoted their dignity.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's needs had been assessed, and were reviewed regularly to ensure any changes were identified and supported.

People were supported to engage in activities individually or in groups.

People's concerns were dealt with proactively to reduce the need to raise formal complaints.

Is the service well-led?

Good

The service was well-led.

People were supported to live the life they chose, and were supported at the end of their lives to die with dignity.

Staff demonstrated the provider's values of respect and inclusion. The registered manager provided clear leadership and supported staff to care for people effectively.

Internal audits were used to review and drive improvements to the quality of care people experienced.

Maple House

Detailed findings

Background to this inspection

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

The inspection took place on 18 and 19 August 2015 and was unannounced. The inspection team consisted of two inspectors, and an expert by experience with knowledge of people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. A Provider Information Review (PIR) had not been requested for this 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 discussed the information that would have been included in this form during our inspection. Prior to our inspection we reviewed information shared by the local authority about this home, and discussed the care people experienced with a specialist nurse who supports this home.

During our inspection some people were unable to tell us about their experience of the care they received. We observed the care and support people received throughout our inspection to inform us about people's experiences of the home. We spoke with five people living at Maple House, and three relatives of people living in the home to gain their views of people's care. We spoke with the registered manager and deputy manager, the provider, and five care workers and nurses. We also spoke with four staff in supporting roles at the home, including the chef, activity coordinator and maintenance person.

We reviewed four people's care plans, including daily care records and medicines administration records (MARs). We looked at five staff recruitment files, and records of staff support and training. We looked at the working staff roster for four weeks from 27 July to 16 August 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how relatives' and staff's comments and quality assurance audits were used to drive improvements in the service.

We last inspected this service on 19 May 2014, and did not identify any areas of concern.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home. Their comments included "I feel safe with the staff here and there is absolutely nothing untoward going on," and "I think I feel safe because all the nurses are so kind." One person told us "I feel safe even if it is in the night. I only have to press the buzzer and someone will be here in minutes." They also stated "You feel secure, you're not on your own because there is always someone near to help. I can't think of anything not so good, everyone here is so nice." Relatives confirmed that they also felt their loved ones were safe at Maple House.

We found documentation was not sufficiently robust to evidence that staff recruitment processes always met the requirements of the Regulations. Some checks, such as proof of applicants' identity, investigation of any criminal record, and evidence of registration with professional bodies, such as the Nursing and Midwifery Council, had been satisfactorily investigated and documented. However, recruitment files did not always show evidence of applicants' full employment history, or document that character references had been sought from all of their relevant previous employment positions in health and social care.

The registered manager was able to explain most of the employment gaps we identified during our inspection. Following our inspection the registered manager provided verification that all the gaps we identified had been satisfactorily explained, for example through maternity leave, job seeking or immigration processes. The provider's recruitment process had not been sufficiently robust to identify the need for investigation of good conduct in all health and social care roles prior to an applicant's employment at Maple House. Following our inspection, the registered manager confirmed that they had risk assessed the impact of this, and showed us that they had now sought verification of good conduct in these roles for all staff employed within the last 12 months. They had assessed that the risk of people receiving inappropriate care from staff of longer standing was sufficiently managed, because of regular competency and monitoring checks.

We recommend that the provider reviews their recruitment policy to ensure it documents all the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were aware of the indicators that people were at risk of or had been abused. They understood the provider's safeguarding policy and procedures, recognised the importance of reporting concerns, and had confidence that the registered manager would deal with these appropriately. Contact details to report safeguarding issues to external authorities, such as the local safeguarding team, were displayed on the staff information notice board. This ensured that staff were aware of who to raise concerns with if the registered manager was unavailable. All staff had completed safeguarding training, and could access the provider's safeguarding policy for reference.

A whistle blowing policy provided staff with guidance on raising concerns outside of the home should they feel issues had not been appropriately managed. Following a training session, learning was evaluated through a questionnaire. This ensured that staff understood the process to whistle blow on poor or unsafe care. Staff told us they would be prepared to follow this process if they were concerned for people's safety. This helped to protect people from unsafe or abusive support.

Risks to people's health and wellbeing were identified, and actions implemented to reduce the risk of harm. For example, people's falls were reviewed to identify the cause, and actions had been taken to reduce the risk of them experiencing repeated falls, such as increasing their monitoring or the provision of equipment to support people to walk safely. Where people had been identified as at risk of malnutrition, food and fluid charts were used to monitor their daily intake, and ensure this was sufficient to maintain their health. Re-positioning charts demonstrated people unable to turn themselves unaided were supported to re-position regularly to prevent pressure damage to their skin. Risk assessments were reviewed monthly, and actions taken as people's needs changed, for example by referring them to health professionals to ensure their needs were met appropriately, or ensuring pressure-relieving mattresses and cushions were used to reduce the risk of pressure ulcers.

Emergency procedures and training in emergency first aid ensured people's safety was managed effectively during medical emergencies. Staff were prompt to identify when people were unwell. Equipment within the home, such as a defibrillator and nebuliser, meant that nurses were able to support people's emergency health needs until the GP or paramedics intervened. A defibrillator detects the heart's

Is the service safe?

rhythm, and can be used to shock it back into rhythm if required. A nebuliser delivers asthma medication to people through a face mask. A 'grab bag' was held in the clinical room, containing emergency medical equipment, and staff understood how to use this in the event of a medical emergency.

Generic risks, such as sunburn, or the risk of slips caused by snow and ice, were managed because staff followed risk assessments and policies to mitigate identified risks, through the use of sun cream and keeping external stairs and ramps ice free. The home was kept safe for people and others through a system of training, checks and servicing. For example, all staff were trained in the actions to take in the event of a fire. Practical training ensured they knew how to use fire extinguishers, actions to take should they find a fire in the home, and how to safely evacuate people. Fire extinguishers were serviced regularly to ensure they were in working order, and the fire alarm was tested weekly.

The maintenance person carried out regular checks, such as ensuring call bells worked and water temperatures did not exceed the maximum permitted temperature. These checks protected people from risks such as a lack of response to calls for assistance, or scalding. External contractors carried out regular equipment servicing, for example on the lifts and emergency lighting.

People, relatives and staff did not raise concerns about staffing levels. One person told us "I feel safe because there is always a lot of staff about", and another said "It's pretty good here, when I press the buzzer they come quickly." People told us there were sufficient staff at night as well as during the day. One care worker described how work was arranged to ensure they always got their planned breaks, and they had sufficient time to spend quality time with people during the day to sit and chat, as well as to attend to their needs. We observed that staff responded to call bells promptly, and there appeared to be sufficient staff to meet people's needs and wishes throughout the day.

The registered manager explained that people's dependency was assessed, and staffing levels were adjusted to meet this. Staff rosters were planned to include a period of handover between the nurses. This ensured that staff coming on shift were informed of any changes to people's care needs.

People told us they received their prescribed medicines at the same time daily. Nurses followed people's medicine administration records (MARs) to ensure they provided people with their prescribed medicines at the correct time. They worked closed with the pharmacy, and used an electronic medicine administration records (EMAR) system that could be checked directly by the pharmacy to identify any errors or gaps in people's medicines. One nurse told us the EMAR system was so easy to use it was difficult to make a mistake with it, as it prompted staff to follow safe and thorough procedures and document their actions when administering people's medicines. Nurses reviewed EMARs daily to identify any errors, and told us the registered manager addressed any continued errors through additional training and competency reviews.

Medicines were kept securely, temperature checks ensured medicines were stored at the correct temperature, and medicines were labelled when bottles or tubes were opened. This ensured that medicines were not used if they were out of date.

We observed a medicines administration round. The nurse referred to each person's EMAR chart to ensure they received their prescribed dose. They provided the person with reassurance by speaking quietly and touching them gently, and explained that they were providing them with their medicines. Medicines were provided at the person's pace, as the nurse waited patiently for them to swallow a few tablets at a time. When one person refused their medicines, the nurse tried to persuade them, but accepted their continued refusal, and logged this on their EMAR. They explained that continued refusal would be discussed with the GP, and their medicines would be reviewed to consider if it was important enough to follow the process to give these covertly, for example by hiding medicines in food. No one received their medicines covertly at the time of our inspection. People's medicines were administered safely.

Good

Is the service effective?

Our findings

Staff told us they were confident they had the skills and knowledge to support people effectively. Staff refreshed their training in the provider's mandatory subjects including safeguarding, moving people safely, dementia care and food hygiene annually. Training was followed by a questionnaire or competency assessment to ensure staff understood and had implemented their training. Training records evidenced that staff had the skills and knowledge to support people effectively.

New staff completed an induction and probation period, and were required to work towards achieving the Care Certificate. This is a nationally recognised standard of care in the health and social care industry. Induction included the new staff member shadowing experienced staff, and developing their skills through a planned work programme to develop their confidence and ability. The deputy manager planned staff rosters to ensure new staff were paired with experienced staff to guide them. Nurses were required to spend time working as a care worker during their induction. This ensured that they understood the role of the care worker, and were able to provide this care for people if required.

Additional training was available to ensure staff maintained and developed the skills required to meet people's diverse needs. Nurses told us they had additional training in topics such as end of life care and emergency first aid and equipment use to maintain and revalidate their nursing registration, and records confirmed this. Nurses and senior care workers were encouraged to attend regional training events to develop their skills and knowledge, for example in pain management. The registered manager told us staff attending external training were required to share their learning with other staff. This meant that learning was used effectively to develop knowledge and understanding in the workforce.

Staff told us they had regular supervisory meetings, and there were also opportunities outside of these to discuss any concerns or issues, as the registered manager and deputy manager were visible and approachable. Records demonstrated that supervisory meetings were used to review staff training and development, discuss any employment issues, and provide support or guidance as required.

Regular meetings provided opportunities for staff to raise issues or concerns, and ensured information was shared. Minutes from a staff meeting held in June 2015 reminded staff to read updated policies and procedures, and reminded staff of protocols such as smoking breaks and maintaining security in the home. We noted issues raised during these meetings had been addressed. For example, staff took planned breaks to ensure sufficient staff were available to respond to people's calls at all times.

People told us staff always asked them for their consent before providing personal care. We observed staff explained what they planned to do for people, and sought their permission to do so. For example, when one person needed to transfer from their chair to a wheelchair, staff explained they planned to use the hoist to help them mobilise, and ensured the person understood and smiled their consent.

One care worker explained "I try to be positive, encourage [people] to be independent and try things". They explained that because they understood people, they knew how to encourage them to do things when they originally refused, for example by asking another staff member to try to persuade them, or asking them for consent later in the day. They knew music or television programmes that lifted people's moods, and made them more likely to agree to care when asked later.

People's care plans noted when people had difficulties retaining information, and provided guidance to ensure staff promoted choices for people, for example in the clothing they wore, the meals they ate and activities they attended. Staff were reminded that people should be allowed to make unwise decisions if they wished. Consent to specific actions, such as the use of their photograph, consent to treatment and personal care, and administration of medicines, was documented in people's care plans when this had been given. A nurse told us "If they have capacity they tell us what they want as well as what they need. We explain things even if they don't understand. They always have the right to refuse". Staff had completed training in the Mental Capacity Act (MCA) 2005, and understood the importance of seeking consent for the care they provided.

A record of those with Lasting Power of Attorney (LPA) to legally make decisions for people was documented in

people's care plans. This noted whether LPAs covered health and welfare decisions. Relatives or others were only permitted to make decisions on a person's behalf at Maple House when they had the legal right to do so.

When people may have lacked the capacity to make specific decisions, records evidenced that a nurse had assessed their mental capacity, and where appropriate sought guidance from their LPA or made a decision in the person's best interest. They collaborated with others, such as health professionals, keyworkers or family, to ensure the person's views and wishes were considered alongside their health needs. Records of night time care or provision of vaccination against influenza demonstrated that where people lacked the mental capacity to make these decisions, the process of assessment and best interest decision-making was appropriately followed.

People's safety was protected by the use of stair guards and a keypad lock on the front door. This ensured that people who were unable to identify dangers, such as falling down stairs or road traffic, were protected. The registered manager or nurse had assessed the impact this had on people who may be unable to open door guards or use keypads. Where these actions restricted people's liberty, they had completed the process to apply for Deprivation of Liberty Safeguards (DoLS).

DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this is a necessity to promote their safety. The DoLS are part of the MCA 2005 and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. The registered manager understood the process to identify potential restrictions to people's liberty, and when it was appropriate to make a DoLS application. DoLS applications had been submitted for 24 people to the safeguarding authority, and ten had been granted at the time of our inspection. This ensured that restrictions on people's liberty were lawful, and promoted their safety in the least restrictive way.

People spoke positively about the meals provided. One person told us "The food is very good here and you get a choice. I'm not keen on the pudding so I always get a savoury choice", and another person explained how their dietary needs were accommodated with the provision of gluten-free meals. Staff were aware of those with specific dietary needs, and risks such as choking, and ensured the meals provided were appropriate to each person's needs. For example, the chef kept a list of people requiring pureed meals, and ensured a sufficient number were prepared as needed.

People's dietary needs and preferences were discussed with them before they were admitted to the home, and reviewed with them regularly. This ensured that changes to people's likes or dislikes were met. A survey had been conducted earlier in 2015 to consider people's meals preferences, and drive changes to planned seasonal menus.

We observed lunchtime on two separate days. We found people were supported to dine in the venue of their choice. Some people ate together at a dining table, some chose to eat in the conservatory, and others dined in their rooms or the lounge. Meals were provided promptly, and sufficient staff were available to support people to eat when this was required. Staff were prompt to offer help to cut food up if they noticed a person was struggling. When they supported people with their eating, each mouthful was provided at the person's pace, and staff chatted with the person whilst supporting them. This helped to make mealtimes a positive experience for people. People were encouraged to eat independently when they were able, and the dining experience was a vibrant and social occasion. People were supported to effectively maintain their nutritional requirements.

Staff were aware of people at risk of malnutrition or dehydration. Where people's dietary intake required monitoring, staff completed food and fluid charts to ensure their daily intake was documented. Nurses reviewed these charts daily, and monitored people's weights monthly, to ensure that risks to their health were managed. Where actions taken had not been sufficient to protect people from malnutrition or dehydration, nurses had referred people to the GP, dietician or Speech and Language Therapist to ensure appropriate actions were implemented to protect people from harm.

People told us they were able to see health professionals, such as the GP, as they needed. One person said "I have good access to a doctor, I can see the GP more or less when I want to". They told us attention to their medical condition was good, and had promoted the healing of wounds developed prior to their admission to the home.

Good

Is the service effective?

Nurses told us they had a good relationship with the GP and other health professionals, such as the mental health team, staff from the memory clinic and occupational therapist. Nurses accompanied the GP on weekly rounds. This ensured that they were aware of changes to people's prescribed medicines or planned treatment. Health professionals were included in reviews of people's care when necessary, and this was documented in their care plans. For example, we saw records of discussions to review people's medicinal supplements. People were supported to maintain good health.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring, kind and supportive. A relative told us staff had cared for their loved one "Better here [at Maple House] than in the hospital" following a medical emergency. "I am very happy with the care in this home". One person told us "I feel as though staff here care for me and I am sure most of them do. They have asked about my history and know my likes and dislikes. When I came in here suddenly there was a family around me, there is always someone to talk to".

Other people confirmed that staff took time to chat with them, and we observed people and staff sat together, chatting and laughing. One care worker explained how they chatted with people while providing their personal care. They sang to them and told jokes to brighten up their day, and valued the time they were able to spend with people on a one to one basis. People were congratulated on their singing during a karaoke sing-along before lunch. The activity coordinator leading the session asked people if they knew the song, and encouraged their participation. They knew songs that people enjoyed singing along to, and asked for suggestions of songs to select. They demonstrated how they valued people's comments in the song selection chosen.

Nurses discussed people's wishes and preferences with them when they were first admitted to Maple House, but told us they offered choices daily "Because people's wishes can change". One person said "The carers respect my wishes, I have only got to ask if I need anything, they are very good."

People's wishes, likes and preferences were documented in their care plans, and updates demonstrated that these were reviewed monthly. Care workers spoke knowledgeably about people's preferences and wishes, and daily notes documented that people had control over their lives, for example regarding the time they wished to get up in the morning, or where they dined. Records demonstrated that people's wishes influenced their plan of care, and they were involved in decision-making. One person told us of changes that had been made to accommodate their needs and wishes. "A lot was done to make it okay for me. They have got some really lovely people working here".

We observed one person in their wheelchair. The care worker explained that it would be safer for them to place their feet on the foot plate when they wheeled them into the dining area, to protect them from the risk of trapping their feet. When they moved the person's feet onto the foot plate, the person took their feet off, and repeated this movement when the care worker tried again. This indicated that they did not wish to place their feet on the foot plate. The care worker then wheeled the person backwards, and explained to the person that this would protect their feet from becoming trapped. The person smiled, and was relaxed and contented as the care worker moved them. This demonstrated that staff took account of people's wishes whilst supporting them safely.

People told us staff listened to their comments, and respected their wishes. One person said "I wouldn't like to be in their [care worker's] shoes if the manager walked past and they weren't respecting my privacy". We observed the registered manager reprimanded a care worker for not asking first before placing a protective cover on a person's clothes prior to lunch, explaining that they should always be asked about their preference to use this or choose not to. People's choices and wishes were respected. Staff knocked on people's doors before entering, and listened closely to their comments to ensure they provided them with the care and support they wanted. They respected people's wishes to remain in their rooms or join in with activities. They provided people with options to ensure that they were able to make informed choices, for example about where to eat their meals.

The activity coordinator explained how they spent time with people on a one to one basis, and extended this time if the person appeared upset or in a low mood. They understood some people did not enjoy mixing in groups, and ensured their wishes were respected whilst offering support to reduce the risk of social isolation. People were supported in a kind and caring way by staff who demonstrated a sound knowledge of their wishes and preferences.

Good

Is the service responsive?

Our findings

People told us staff listened to their comments about their care, and involved them in discussions and reviews of their care and treatment. One person said "They listen to what I have to say about my [treatment]. Actually they are all very easy to talk to about it." Relatives told us they were involved in decision-making about people's care or treatment when it was legally appropriate to do so.

People's needs were assessed, discussed and documented in their care plans when people were admitted to the home. Monthly updates reviewed any changes to people's needs or wishes. People or their lawful representatives were encouraged to review and discuss their needs with the nurses or their keyworker, to ensure their views and comments informed their plan of care.

Care staff confirmed they read care plans to understand people's required care, and effective handovers ensured they were made aware of any changes to this. We observed a handover between shifts. Nurses and care workers shared updates on people's conditions, moods and health to ensure people were supported as they needed and wished. Staff were alerted to changes that may indicate the initial stages of ill health. For example, a care worker noted that one person had a reddened area of skin during their personal care that morning. This could be an indicator of pressure on the skin, and could lead to a pressure ulcer if untreated. The nurse and registered manager immediately informed care workers of the actions required to promote this person's skin integrity, such as ensuring pressure was alleviated through re-positioning and a pressure-relieving cushion. The area was documented on a body map to ensure staff could monitor any changes. Staff followed the provider's pressure care protocol to protect the person from potential harm.

Each care worker referred to an allocation sheet to ensure they provided people in their care with the support they required. One care worker told us the sheet was "Amazing", as it guided them to deliver each person's required care as they wanted. The allocations sheet noted when people required support to re-position, and the number of staff required to do this safely. It documented information such as people's dietary needs, health conditions that should be monitored, and preferences for an afternoon nap. Staff told us the allocations sheet was updated weekly, and handovers held between each shift change meant staff were updated on any alterations required throughout the day.

Care plans included guidance for staff on how to communicate effectively if people were unable to verbally inform staff of their needs or wishes. Assessment tools were used to monitor known health risks and ensure people's care promoted their health and welfare. For example, indicators of pain were monitored to ensure people's pain was managed effectively.

A 'This is Me' section of the care plan documented the person's personal history, such as their family, employment and key stages in their life. This had been completed with the person or their family as appropriate. It noted their wishes as well as their needs, and the support that would provide them with comfort when they were anxious or upset. The activities coordinator explained how they used this information to drive conversations during one to one chats, and to consider activities and trips related to people's interests. "We pick up on their passions".

People's feedback on the activities provided was mixed. Two people told us activities were sparse, and that staff rarely visited them in their room. But others told us of one to one visits they experienced in their rooms, and of the range of activities provided. One person told us "The activities are very good and there is something going on every day". Another commented "That was good, I loved it" following a sing-along session.

Activities were planned throughout the day, but the activities coordinator explained that they changed these around according to people's moods or participation. They told us "This is their life, not their job", and explained sometimes people just wanted to sit and chat rather than join in with singing or quizzes. Entertainers visited people in their rooms if they did not want to join in with group entertainment. For example, a pet therapy team and choir visited people individually as well as providing group activities. The vicar and hairdresser saw people on a one to one basis if they wished. This ensured that people who chose to spend time alone did not miss out on the range of planned activities and visitors.

Outings, for example to a ballroom dancing competition, a canal boat trip or the local garden centre, were organised to provide people with the opportunity to access the local

Good

Is the service responsive?

community if they wished. A raised bed in the garden provided people with the opportunity to grow plants and vegetables, and vegetables grown by people were used at mealtimes. This provided meaning to people's hard work, and indicated that it was valued by staff.

The activity coordinators did not work at weekends. Although activities were planned throughout the weekend, care workers had to deliver these in addition to providing people with their planned care and support. Relatives told us this did not always happen, although the activity coordinators told us staff were "Improving" in their ability and confidence to provide these. Games and manicure items moved from their storage area over the weekend, indicating that care workers had spent time providing activities when the activity coordinators were not working. Nurses checked on people who remained in their rooms on an hourly basis. This ensured that people experienced social stimulation throughout the week, including at weekends.

People and their relatives had opportunities to provide feedback and drive changes to the care and support they experienced. Staff discussed activity plans and ideas with people during group and one to one activities, and considered their suggestions when planning and delivering new activities. Surveys ensured people and their relatives could provide more formal feedback to the provider. Responses to a survey conducted earlier in 2015 indicated that people and their relatives were content with the care provided, and did not raise any issues that required action.

The provider had checked that people and their representatives understood the complaints procedure, and included this in information provided, such as the residents' charter and information booklet. No formal complaints had been raised since our last inspection, and people confirmed that they had no requirement to complain. One relative told us the registered manager was always quick to respond to their emails, and felt contact was good.

A suggestions box at reception provided an opportunity to raise concerns anonymously, and a 'grumbles' form was provided for people or their relatives to raise minor concerns. The registered manager explained these were used to "Nip complaints in the bud", and address issues before they escalated. A minor issue regarding laundry had been addressed promptly to the person's satisfaction when raised in this manner. Relatives meetings provided an opportunity to discuss plans and raise any issues. Minutes from a meeting held in March 2015 reminded relatives of the complaints procedure and provided an opportunity to discuss any grumbles. The minutes did not indicate that any concerns had been raised from this meeting.

Good

Is the service well-led?

Our findings

People and their relatives described the home as well managed. They told us the home was "Friendly" and "Homely" with a "Family atmosphere". They felt supported to live as independent and content a life as they were able. Staff completed equality and diversity training to understand and respect people's diverse needs, regardless of differences such as their sexuality, impairments or disabilities. Different cultures in the work force were celebrated. Staff told us of a fashion show, where staff had dressed in their cultural costumes. People and staff had enjoyed the opportunity to celebrate their different cultural heritages.

A quarterly newsletter remembered people who had passed away, and an annual memorial service celebrated their lives. The provider's values were included in a service user charter, and documented in the service user guide. This included the right for people to live as they chose, to be treated with respect, and to promote their dignity, welfare and wellbeing. The provider's aim was to support people to have an improved and sustained quality of care, and to die well when the time came. Relatives were encouraged to spend time with their loved ones when they neared the end of their lives, and staff took special care to ensure people's last hours were peaceful and content. The registered manager told us "I'm passionate that people should experience a good death".

The registered manager was an ambassador for the Gold Standard Framework (GSF), and the home was accredited for palliative care. The GSF enables staff to provide a gold standard of care for people nearing the end of life, through training to ensure people experienced better lives and recognised high standards of end of life care. Nurses were trained in palliative care to ensure they supported people effectively, managing pain medication to ensure people died peacefully. Relatives were supported sympathetically to come to terms with their bereavement.

People's visitors were offered the opportunity to attend training to support people to mobilise safely if they wished to take people out. Events and outings were advertised in the home to enable relatives to plan their visits or provide support. They were welcomed into the home at any time during the day or evening, and stays were facilitated with accommodation on site when required.

Staff told us they worked together flexibly to provide people with effective care. One care worker told us "Everyone works together". A nurse explained that nurses were responsible for monitoring the work of the care workers, and said "We have to tell them off sometimes, but we have good team work here". We observed staff took constructive criticism well, and used this as an opportunity to improve their knowledge and understanding to effectively support people.

Staff told us meetings allowed them to drive changes to improve people's care. For example, concerns regarding the use of personal telephones in the workplace had been addressed, and staff were no longer distracted by their mobile phones. A questionnaire provided feedback to the provider on issues that could affect staff retention, and reviewed whether staff felt empowered and supported. Responses indicated that staff believed in and adhered to the provider's values, and that they felt management also demonstrated these values.

People told us the home was well managed, efficient and organised, and that the registered manager was well respected by staff. People knew the registered manager by sight, and told us she sometimes chatted with them. Staff described the registered manager as open, fair and supportive, and a nurse told us "Whenever we have a problem they [the registered manager and deputy manager] are there, including out of hours. The manager leads by example, she helps out everywhere". A care worker stated "Any issues are picked up very quickly". Staff told us they were able to discuss concerns at staff meetings with "No judgement", which meant actions could be implemented promptly to address and resolve issues.

The registered manager walked around the home several times daily, and undertook home inspections with key staff, such as the maintenance person. They highlighted any issues and ensured they were dealt with immediately. For example, on the first day of our inspection, the registered manager found a faulty window restrictor. They reported this to the maintenance person without delay, and the restrictor was repaired within 30 minutes. Staff told us any errors identified were used as "A learning curve for us all", and the registered manager confirmed that they used role play to provide practical learning to drive improvements in the care people experienced. Where poor practice was

Good

Is the service well-led?

identified, for example if someone was not supported to mobilise safely, staff training was refreshed, and competency reassessed to ensure safe practice was followed.

Nurses carried out monthly audits to identify areas where improvement was required. They completed audits of topics including medicine administration, night care and care plan reviews. In addition, they completed weekly and daily checks, such as reviewing nutrition, hydration and re-positioning charts, and ensured medical equipment was fully functioning. The registered manager carried out spot checks to ensure audits were completed robustly, and that actions required had been identified and addressed. Any actions required were discussed and agreed with the registered manager to ensure people experienced appropriate care and support.

The registered manager explained that because they addressed any issues straight away, they did not have a requirement for an action plan to document progress towards resolution. However, a business plan noted improvements planned to drive high quality care for people, such as a planned upgrade in flooring and furniture, and the installation of internet access throughout the home to enable use of EMARs. The provider told us they visited the home regularly, although we did not see evidence of provider audits or reports. Improvements had been considered and actions implemented to ensure people experienced high quality care at Maple House.