Chantry Retirement Homes Limited

Euroclydon Nursing Home

Inspection report

Hawthorns
Drybrook
Gloucestershire
GL17 9BW

Tel: 01594543982
Website: www.chantryhomes.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection site visits took place on 27, 29 and 30 January 2018. The first day of the inspection was unannounced. This was our third rated inspection of this service.

Our first rated inspection on 22, 23, 27 and 28 July 2016 found a breach in relation to the cleanliness of the environment. Improvements were also needed to the activities in the home as well as people's care plans and mobility support. The service was rated Requires Improvement.

During our second rated inspection 7 February 2017 we found the provider had taken action and had made the required improvements. We again rated the service Requires Improvement as these improvements needed to be sustained over time in order for the home to be rated Good.

At this inspection we found all improvements had been sustained and the home's overall rating improved to Good.

Euroclydon Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Euroclydon Nursing Home provides accommodation, nursing and personal care. The home specialised in providing care to people who lived with dementia and to some with specific physical disabilities.

The care home is registered with the Care Quality Commission (CQC) to accommodate 48 people. Since 2016, the provider has accommodated no more than 27 people in one adapted part of the building. This is because alterations for the use of the rest of the building are in progress. At the time of our site visit 27 people were accommodated.

Accommodation comprised of single bedrooms with private washing facilities and sometimes toilet facilities, a window, bedroom furniture and heating. People had the use of several communal rooms. There were ample communal toilets and bathrooms. A conservatory provided access to an enclosed garden. People who lived at Euroclydon Nursing Home had access to the provider's day centre which was on site. There was parking for eight visitors with one designated disabled parking space.

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

People were kept safe because staff assessed risks which may have an impact on people and managed these effectively. People were protected from abuse and discrimination because staff had received training on these issues and knew how to recognise them and report concerns. There were enough staff, who were

safely recruited, to meet people's needs. People received support to take their medicines as prescribed. People lived in a home which was clean and where there were infection control arrangements in place.

People's needs were assessed prior to admission and thereafter to ensure these were identified and met. People were cared for by staff who had received appropriate training and support. People received help to eat and drink, were provided with a choice of food and their nutritional wellbeing was supported. The principles of the Mental Capacity Act were adhered to. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the home supported this practice. Adaptations had been made to the environment to support people's mental and physical needs.

Care was provided in a kind and compassionate way. Staff took into consideration people's wishes and preferences and tailored their care around these. Staff were skilful in communicating with people and supporting them to live well with dementia. People's dignity and privacy was upheld. Relatives and friends were made to feel welcomed.

People and where appropriate their relatives were involved in making choices about their care and treatment. Care plans gave staff guidance on how people wished their needs to be met and how these should be met safely. People were supported to take part in activities which they enjoyed and which enabled them to be socially included. Arrangements were in place for complaints and areas of dissatisfaction to be raised, listened to and resolved, where possible. People were supported to have a dignified and comfortable death. End of life care was discussed and prepared for so people's wishes and preferences were met.

The service was well managed by a registered manager whose values and visions promoted and achieved good outcomes for people. They had supported a period of change in 2016-2017, where people, relatives and staff had needed additional support to get used to a new environment. They kept their personal skills and knowledge up to date in order to promote and support best practice. There were arrangements in place to monitor the services provided and to drive improvement. Links with the community were made which benefited the people who lived in the home and those in the wider community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People lived in a clean home where infection control measures were in place.

Risks to people's health and their safety were identified and actions taken to reduce these.

Actions were taken to protect people from potential abuse and discrimination.

People received support to take their medicines safely and as prescribed.

There were enough staff to ensure people's needs were met. Thorough staff recruitment processes helped to protect people from those who may not be suitable.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care was delivered by staff who had been appropriately trained and supported.

People were supported to make independent decisions. The principles of the Mental Capacity Act were adhered to and this protected those who lacked mental capacity.

People had access to health and social care professional as needed.

People's nutritional wellbeing was supported and risks related to this identified and managed.

Adaptions had been made to the environment to meet people's diverse needs.

Is the service caring?

Good

The service was caring.

People's care was delivered with kindness and compassion.

Staff had taken time to get to know people and they delivered personalised care which met people's diverse and individual communication needs.

Relatives received support and were welcomed when they visited.

People's dignity and privacy was maintained.

Is the service responsive?

Good

The service was responsive.

People and relatives were involved in planning the care which was delivered.

People were supported to take part in activities they enjoyed and which had a therapeutic value.

There were arrangements for complaints and areas of dissatisfaction to be raised, listened to and addressed.

At the end of their life people were supported to die in a dignified and comfortable way.

Is the service well-led?

Good

The service was well led.

People benefited from there being a strong leader in place with values which supported their wellbeing.

Staff were provided with the support which enabled them to provide care which was in line with best practice.

The service provided to people was monitored and a proactive approach was taken to continue to improve this.

Links with the community offered people in the home and people in the local community to come together.

Euroclydon Nursing Home

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.

Inspection site visit activity started on 27 January 2018, continued on 29 January and ended on 30 January 2018. One inspector carried out this inspection. It included speaking with people, relatives, staff, observing the support people received, reviewing records relating to people's care and the management of the home.

Prior to the site visit we reviewed the information we held about the home. This included statutory notifications since the last inspection on 7 February 2017. Notifications contain information about events in the home, which the provider must legally inform us about. We did not request a Provider Information Return (PIR) prior to this inspection. A PIR is a form which gives some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the site visit we spoke with two people who lived at the home but we observed the care and support given to many others who were unable to tell us about their experiences. We spoke with seven relatives, one friend, the registered manager and six members of staff. We reviewed two people's care files and records relating to the Mental Capacity Act for ten people. We reviewed two staff members' recruitment files, staff rosters and staff training arrangements. We reviewed all maintenance and health and safety monitoring records. We reviewed all servicing records and certificates for the home's equipment, utilities and safety systems. For example, the water system, call bell and fire safety systems. We reviewed the home's complaints log. We reviewed records relating to quality assurance and quality monitoring of the service. This included information from relatives' feedback questionnaires, a selection of audits and action plans.

We requested the provider forward to us their policies on safeguarding and equality and diversity, which they did. We obtained feedback from adult social care commissioners including a copy of the report of their last annual review visit completed in July 2017.

Good

Is the service safe?

Our findings

There were arrangements in place to keep people safe. One relative said, "I know my [relative] is safe and [relative] knows she is safe because she is relaxed."

We observed the home to be clean. There were arrangements in place to maintain its cleanliness. A member of staff told us they followed cleaning schedules and recorded what cleaning they had completed. The registered manager checked these records and carried out visual checks to ensure adequate cleaning had taken place. Carpets were cleaned on a rotational basis and in- between when needed.

One relative said, "[Name of relative's] bedroom smells lovely, always does each time I visit." Feedback provided by a relative, since the last inspection stated, "….. the home was always spotless and may I say there were no underlying odours." One relative told us they had complained to the registered manager about the odour of one carpet. The registered manager confirmed this carpet was frequently cleaned but explained it was due to be replaced. This was to happen soon as part of an on-going project, started earlier in 2017, of replacing existing floor coverings.

Actions were taken to reduce the risk of infections. Water samples were taken to test for legionella bacteria in the water system. The last testing in July 2017 reported no legionella bacteria present. A legionella risk assessment was in place. This recorded the actions to be taken to reduce this risk and keep the water system healthy. Maintenance records showed these were being completed. Other actions to prevent the spread of infection included, staff wearing protective gloves and aprons; when delivering personal care and supporting people with their food. Staff were observed washing their hands and hand sanitizers were available, including one in the reception area for visitors. Soiled laundry was segregated, handled and managed separately from other laundry. An "Infection Control Daily Management Plan" was in place to ensure equipment used by care and nursing staff was kept cleaned.

Kitchen staff were responsible for the cleanliness of the kitchen. The home had been re-assessed by the Food Standards Agency in January 2018 and re-awarded a rating of '5'. This is the highest rating an establishment can achieve for kitchen hygiene and food safety.

Actions were taken to reduce risks to people's health. Pressure ulcer risk assessments were completed for everyone and reviewed monthly. One person's relevant care plan referred to all factors which could contribute to pressure ulcers developing. It went on to give best practice guidance on how these were to be avoided. Where there was a potential risk of pressure ulcers developing, appropriate action had been taken. A relative told us they had been informed about their relative's risk in relation to this. They confirmed actions had been taken to address this. These actions included the use of pressure reducing mattresses, cushions and the repositioning of people. One person had been admitted to the home with a pressure ulcer already established. A health care professional commented, "It's a credit to the care that was given that it eventually healed as it was not expected to."

Everyone's risk of falling was assessed on admission. Falls risk assessments stated the level of risk and the

actions staff would take to reduce this. Two people had been assessed as high risk of falling on admission. One person had been admitted a few weeks prior to the inspection for respite care (short-term contract). All contributing factors had been reviewed. We observed this person receiving the support they needed to walk safely. The same actions had been taken for the second person. They now lived permanently in the home and a falls audit recorded this person as having not experienced further falls in the last three months.

Another person had been assessed as at risk of falling from their bed. Appropriate equipment had been put into place to manage this risk. This equipment allowed staff to reduce the likelihood of injury to the person but in the least restrictive way possible. A bed which could lower almost to floor, with a padded mat (crash mat) alongside had been installed. If the person rolled off their bed the risk of injury was reduced by the mat. The lowered bed negated the need for bed-rails. It reduced the risk of the person, who lived with dementia, climbing over these and falling from a height. This person's relative told us they visited most days, at various times and the padded mat and bed were always in the right position. Safe moving and handling assessments recorded the support people required to be moved safely. Staff had received training in safe moving and handling techniques and in the use of mechanical hoists.

We reviewed all maintenance records which showed actions were being taken to keep the environment and building safe. The provider employed maintenance people and had contracts in place with specialised companies to keep equipment and systems in the home safe. There was a fire risk assessment in place and other arrangements to keep fire detection and fire fighting equipment in working order. All utilities were checked for safety. All lifting equipment including hoists and the passenger lift were serviced regularly. The call bell system was maintained and due to be updated in the next year.

People were protected from potential abuse and discrimination. Relatives who visited on a regular basis told us they had never witnessed staff treating people in an abusive or discriminatory way. The registered manager confirmed there was zero tolerance of either. They said, "My staff know, if they did anything like that I would report them." The registered manager adhered to the provider's safeguarding policy and procedures and those of the local authority. They therefore shared any concerns and relevant information with other agencies and professionals, when it was needed, to safeguard people. Staff had received training on how to recognise potential abuse and report concerns. They had received training on the Equality Act and issues around potential discrimination. People were treated equally, irrespective of their gender, disability, sexuality, spiritual and religious and cultural beliefs. Staff were expected to apply these values towards each other. The provider's policies supported this approach.

People received their medicines safely and as prescribed. We observed medicines being administered. This was done following best practice and people received the support they needed to take these. Records were completed accurately following administration and medicines were kept secure. The overall medicine system and its records were audited both by the supplying pharmacy and care home staff on a regular basis. We reviewed these audits and where minor improvements had been needed, these had been completed and the audit signed off and closed. This ensured the management of medicines remained safe and in line with relevant best practice.

The registered manager ensured there were enough staff on duty to respond to people's needs. Care staff told us the team was "quite good" at making sure there were always enough staff on duty. Staff contributed to this by being flexible when staff sickness or holiday leave needed covering. This avoided the use of agency staff. Recruitment of staff since the last inspection had included new cleaning staff, a new head cook and nurse. Staff recruitment records showed that robust recruitment processes had been followed. This protected people from those who may not be suitable to care for them.

Good

Is the service effective?

Our findings

People's care, treatment and support promoted an improved quality of life and was based on best practice. Pre-admission assessments gave the registered manager the information they needed to decide if the home could meet a person's needs. There were arrangements to assess people's on-going needs following admission. This process ensured people's care and treatment met their altering needs.

Five relatives made specific comment about the assessment processes and the care provided to their relative. One relative said, "I'm very happy with the care… I can't praise the staff enough." Another relative told us they had been able to contribute to the assessment process. Their relative had been poorly and a re-assessment of their needs resulted in changes in their care and treatment. This relative said, "They [staff] fought for every breath of my [relative]… they did not give up on [name]." They described how their relative's daily health was monitored and what the staff had done to improve their relative's wellbeing. Another relative said, "I think the care here is wonderful." A friend said, "It's not the environment that's important, it's what the care is like." They told us the care was "wonderful". One relative was of the view their relative had not received good care. There had been on-going differences about this between staff and relative. As part of this inspection we did speak with health and social care professionals about the care and treatment this person had received.

Staff received training and support to be able to meet people's needs. The registered manager already reviewed staffs' competencies in various care tasks, but they planned to introduce a new and more detailed competency framework. We spoke with one member of staff about their involvement in reviewing staff competencies. Another new member of staff had completed an advanced course in dementia care and told us they planned to ensure care delivered in this area was evidence based and met best practice. They said, "From what I have seen so far the care of people living with dementia is very good here." Staff also attended supervision meetings with their head of department or the registered manager. These meetings were opportunities to discuss learning needs and additional support requirements. Staff also had an annual appraisal where their performance over the year, future goals, aspirations and training needs were discussed.

All staff completed induction training when they started work. This included awareness of the provider's policies and procedures. Training subjects included for example, health and safety related topics, safe moving and handling of people or loads, infection control, food hygiene and safeguarding adults. It included opportunities for new staff to work alongside existing staff until they felt more confident. Staff were also supported to update their skills and knowledge on an on-going basis and complete training specific to their responsibilities. For example, the head cook had completed training in texture modified foods (soft, fork-mashable and pureed) provided by the NHS.

Staff new to care completed the care certificate. This training, once completed, aimed to ensure new care staff delivered basic care to a recognised standard. If staff required specific and new skills, training for this was organised. One person had been admitted with complex needs. Training on how to meet one aspect of their care and been obtained from the NHS. Nurses were supported to access training to update their skills

and to maintain their registration and re-validation with the Nursing & Midwifery Council (NMC).

We checked whether the service was working within 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 MCA 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 make particular decisions, any made on their behalf, must be in their best interests and be as least restrictive as possible.

We found people were supported to make independent decisions and care was delivered in the least restrictive way possible. For example, bed rails were not used if a person could not understand the purpose of these and could not provide consent for their use. Staff understood that people's ability to make decisions sometimes altered. Representatives, who were legally accountable for ensuring a person's best interests, were involved in decisions made about a person's care and treatment. A relative, who held power of attorney for health and welfare, confirmed this to be the case. A decision to administer one person's medicines covertly (hidden in food) had been made, in their best interest, at a time they had been refusing their medicines. This decision had been made collectively by a family member, the staff and the person's GP. However, the least restrictive practice of offering the person their medicines non-covertly first, had remained in place. Since this decision the person had been able to decide to take their medicines and the covert administration had not been used. The principles of the MCA were therefore met.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found four people had authorised DoLS in place. We reviewed conditions which had been applied to two of these and found these were being met by the home.

People had access to health care and social care professionals when needed. Decisions regarding resuscitation were discussed with a GP and then by the GP with people or an appropriate relative. These decisions were clearly recorded so that visiting emergency health care professionals were aware of what these were. One person had complex needs and specific arrangements had been made for quick access to the NHS Rapid Response Team in an emergency. A GP visited on a regular basis to review people's health needs. Staff ensured referrals to other health care professionals were requested when needed. Training for staff was soon to be organised prior to implementation of the Modified Early Warning System (MEWS). This tool helps practitioners evidence signs of deterioration in a person's health early on, so that medical intervention can be sought with a view of preventing an admission to hospital.

Staff worked with, physiotherapists, occupational therapists and mental health practitioners to help meet people's health needs. People had access to chiropody (foot) care and optical (eye) services. NHS dental care could be accessed when necessary. Three people lived with a PEG (percutaneous endoscopic gastrostomy). An opening on the outside of the body connected to the stomach on the inside by a feeding tube. This and the person's nutrition was managed by nurses in the home supported by speech and language therapists and visiting dieticians.

People were supported to eat and drink and maintain nutritional wellbeing. We observed a mealtime where people were supported to make choices about what they ate. Staff provided people with supervision, prompting and one to one support to eat and drink. Staff also provided this support in-between meals and in a way which was encouraging, kind and un-rushed.

Nutritional risks were identified and managed. One person was reluctant to eat and staff explained their

appetite was poor. They continued to prompt this person gently throughout their meal. People's weight, including this person's, was monitored. Any gains and losses were discussed with the GP and action taken to reduce people's nutritional risk. We spoke with the head cook who told us they were kept up to date with people's weight. Where people required additional calories, they provided food which was fortified, as had been the case for the person with a poor appetite. This meant, food had additional butter, cream and powdered milk added to it. The cooks followed NHS food fortification guidance and knew exactly how many additional calories they were providing in fortified foods. Fortified drinks were also provided in-between meals; 'smoothies' were popular with people. These had always included fruit, but now included for example, liquidised spinach; rich in vitamins and other essential nutrients.

Guidance provided by NHS dieticians was followed to ensure all meals contained a balanced nutritional value. The head cook said, "It's also about enjoying food" so they were keen to ensure people had the opportunity to eat what they liked. We observed staff providing people with opportunities in-between meals to enjoy snacks, fruit and chocolates.

Technology was used to support people and their independence. For example, sensor mats were used for people who were prone to falling and who attempted to be independent, but were unsafe doing this. Sensor mats alarmed when people applied pressure and alerted staff to movement. They could then attend and provide the person with additional support.

Adaptations had been made to the environment to support people's physical needs and the needs of those who lived with dementia. For example, a passenger lift helped people access the second floor and bath hoists helped people get into the bath safely. Toilets had nearby grab rails to support those who needed it. Pictorial as well as written signs helped people orientate themselves. Corridors and communal rooms provided enough space to allow safe use of wheelchairs and hoists. Some bedrooms were smaller than others, so consideration was given to the use of these in relation to the equipment a person needed to support them. Outside, a path led people around a secured garden. Access in and out of the building was restricted through the use of keypad locks. Fire exits were alarmed to alert staff if these were opened without staff support. The enclosed garden acted as the outside 'safe zone' in the event that people who lived with dementia needed to be evacuated from the building.

Good

Is the service caring?

Our findings

Staff delivered personalised care which supported people's wellbeing in a kind and compassionate way. Both staff and the management were fully committed to ensuring people lived well with dementia. They also supported and cared for relative's, who sometimes found visiting difficult and upsetting. They supported each other; some staff had worked at the home for many years because they enjoyed working there.

One relative told us the staff "genuinely care" and "I have never felt side-lined by them." They described how they felt this from all members of staff to include kitchen and laundry staff. They described staff as being "sensitive" not only to their relative's needs, but also to their needs. Another relative said, "The atmosphere is good, it's friendly and kind." Another relative told us the staff saw the care home as being the home of the people who lived there. They described staff as being "respectful", "patient" and "caring". One person's friend described the staff as being "very caring." A health care professional described staff as being "incredible" in the way they cared for people.

Staff clearly knew the people they looked after well. They interacted with people in an informal and friendly way, but at all times remained professional. One person approached a member of staff in a way, which if the member of staff had not understood the person's actions and responded skilfully, could have resulted in the person becoming upset. This member of staff welcomed the person, thanked them for their involvement and help and diverted their thoughts by walking with them and helping them to push their trolley down the corridor. We learnt later that this person had held a position of authority in their life, had been responsible for staff and a role which had kept them very busy and concerned for others. This was reflected in how they behaved now and staff understood this.

Staff took time to learn about people's lives, what they had done for work, their family relationships, who mattered to them and their hobbies. An understanding of all of this helped staff to have meaningful and positive interactions with people, such as that described above. Sometimes staff went above and beyond to ensure people felt special and cared for. One member of staff had driven to Gloucester (14 miles one way) especially to get one person's favourite fast food take away. They said, "I drove in because I knew [name] really likes it and had said they really fancied it on their birthday." Another example had been when staff arrived to escort a person from hospital to the home. This person had no outdoor clothing and no family to provide these. Staff went to a local shop and bought these as they had not wanted the person to feel they had to walk out of the hospital and arrive at their new home in NHS bed attire. This person's dignity and self-pride had been supported.

Some people's physical and psychological needs had an impact on how they could effectively communicate. For some people, their social history was reflected in how they communicated. This was the case for two people where staff understood this and supported them to feel they mattered and had a voice. Others lived with dementia which gradually changed their ability to communicate rational ideas and to reason clearly. We observed staff to be skilled in understanding people's communication needs. They had learnt how to communicate and respond effectively with individual people. This skill enabled them to help

people retain their wellbeing and quality of life.

We observed one person throw their meal and plate across the room. Staff told us this person usually did this when, what they had, was not what they wanted. In this case sandwiches but they wanted a cup of tea. Staff also knew this person well enough to know this person was communicating and they usually exhibited this type of behaviour when they felt unwell. Staff approached this person in a kind way, they knelt down to the person's level and spent time listening to them helping them to settle. Investigations were planned to see if there was an underlying infection making this person unwell.

Staff were caring and supportive towards relatives and they were welcomed when they visited. Some relatives found the situation their relatives were in and visiting them upsetting and they told us they valued the staffs' support. Staff kept relatives updated with changes in their relative's care and health. Where appropriate they provided explanations to relatives. One relative told us staff had not contacted them on one occasion when their relative's health had altered. They confirmed this had been the only time, which had now been resolved. They said, "I'm well informed." Other relatives had been communicated with and had been given opportunities to speak on behalf of their relative. Where people were able to voice their own thoughts and wishes about their care, care records showed their voice had been included in the planning of their care. Staff knew how to support people and to help them access independent advocacy services if this was required.

People's dignity and privacy was maintained. All personal care was carried out behind closed doors. Information about maintaining people's dignity in care was seen in the home. When planning and delivering people's care, the eight factors laid out by the Social Care Institute of Excellence were followed. For example, 'choice and control' – staff supported a person to choose their own clothes to wear and to make their own decisions, 'communication' – staff addressed people in their preferred way and in a respectful and non-patronising way, 'privacy' – staff respected people's possessions and their personal space and 'inclusion' – staff had friendly chats with people and supported their involvement in social activities. As part of staff reviewing how they maintained people's dignity and privacy during care, 'Do Not Disturb' signs had been provided for each bedroom door.

All information about people's care was kept confidential and secure.

Good

Is the service responsive?

Our findings

People needs were met in a personalised and proactive way. Where people were able to be actively involved in making choices and planning their care, they were supported to do this. Where people were unable to do this, appropriate relatives were involved in care planning. Relatives told us they were able to speak on behalf of their relative and staff listened. One relative described how the care planned for their relative had altered as their relative's needs had altered.

Care was also planned around people's likes, preferences and wishes. Care plans also recorded the areas people wanted to remain as independent as possible in. Care plans gave staff guidance on how people were to be supported to utilise the skills they had retained. The registered manager told us how the staff supported one person's desire to remain as independent as possible, whilst helping them to recognise and manage potential risks to their health.

People's care plans gave information about their diverse needs. One person's wishes, in line with their spiritual beliefs, had been recorded. Guidance on these beliefs were available for staff to read and learn about. In another person's case it was essential they were supported to wear their hearing aids so they could communicate and be included in activities. Care plans were specific in how people's behaviour, which could be perceived as challenging, was to be supported. Staff had received training in positive behaviour management and how to manage distress. This ensured people's care remained consistent and met their needs when they were anxious or distressed.

Social activities were supported by the care staff as well as members of the activities team. We observed a music session where people were thoroughly engaged and enjoying themselves. Simple percussion instruments were introduced to help some people remain focused and engaged. Since the last inspection, links had been made with a local musician who had become a member of the activity team. They provided group and individual music and singing sessions in the home, as well as in the provider's day centre. An external group also visited providing singing sessions specifically designed for people who lived with dementia. Physical exercise, art and baking were all activities which took place.

People in the home could attend the day centre at no additional charge. For one person in particular, attending the day centre had provided an extra quality to their life. They enjoyed individual time with the musician and were able to spend more individual time with staff preparing for example, scenery for the home's production of Phantom of the Opera. This was performed at the home's Halloween party, which was attended by staff who were off duty, relatives and children. We were shown a picture of one person who rarely leaves their bedroom. They had made a particular effort to dress up and attend this. An inclusive and family like culture had been developed. At Christmas for example, some relatives had dressed up and had travelled around the home singing carols. The registered manager sometimes brought their children and dog in to visit people which people enjoyed.

Arrangements were in place for people to raise complaints and areas of dissatisfaction and for these to be listened to, acted on and where possible, resolved. One relative told us they had raised areas of

dissatisfaction with the registered manager and had found them to be "approachable" and "keen to sort things out." Another relative told us they had raised one area of dissatisfaction which had been listened to and resolved. Some relatives told us they had not needed to raise a complaint or voice any dissatisfaction, although, they felt confident that if they did, the registered manager would listen to them and take appropriate action. We reviewed relative feedback given as part of a satisfaction survey carried out by the provider in October 2017. The majority of relatives had commented they felt able to raise areas of dissatisfaction and had felt these had been listened to and acted on.

These views were not shared by one relative. They shared with us their view on how they considered their complaints and areas of dissatisfaction had been responded to. The Care Quality Commission (CQC) does not investigate individual complaints so the on-going issues were not investigated as part of this inspection. However, the CQC does inspect the systems in place to ensure complaints are responded to in accordance with the provider's complaints policy and resolved, where possible. This was included as part of this inspection. We reviewed information we gathered from relatives, the registered manager, complaint records and other agencies. We found complaints and areas of dissatisfaction had been responded to but in the above case, a satisfactory resolution had not been achieved.

In 2017 the registered manager reviewed how easy it was for people, relatives and any other visitors to the home to feedback and communicate their concerns or areas of dissatisfaction to them. This had done this in response to a low number of complaints having been received. They had wanted to ensure people, relatives and other visitors felt able to communicate with them before they felt they had no other option but to make a complaint. They had therefore introduced an initiative called "Let's Communicate". We saw posters about this around the home. There were forms available for recording feedback, which could be slipped under the office door. The registered manager would respond as soon as they could to these. The registered manager confirmed they could still be emailed or telephoned at any time, which is what some relatives told us they did.

People were supported at the end of their life to have a dignified and comfortable death. Staff followed best practice in end of life (EoL) care. They had received training in how to support good EoL care and more training was planned. The majority of staff were experienced in providing this care. However, there were arrangements in place to support those who had not experienced a person's death before. Staff had also received guidance and support in how to support relatives and friends with this. Arrangements could be made to support people's spiritual and cultural preferences. At the time of the inspection no-one was in the last few days of life.

The home had previously been part of a pilot study for setting out locally agreed pathways of care for EoL care, for people who lacked mental capacity. Staff gave EoL care in line with guidance from the National Institute for Clinical Excellence [NICE]. Advanced EoL care planning was therefore supported and consideration given to people's mental capacity to be able to engage in this. Staff were aware of who held power of attorney in health and welfare. So, the right representative was involved in any decision making and other relatives were consulted. People and relatives were supported to discuss EoL wishes and preferences from admission onwards so their full engagement in these discussions could be sought. The home's aim was to ensure that in the last few days of life, all staff and other professionals involved were aware of any specific EoL decisions. It ensured all necessary equipment and medicines were ready for use and the care delivered at this time was fully tailored to the person's needs, wishes and preferences.

The registered manager explained how staff often had fond memories of people who had lived at Euroclydon Nursing Home and who had died. Staff always attended people's funerals, both out of respect for the person and the relatives but also to gain personal closure. In one person's case the registered

manager described their staffs' actions as "going the extra mile" to ensure a person's wishes and dignity were upheld. This person had no family to arrange a funeral or register their death; the registered manager personally did this. Staff had known this person's final wish and had wanted to ensure this was met. Along with a friend of the person the staff had arranged the person's funeral. The funeral had been attended by the friend, members of staff and one health care professional who had supported the person's EoL care. Afterwards staff had liaised with the local authority to finance a simple headstone. They were also in the process of making local arrangements to maintain the grave.

Good

Is the service well-led?

Our findings

The registered manager had managed the home since 2012. They had clear visions and values and had provided strong leadership through a period of considerable change [2016-2017]. These changes had been in response to an ever changing health and social care market. A complete re-configuration of the home's environment aimed to provide a more flexible service to the local community moving forward. Discussions were therefore in progress with local health and social care commissioners about this, in which the registered manager was taking a leading role.

The registered manager had been aware of the needs of people, relatives and staff during this period of change. They were present in the home most days and when they were not they were contactable. One relative said, "I find [name of registered manager] very approachable." The registered manager was aware of the culture in the home. The changes had brought a feeling of uncertainty which had needed to be managed. There was evidence to show that the registered manager had done their best to ensure people, relatives and staff had felt communicated with during this time. Staff told us morale had dropped but they also confirmed that they felt this had improved. Staff found the reconfigured and refurbished environment more manageable and nice to work in. Two relatives spoke about the changes made to the home. In particular, their initial concerns with the loss of a small 'dementia care unit' called Bluebell. They however, also confirmed they felt things had settled and the home was working well.

Many staff had worked at Euroclydon Nursing Home for a long time. One health professional described staff as "clearly very devoted and dedicated" to the home and the people who lived there. We found staff were proud of what they achieved for people. Staff meetings were planned for the year ahead and held regularly. One member of staff told us the registered manager was always interested in staff ideas and suggestions. Heads of departments were supported to take ownership of their own areas and to support their particular staff. Relative meetings were held on the last Friday of each month. A representative of the provider sometimes attended meetings, but if not they were always made aware of the feedback received at them. Feedback was also sought from relatives through more formal methods such as satisfaction questionnaires.

The results of the last survey in October 2017 were displayed and available to read. Responses to the comments received back had been given and were also displayed. For example, in response to car parking issues - eight spaces had been made available, it was explained that no more were possible and staff parked elsewhere to help the situation, loss of laundry - relatives had been reminded to label items of clothing, more staff needed – staffing had been reviewed and considered to be sufficient, delays in answering the doorbell out of administrator's hours – it had been explained that people's care took priority and for visitors to remain patient. We observed a visitor ring the doorbell twice before staff answered the door. Staff had been busy attending to people and the visitor told us they understood this. Positive feedback had included: staff were flexible, dedicated, professional and caring, treated people with respect and dignity, staff listened to people and relatives and were polite and patient, actions were taken to address concerns.

Quality monitoring arrangements were in place to monitor the services provided. Where improvements were needed, actions were taken to address these. A relative said, "There is a constant striving to do the best

possible." We reviewed a selection of audits completed by the registered manager as well as other monitoring checks, carried out by other staff. The results of these were made known to a representative of the provider who visited on a regular basis. They discussed the improvement actions taken with the registered manager and checked completion of these. During these discussions the registered manager also held the provider's representative to account for actions which needed to be completed by them.

Improvements planned and due to take place were a new nurse call system, main hallway to be decorated and replacement lighting in areas of the home. We commented on the dullness of the lighting in particular in the conservatory one evening and were told this would be improved.

It was the registered manager's responsibility to quality monitor and drive improvement in areas of care and nursing practice. They maintained relevant skills and knowledge in order to keep up to date with best practice. They completed professional development to remain registered with the Nursing and Midwifery Council (NMC). They tapped into various forums and meetings to keep abreast with new initiatives. They personally received regular supervision from a person clinically qualified to provide this. They supported staff to up-skill and we spoke with one member of staff who was completing a qualification in health and social care management. The registered manager was keen for staff to broaden their understanding of current issues in health and social care: with this in mind, they had booked places for 11 staff to attend a one day seminar organised by a local NHS Trust. This was due to cover the topic of inequalities in health and the importance of assessment and diagnosis in people with dementia.

The registered manager was keen for the home to contribute to the local community. One member of staff had delivered workshops in the community, with a mental health nurse, on living with dementia. This was done through a link with Dementia Action Alliance and they hoped to continue with this in 2018. The home had organised times for carers of people in the local community to come in and start a support group, but these opportunities had not been used. The registered manager and a local musician had plans to start a community choir for people who lived locally with dementia. They planned to look into this further later in the year. In May the home was due to host a development day. This would be open to staff of other nearby services and relatives and would include outside speakers. For example, in person centred care and pain control in people who lived with dementia. Other links included those with a local church who provided Holy Communion for people in the home and with a small holding run by the Orchard Trust. People visited this when the weather was warm and enjoyed meeting the animals. The local shop was used frequently by people who were supported to do this.