Care UK Community Partnerships Ltd

Queens Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

What life is like for people using this service:

• The service met characteristics of Good in all areas.
• People, relatives and other stakeholders told us the quality of care and support had significantly improved over the past 12 months since the new provider had taken over the running of the service.
• The service employed and rostered safe levels of staff on duty. The service planned to recruit more nursing staff at night to reduce the use of agency staff and improve continuity of care. We saw this plan was underway.
• The service had safe systems around safeguarding and risk assessment and implemented the least restrictive principle to promote people's safety and rights.
• People and relatives told us staff were kind and caring. They could express their views about the service and provide feedback.
• Staff received appropriate training and support to enable them to perform their roles effectively.
• People's care was personalised to their individual needs. There was sufficient detail in people's care documentation that enabled staff to provide responsive care.
• The service provided a variety of activities in line with people's interests and encouraged people's involvement. People, relatives and social care professionals told us staff engagement and interaction had a positive effect upon people's quality of life.
• The environment was comfortable and was adapted to meet people's needs.
• Management and staff demonstrated a good understanding of and response to people's diverse needs.
• The service had processes in place to measure, document, improve and evaluate the quality of care.
• More information is in the full report.

Rating at last inspection:

The service was registered by CQC with a new provider on 29th December 2017. This was the first inspection visit to the service under the new provider.

About the service:

Queens Court is a care home with nursing is a residential care home that provides personal and nursing care for up to 60 people. At the time of the inspection 48 people were using the service. The property is comprised of three floors and the new provider had made changes to the type of care being delivered on each floor. A new dementia suite was developed on the second floor in August 2018, the first floor is specific to people requiring nursing care, and the ground floor is dedicated to residential care.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care

people received.

Follow up:

We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Queens Court

Detailed findings

Background to this inspection

The 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.

Inspection team:

Two inspectors and one Expert by Experience carried out the inspection on day one. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was carried out by one inspector.

Service and service type:

Queens Court is a care home with nursing. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

This inspection was unannounced on the first day.

We inspected the service on the 11 and 12 December 2018. The inspection included speaking to people using the service, staff and relatives at the care home and a visiting healthcare professional.

What we did:

Our inspection was informed by evidence we already held about the service. We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders, for example the local authority and members of the public. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 14 people who use the service and five visiting relatives. We used observations to gain an understanding of staff interactions and engagement and the care people received. We also received feedback from the local authority, two other health and social care professionals and another community professional who worked in partnership with the service.

We spoke with 12 members of staff during the inspection, including the chef, deputy manager, clinical lead, team leader, activities coordinator and care workers. We also spoke with the registered manager, regional director, and the quality manager.

We reviewed a range of records. This included six people's care records and multiple medicines records for the preceding four weeks. We looked at five staff recruitment files and all agency care worker profiles and induction records. We also checked four weeks of staff rotas, menus, accident and incident reports and records used to measure the quality of the service, including health and safety checks, provider audits and management improvement plans. After the inspection visit the provider sent us policies and procedures and the staff training matrix.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Staffing levels

• All staff we spoke with said there were enough staff on each shift. One staff member told us that managers listened to and acted on feedback regarding the number of staff required to cover shifts. During our visit we observed staff interact with people and did not appear to be rushed or task orientated.
• People we spoke with told us staffing levels were appropriate to meet their needs. One person said, "I haven't yet found an occasion when there haven't been enough carers." We received mixed feedback from relatives about staffing deployment. One relative told us the regular staff were "good workers" but felt the service could improve by using less agency staff, stating that at weekends "Nobody seems to know who is in charge…The minute [the manager] walks out of the door the whole thing changes." Another relative said that "day staff are wonderful" but felt night staff were not as attentive to people's needs. A member of staff also raised that agency staff were less committed to updating people's care plans in response to changes, which they said sometimes put additional pressure upon permanent nursing staff to ensure this was done. We discussed staffing levels and deployment with management who told us that 22% of shifts were covered by agency staff, and that all the night shift nursing staff were agency. Management said recruiting qualified nurses to work at night was a challenge and they had exhausted local recruitment campaigns. The provider had acted, and alternative efforts were made to improve the situation through the recruitment of overseas staff, and the service was expecting two nurses to commence their inductions within a month.
• There was an understanding of people's direct contact hours based on their needs assessment and this was interpreted into appropriate staffing levels on the rota.
• Team leaders and clinical leads were clearly identified and sufficiently allocated. This was limited at night as all nursing positions were vacant. The provider had systems in place to book regular agency nursing staff, which helped with continuity of care until permanent staff commenced employment in these positions.
• Safe and robust recruitment procedures were used when people were employed. We saw required checks and information were sought before new staff commenced working for the service. We looked at agency profiles and background checks which met requirements and induction documentation was consistently completed.

Systems and processes

• Staff demonstrated a sound awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. Staff told us that if they were unhappy with action taken by management they would escalate their concerns, and if necessary contact the local area safeguarding team or Care Quality Commission (CQC).
• One person using the service we spoke with commented, "Do I feel safe? Yes; there's no trouble here." A relative said they felt their family member was safe although they worried about people wandering into their

room. We spoke with management about the security of people's private spaces who told us about measures in place such as the option for people to lock their own doors, hourly staff checks and closer supervision of people who were known to become disorientated.
• Training records for the service indicated 98% of staff had completed safeguarding e-learning in line with their role. The service had provided time frames for staff members to complete this training to be 100% compliant.
• The service followed a safeguarding policy and procedure which was up-to-date and in line with current legislation and national guidance. This included specific and easy to follow guidance for staff about their roles and responsibilities in recording and reporting safeguarding concerns. The local authority safeguarding contact number was also displayed at every nurse's station.
• We saw a service whistleblowing policy and procedure and staff referred to this when speaking about guidance available in relation to raising concerns about poor practice.
• The service kept a log of safeguarding referrals to the local authority and took the initiative to regularly follow-up with the safeguarding authority. This ensured that outcomes were shared with people involved, other relevant professionals and CQC.
• We contacted the local authority who confirmed the service had submitted referrals appropriately and their intelligence and safeguarding data did not suggest they needed to escalate monitoring.

Assessing risk, safety monitoring and management

• The service risk assessed people's individual needs such as pressure ulcer, moving and handling, diabetes, and falls. We saw that risk assessments were comprehensive and reviewed regularly and in response to people's changing needs.
• We questioned why people who were identified as being at a low risk of falling and where there were no other causes for concern were visually checked every hour throughout the night. The regional director explained it was the provider's policy to regularly check upon people's wellbeing. However, they said they would raise this with the provider's quality and governance team to consider proportionate safe measures in relation to risk whilst protecting people's privacy.
• We saw evidence of good practice where the service was quick to review the standard use of bed rails under the new provider's registration. The outcome of this was the reduction of 12 bed rails to two due to the implementation of less restrictive equipment and technology such as low-profile beds, crash mats and a pressure sensor mat. This was a proportionate and less restrictive alternative to identified risk, which valued and promoted individual's freedom of movement.
• The provider used a maintenance contractor to ensure required safety checks and remedial work were completed for areas such as water safety, gas and electricity. We reviewed maintenance records which were organised, up-to-date and covered all key aspects of environmental and equipment safety.
• The service employed a full-time maintenance worker who spoke with enthusiasm and knowledge about his role and the standards expected. One relative told us, "[The maintenance man] talks to these folk (residents). [They are] very, very caring. If you ask, they will get things done."
• We were also told the provider had invested in the safety of the premises. For example, we saw that all the home's window restrictors were replaced with improved fittings, and all balcony levels were raised so all people could make full use of this space safely.

Using medicines safely

• The clinical lead demonstrated sound knowledge about medicines management and referred to national good practice guidance and expectations of care home staff. They facilitated a weekly clinical meeting to review medicines practice and people's needs. The GP visited once, and a paramedic visited on a different day each week to review medicines if indicated.

• The GP was visiting on the day of the inspection and fed-back to us that the clinical lead ensured prescriptions were ordered are on time and managed medicines changes well, which ensured people received prescribed medicines promptly.
• People told us they received their medicines correctly and on time. We observed a nurse administer medicine in line with the correct procedure.
• Records confirmed people received their medicines including controlled drugs (CD) in line with directions and national guidance for care homes. Homely remedies were listed and approved for individuals by the GP. There were written protocols for "when required" medicines which provided specific instructions for administration. Care records included body maps that identified where topical preparations for people were to be applied.
• There was an appropriate system to document stock reduction. This acted as an early warning system to identify and rectify any discrepancies.
• There were suitable facilitates for the secure storage of medicines including controlled drugs (CD) and appropriate temperature checks.
• We saw the required process and documentation was on file for a person who received their medicine covertly.
• A clinical lead told us that internal audits had previously identified inconsistent staff practice in recording the dates that prescribed creams and lotions were opened. This was addressed and resolved by the service, and we saw this was recorded appropriately on opened containers. Medicine audits were completed once a month and most recently completed on the 4 December 2018. We saw that actions required were being followed up and signed off. Provider audits identified this had not always been the case and this was subsequently addressed by the clinical lead. Evidence of this was presented for review which confirmed practice had been adapted.
• Staff received medicines training and we saw competency assessments were completed before staff were authorised to administer medicines. This was repeated if staff poor practice led to medicines errors or near misses.

Preventing and controlling infection

• Staff received infection control training every three years. We saw that there was reference to the service infection control policy and procedure and guidance within staff induction and training.
• Staff had access to appropriate personal protective equipment (PPE) and hand wash and infection control facilities and we saw this in use throughout our visit.
• All staff attended food hygiene training and we observed kitchen staff and care workers handling food hygienically during lunch time. All staff serving food wore aprons and the temperature of food was checked on arrival and before serving. The service received 5/5 rating from the relevant food authority's inspection, dated 31 May 2018.

Learning lessons when things go wrong

• Accidents and incidents were thoroughly investigated and with immediacy. However, we noted this was not documented on a standard investigation template. The regional director rectified this and provided the registered manager with a root cause analysis investigation template to implement with immediate effect.
• Safeguarding was a regular agenda item in the staff monthly team meetings which included a debrief about safeguarding referrals and accidents or incidents to aid learning at the service.
• The provider monitored all accident and incidents and safeguarding referrals and advised the registered manager of appropriate actions. The provider's quality assurance team checked for trends which were used to improve procedures and staff practice, and this was followed-up through provider checks and audits. For example, the regional director used reporting data to check pressure ulcer prevention and skin integrity

documentation during their provider visits.
• A healthcare professional known to the service for several years told us that under the new provider there was now a healthy open culture with regards to medicines errors. These were raised and reported appropriately, and the service implemented systems to resolve any issues and to avoid future occurrences of medicines errors.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Staff skills, knowledge and experience

• Management and provider audits identified that staff had not received regular supervisions or appraisals and we saw a documented plan to resolve this. This had progressed, and more staff had received supervision in line with these plans.
• We noted that regular agency staff were not included in the registered manager's supervision planning tool. We raised the importance of this to ensure all staff felt valued and received feedback about their performance. This was particularly relevant as nurses employed to cover night vacancies were all agency staff. We were told that a couple of the agency staff had received ad-hoc supervision and were included in group workshops delivered by the quality manager. The management team agreed that regular agency staff would be included in planned supervisions in future. This would help to improve staff co-ordination and oversight at night until permanent staff were recruited.
• All care staff spoken with said that their induction and mandatory training had left them feeling suitably prepared for their roles. We saw completed, time specific induction records which were cross referenced with the care certificate standards.
• The provider delivered service specific training for staff to meet people's needs. Examples of training included equality and diversity, life story coaching, effective communication, and wound care for registered nurses.
• We noted that staff were not trained in physical intervention training to maintain individual's, other's and staff's safety. We were told that no one currently presented distress which led to behaviours that challenge. However, we were aware of people previously using the service who may have benefitted from this training. The regional director told us that "break-out" training to remove people from situations to maintain safety was available to the service. They agreed this would be monitored and identified where there was a need.
• We checked training attendance data which indicated high levels of compliance. This was supported by the provider's system to monitor training which included time specific plans and support for staff to meet clearly defined expectations.

We recommend that regular supervision and appraisal for all staff is sustained in line with the provider's policy and procedure and best practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• The service gathered as much information as possible about people and completed a detailed needs assessment before a new care package commenced. We saw that people's emotional needs and support strategies associated with diagnosed anxiety and/or mental health conditions were detailed under the

heading of "communication". We discussed with management that this would be more effective as a specific 'psychological/emotional' need. The regional director explained that individuals received support from the community mental health team but said this was an area the service planned to develop. They said that to document specific behavioural support strategies was the service's next focus.
• Discussion with care staff and management highlighted thinking and consideration of individuals' protected characteristics in line with the Equality Act 2010. People told us how the service met their individual religious and cultural needs, for example a priest was arranged to visit one person regularly. Tangible work had yet to be completed in the service with respect to LGBT support. However it was evident the service planned to build trust to support people to feel 'safe' in disclosing information and living in accordance to their preference.
• We saw technology was used to positively engage, distract and occupy a person in line with relevant research and best practice to benefit people living with dementia.

Healthcare support

• People told us they were happy with the healthcare they received with comments such as, "It's all well organised. We're looked after well", "The doctor comes once a week", "The district nurse comes once a fortnight to do my bandages." Another person told us the optician visited her at the care home. People were supported to attend hospital outpatient appointments and the doctor's surgery to have their dressing changed.
• One person explained that previously they had got out of bed in the night because they were uncomfortable and sleeping in the recliner chair. In response to this the home procured an air mattress for them and they now stayed in bed all night.
• The registered manager and care staff were clear about the importance of identifying people's needs when transitioning between services. For example, the service closely followed-up and co-ordinated care and treatment with the community team as part of individual's hospital discharge plans.
• Other agencies such as speech and language therapists (SALT) to assess people's swallowing were involved when required.
• A healthcare professional told us the registered manager worked hard to find solutions when other agencies could not meet people's needs directly. The registered manager explained that he was sourcing specific training and competency assessments for the care home's registered general nurses in liaison with the district nurses team.

Supporting people to eat and drink enough with choice in a balanced diet

• People told us staff knew what food and drink they preferred and they enjoyed the choice of meals provided with comments such as, "It's a good portion of food we get" and "The food is very good now (since change of service provider)." Another person told us if they did not like what was on the menu they could ask for something different.
• Management told us they had recently taken the decision to prepare meals in-house rather than through the external catering company to have control over making changes in response to people's feedback. We were told this was successful and people's experience of meals had improved.
• We observed care workers and kitchen staff worked effectively together on each floor to ensure people's meals were served hot, and were consistently attentive to people's needs. Staff supported people who needed it to eat and drink at their own pace. Staff sat down by their side, spoke with and closely observed the person they were supporting.
• Tables were set with fabric napkins and cloths, salt and pepper and flowers. Condiments were available and provided promptly for someone who requested it. Jugs of juice and water on the tables were smaller than the usual meaning they were easier for people to handle. We noted that contrasting blue plates were

used to help people distinguish the food on their plate, as well as broad sloping rims to make it easier for people with reduced movement to eat independently. Music was playing quietly on one of the floors and the atmosphere was calm.
• Meals served corresponded to the menu and we saw that people were shown plated examples of choices available. We observed kitchen staff puree an individual's meal choice in line with their care plan and the head chef was also over-seeing service in person and seeking feedback across the floors.
• We spoke with the head chef who was knowledgeable about individual's specific needs in relation to food texture, preferences, and allergies. A record of this was kept in the kitchen to ensure up-to-date information was shared and understood by relevant staff.
• People were encouraged to join others but wishes not to do so were respected. We observed staff take an individual's meal choice promptly to them to have in their room, although most people chose to eat in the dining room. A care worker told us that they encouraged eating together in line with best practice, and that because of this people's nutritional intake had improved, which was indicated in their malnutrition universal screening tool (MUST) scores.

Staff providing consistent, effective, timely care

• People using the service told us staff responded promptly when they needed support or used their call bells. We saw literature in the resident's guide which encouraged people to use their call bells. However, the provider considered that some people may still be tentative about this and implemented regular visual checks with people's agreement.
• People's hospital discharge plans were closely followed-up and co-ordinated by the service. The service was clear about the importance of identifying people's needs when transitioning between services. The registered manager ensured that appropriate treatment was co-ordinated with the community team where required.
• We were told by a staff member they were impressed by the support coming from the provider. This involved teams of other registered managers visiting the service at weekends and providing peer support when the provider initially took over. They said this was a huge support during the transition process to ensure people received a quality standard of care.

Adapting service, design, decoration to meet people's needs

• Cleanliness appeared to be to a good standard in all areas visited. We noted a slight smell on entering the top floor at around 10am, associated with wet sheets and incontinence pads; there were no other malodours around the building. Management told us they would investigate this. One relative said the cleanliness of the home had improved under the new provider, stating, "There are no smells like there used to be."
• The décor was planned to be refreshed over the coming months. Management referred to colours and designs that would help people with dementia feeling orientated to their surroundings, such as wall colours, fabric patterns and door colours. This remained a work in progress.
• We were shown new bedroom furniture with clear fronted drawers and wardrobes with the aim of helping those with short-term memory difficulties to see what they had placed inside. This might help to reduce risk of agitation, upset and the need to constantly open to see furniture to what is in there.
• People's private rooms appeared well maintained and were personalised. There were comfortable communal areas which were arranged to meet both social needs as well as quiet spaces for people to access alone or with visitors.
• The service had invested in landscaping the garden to improve accessibility as well as new furniture, which we were told people had enjoyed in the summer months. We observed one individual access the garden to feed the birds during our visit which they appeared to gain enjoyment from.

Ensuring consent to care and treatment in line with law and guidance

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.
• The provider identified that care staff would benefit from additional mental capacity face to face training; the quality manager had delivered specific workshops to facilitate learning and day-to-day understanding.
• One person using the service told us, "Oh yes, they always ask permission before they do anything… [The carers] are all good." Another person we spoke with said staff always ask permission when giving personal care.
• The deputy manager showed us people's mental capacity documentation on standard provider templates. It was clear from the records that a lot of work was undertaken to ensure that individual's mental capacity was assessed, and best interest decisions were facilitated and recorded.
• Management demonstrated a good understanding of the mental capacity code of practice. We saw that people's involvement in the process was diligently recorded. We suggested that some terminology could be changed to make it clear that decisions were specific. As discussion took place between the deputy and the quality manager who quickly agreed how the improvement could be made which was swiftly implemented.
• Where people had capacity, their consent was clearly recorded in care planning documentation. Appropriate lasting power of attorney documentation was kept in people's care files and their consent or involvement was documented appropriately.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported

• People told us they were happy with how staff treated them and made comments such as, "I think it's the highest standard of care possible", "They treat me as I like to be treated", "They are very helpful" and "Most of the staff are pleasant" and "The staff are wonderful, they really are. They're so kind."
• We saw that staff were vigilant of people's needs and were attentive. Staff were all seen at various times to engage warmly with people on an opportunity led basis and with positive regard. People using the service appeared to be comfortable with staff.
• Staff told us they had enough time to engage and interact with people. Management were aware that relatives wanted staff to make more time to chat to people. This was taken on board and we saw a new initiative to prioritise time to sit down and have a chat with people over a cup of tea. There were posters advertising this entitled "Tea at Three" commencing in January 2019.
• Staff demonstrated compassion and empathy. For example, we observed a care worker reassure a person who was distressed. They explained to us the reasons the person was upset and knew how to comfort them. The care worker said they considered and responded to people's stressors and sadness by sitting down, spending time and offering a listening ear.

Supporting people to express their views and be involved in making decisions about their care

• The service facilitated regular resident's and relative's meeting to encourage involvement. They had also recently facilitated a relative's social group as a support and to maintain links and contacts beneficial to people using the service.
• Management demonstrated they were open to people's and relative's suggestions and responded to expectations consistently.
• A relative told us the home contacted them by telephone about "any little thing", for example to let them know that the district nurse had visited her relative.
• We received confirmation from an independent mental capacity advocate (IMCA) they were involved in court of protection work around the issue of deprivation of liberty. The registered manager had sought their advice about general advocacy services and leaflets were displayed in the home.

Respecting and promoting people's privacy, dignity and independence

• People using the service told us staff respected their privacy and dignity; "The carers will always help you if you need it but they don't interfere. They're always there but they don't intrude", "They try to let you do what you can yourself without intruding." Another person confirmed staff knocked before entering their room and

shut the bathroom door when they supported them with personal care.
• Care plans included individual's abilities and the level of staff support needed for all aspects of day-to-day living. This included the level of encouragement people needed to promote engagement and interaction to avoid social isolation.
• One staff member we spoke with emphasised the importance placed on helping people to retain independence and encouraging them to do what they could for themselves; support was informed by this principle rather than a need for quickness.
• People's care records were stored securely in offices and on computers with username and password login details, therefore they were only accessed by authorised staff. We did not observe records left in inappropriate places.

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

People's needs were met through good organisation and delivery.

Personalised care

• People's needs assessments included comprehensive information about their background, preferences and interests. Staff also supported people to complete a "Life Story" book. This information aided staff to initiate topics of conversation that were of interest to people. We were told conversations with people about their history and background reassured people, particularly if they had difficulty with their memory.
• Staff spoke knowledgeably about people's needs as well as their interests, which was accurate according to people's care assessments and plans. One person using the service said, "They're marvellous because they know I cannot walk", "They know they have to be careful with my right leg." Another person said, "I try to walk with my frame or walker. They walk with me [because] they know I don't feel safe on my own." Staff also supported the person to visit their friend who lived on the floor above which was important to them.
• In relation to person centred care, a care worker said this meant "what they wish for and want is what they get." They provided examples of people choosing to have a wash, shower or bath according to preference, the time people wished to go to bed and get up, the clothes they liked to wear and the food and drink they preferred.
• People and relatives told us they were impressed with the range of activities provided and spoke highly of the activity co-ordinator personally and the work he did. A yoga class was led by a volunteer and three schools visited regularly. People commented, "Last week some little children came with their mothers and we had prayers and sang carols, which was nice" and "I like it when the school children come in and we read to each other". A relative told us, "[My family member] loves the man that comes in to sing", "[My family member] is as happy as they can be here. Gets their hair done, nails done, pampering and shoulder and head massage." A social care professional told us the introduction of an activities co-ordinator and regular and focused engagement improved empowerment and personalised support and a person's overall quality of life.
• Every notice board was covered with information about up and coming events or something interesting or attractive to look at. The activity co-ordinator had transformed otherwise 'dead ends' of corridors into themed areas. This area was used by an occupational therapist and staff to provide structured engagement and interaction opportunities for people one to one or in groups. We observed one person using one of the accented areas who said, "I like this end. The only time I go in my room is when it's dark." They told us they did not feel cut off; "[the staff] walk around and they always stop and talk to me. I laugh with the staff", "I can't be put to one side. I always want to join in."
• People's protected characteristics were assessed and identified in care plans when information was disclosed. The activities co-ordinator had arranged two different faith leaders to hold regular Mass at the home, and they were in discussion with another faith leader to visit an individual at home. They had also co-ordinated a Diwali party and we were told this was received positively by people. We saw Christmas themed activities underway and people were supported to make decorations and other crafts. This was well

attended by people and we saw and heard a great deal of merriment and singing, encouraged by the enthusiastic activities co-ordinator and other staff members.
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements. People's communication and sensory needs were assessed, recorded and shared with relevant others. There were specific details in people's care plans about their abilities, needs and preferred methods of communication. A library visited the home every six weeks with large print material and the service received a specific reminiscence newspaper for older people. We were told that staff with specific language skills were matched with people to meet their needs. There was pictorial signage around the home to help people orientate. The service was also considering the use of electronic virtual assistants as a communication aid and to give people more control. This remained a work in progress whilst the provider was trialling how to ensure people's confidentiality and privacy would be protected.

Improving care quality in response to complaints or concerns

• People using the service and relatives stated they felt comfortable raising concerns. A person we spoke with said, "I think the care is excellent. I don't find anything to complain about at all. I'm quite happy. I'm sure if anything had to be righted they would soon do something about it."
• There was clear and appropriate information about how to make a complaint in the "Resident's guide." These were provided to people when their care commenced and were available at the entrance of the home.
• Staff we spoke with all said that they would refer any matters they were unable to resolve to the manager and that people would be supported to make a complaint if they felt the need to do so.
• We checked the service complaints records and saw documentation that people received written acknowledgement of their complaint and investigations outcomes were provided in a timely manner. We were aware of a recent complaint and the regional director was able to update us with the provider's actions. We received further satisfactory information and organisational learning about this after the inspection.
• The service kept records of compliments and shared these with staff at team meetings. We saw an array of thank you notes and emails. For example, a relative thanked the service for the garden party and the chef for the food buffet (in honour of the Royal wedding) which their family member had enjoyed. Another relative wrote that a new nurse on their family member's floor was a "breath of fresh air."

End of life care and support

• All staff attended palliative/end of life care training and there was a provider policy and procedure in place containing relevant information. Staff demonstrated that they felt prepared and understood how to support people at the end of their life.
• Care plans identified people's preferences at the end of their life and the service co-ordinated palliative care in the care home where this was the person's wish.
• On the first day of our visit the GP had reviewed one person and advised they required palliative care. Appropriate arrangements were made and followed-up promptly by home staff, and we noted the person's care plan was updated immediately.
• Staff demonstrated compassion towards people at the end of their life. We were told about a person who was at the end of their life regularly wanting to be read passages from religious scriptures. Staff told us that workloads were managed to ensure there were opportunities to meet their wishes.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

• The service demonstrated a person-centred and inclusive culture where values of empowerment were evident towards people using the service and their relatives. The registered manager told us it was important to them to "look after and have empathy" with relatives too, to benefit the people using the service.
• People using the service, relatives and other stakeholders all said the service had improved under the direction of the new provider and registered manager. One relative said, "It's just like another family here. It's oodles and oodles better than a year ago. It's got a new lease of life. It was so dreary before. It's ten times better."
• Staff were provided with equality and diversity training. The management team and staff we spoke with had a good understanding of people's diverse needs and their duty to uphold people's rights.
• The registered manager understood their duty of candour responsibility and we were presented with an example of a letter of apology to a person and their relative.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

• The registered manager demonstrated a positive attitude and ethos towards their role and the service and possessed knowledge and understanding of their legal responsibilities and regulatory requirements.
• The staff team appeared motivated by the home's leadership and told us they felt valued by the registered manager and the provider.
• Staff we spoke with were clear about their level of professional accountability, the scope of their roles and how this related to both service expectations and requirements of their professional registration with the relevant agency.
• The registered manager told us they were well supported by their line manager and the provider's quality and governance team which they felt enabled them to perform better in their role.
• The governance of the service involved regular audits and checks and visits to the service. Documentation evidenced that identified actions were reviewed by the registered manager, the regional director and the quality governance team, and progressed satisfactorily. For example, we saw the provider had identified that people's deprivation of liberty authorisations required reviewing. The registered manager had completed a time specific plan to achieve this which was delegated to the deputy manager and was on track

to be achieved. Some actions were ongoing and were monitored to ensure practice was embedded and sustained.
• Management from the service and the provider attended monthly meetings where they reviewed progress and agreed new actions. The local authority was involved in these meetings and informed us performance management was now more robust and had improved with the new provider. We were told there was a significant improvement and feed-back from relatives were largely positive and complimentary, and complaints had dramatically reduced.

Engaging and involving people using the service, the public and staff

• We saw there was a genuine commitment from the service to try and engage and involve people using the service. The provider sent regular surveys to people and provided the results in an easy to follow pamphlet and themes identified were responded to. For example, the survey indicated people wanted improvements to the menu. The head chef informed us of the detail and confirmed what action was taken.
• The service also involved relatives in the development of the service through regular meetings. Relatives told us they were comfortable to raise issues although one person's relatives expected the service to be more forthcoming with details in response to their feedback and actions agreed. There was a general sense of frustration about the use of agency staff without a quick resolution. Management were aware of this and planned to resolve the situation with recruitment from overseas. We also discussed comments from one person's relative about the lack of management presence at weekends. Management confirmed that regular spot checks occurred out of hours and that team leaders and clinical leads were allocated across the weekend. Management agreed to look into these comments to ensure staff provided the necessary leadership required on shift.
• The registered manager considered and maintained good relationships with the home's surrounding neighbours. For example, they had arranged refuge collection to occur at a time of day when the noise was less disruptive.
• We were provided with an example where a passing member of the public required help with their older family member's personal care at the weekend. Home care staff were quick to offer their discreet assistance and made facilities available. This demonstrated a considerate and helpful staff ethos and the member of public returned later to note their gratitude for the help and professionalism they experienced.
• People and relatives gave us positive feedback about management with comments such as, "The managers here are really lovely, they're wonderful", "They're so considerate." Another person said management visit them "every now and then" and a relative said, "I like [the manager] He always speaks to you and asks how you are."

Continuous learning and improving care

• Throughout our inspection we saw evidence the provider and the registered manager were committed to drive continuous improvement.
• A member of staff told us the new provider had allocated resources and encouraged learning. They said there was also more expectation from the provider, but they felt this motivated staff and they felt "safe" with the management and provider structure. The team were able to access career development opportunities and qualifications, and ideas were shared from the provider's other care homes. As a result, the staff member believed the overall staff attitude and skills had improved.
• Staff told us there was not a "blaming culture" at the service. The provider and registered manager facilitated coaching sessions and reflective opportunities, and we saw documented examples of this.
• The service valued sharing information and held regular team meetings to facilitate this. We saw team meeting minutes covered various topics such as people's changing needs, head injury information, incident debriefs, evening activities and engagement, silent fire drill practice to build confidence, cleaning of

equipment and looking after new furniture. Staff we spoke with all said that they felt involved in the development of the service and received a good level of information from the registered manager about the service and future plans.
• Feedback from people using the service, relatives and other stakeholders consistently told us the service had significantly improved under the direction of the new provider. One person told us, "I think they're up to scratch here. They've done a lot of work [since the new management came]." When asked if things had improved they replied, "Oh yes. Definitely."
• We were provided with information about robust performance management which held staff to account with the aim to improve practice where appropriate.

Working in partnership with others

• We heard from health and social care professionals that the service communicated and worked effectively with other agencies to benefit people using the service.
• The service had a good working relationship with the local authority and contract monitoring officers and took the initiative to seek feedback from the safeguarding team.
• One of the local schools told us that management and staff were keen to welcome schools into the care home and were open to ideas to encourage people's meaningful engagement and participation. They said that people using the service and children were able to get to know each other and appeared to "delight in each other's company and knowledge."
• The service submitted relevant statutory notifications to us promptly. This ensured we could effectively monitor the service between our inspections. When needed, the management team provided information to us to help with our enquiries into matters.