Somerleigh Court Ltd

Somerleigh 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

This inspection took place on 19 February 2018 and was unannounced. The inspection continued on 22 February 2018 and was announced.

This service combines a care home, known as Somerleigh Court and a Domiciliary Care Agency known as Close Care.

Somerleigh Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 40 people across three floors. The service is located in Dorchester and is a large purpose built building with rooms arranged over three floors. Each floor has a communal lounge and dining area. There is lift and stairs access to each floor. People are able to access secure outside space at the home. There were 36 people living at the home at the time of our inspection.

Close Care is a domiciliary care agency. It provides personal care to people living in their own apartments in the village surrounding Somerleigh Court. There are 68 apartments in the surrounding village. Close care provides a service to older adults. Not everyone living in the village receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of inspection, Close Care was providing support to 13 people.

At our last comprehensive inspection of both services on 10, 11 and 17 November 2016 we found that the provider did not have systems that effectively and consistently assessed and monitored the quality and safety of people using the service and therefore they did not have an effective system to identify areas for improvements.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take steps to improve and ensure that they were compliant. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Well Led to at least good. At this inspection we found that improvements had been made.

There was a registered manager in post. 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.

Care Home and Care at Home services.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care. Medicines were stored securely and recorded accurately.

People were supported from the spread of infection by staff who understood their role in infection control and used appropriate Personal Protective Equipment (PPE).

People were supported to make choices about all areas of their support and staff understood the principles of mental capacity. Where decisions were needed in people's best interests, these were in place.

People were supported to have enough to eat and drink and there were systems in place to ensure that any concerns around weight loss were monitored. People's preferences for meals were well known and choices were offered if people did not want the meal provided.

People were supported to receive personalised, compassionate end of life care and their wishes and preferences were recorded.

People and those important to them were involved in planning the support they would receive and also regularly asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People were supported by staff who respected their individuality and protected their privacy. Staff understood how to advocate and support people to ensure that their views were heard and told us that they would ensure that people's religious or other beliefs were supported and protected. Staff had undertaken training in equality and diversity and understood how to use this learning in practice.

Interactions with people were kind and caring and relatives told us that they had peace of mind that their loved ones were receiving safe, compassionate care.

People were supported to access social opportunities in the community, participate in group activities or have one to one time with staff in social activities which were meaningful to them. Visitors were welcomed at the home and kept up to date about their loved ones.

Staff were confident in their roles and felt supported by the registered manager. Feedback from people and relatives indicated that the management team were approachable, listened and took actions where

necessary.

Quality assurance measures were used to highlight whether any changes to policy, processes or improvements in practice were required. We were given examples where feedback had been used to drive improvements at the home.

The service used innovative approaches to improve the care and treatment received by people and had clear development plans in place. Changes were made in collaboration with people, relatives and staff.

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

Risks people faced were understood and managed by staff and reflected in people's care plans.

Medicines were managed safely, securely stored and correctly recorded.

People were supported by staff who had been recruited with safe

pre-employment checks.

Sufficient numbers of staff were deployed to meet people's needs.

People were protected from the risks of abuse by staff who understood the potential signs and were confident to report.

People were protected from the spread of infection by staff who understood the principles of infection control.

Lessons were learnt and improvements were made when things went wrong

Is the service effective?

Good

The service was effective.

People were asked to consent to their support and assessments of capacity and decisions were made in people's best interests where needed.

Staff received training and supervision to give them the skills they needed to carry out their roles.

The service worked with other healthcare services to deliver effective care.

People's needs and choices were assessed and effective systems

were in place to deliver good care and treatment.

People were supported in an environment which was adapted to meet their needs.

People were supported to eat and drink enough and concerns about weight or fluid intake were effectively managed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate and kind in their approach.

Staff knew how people liked to be supported and offered them appropriate choices.

Visitors felt welcomed at the service and visited whenever they chose.

People and their relatives were listened to and felt involved in making decisions about their care.

People were supported by staff that respected and promoted their independence, privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were supported to form links with the local community and were engaged in person centred activities which were tailored to meet their individual interests.

The home used technology and innovative approaches to engage people in ways which were meaningful to them.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People received person centred, compassionate end of life care.

Is the service well-led?

Good

The service was well led.

Staff felt supported and were confident and clear about their roles and responsibilities within the service.

Feedback was used to highlight areas of good practice or where development was needed. Information was used to plan actions and make improvements.

The management team promoted inclusion and encouraged an open working environment.

Quality monitoring systems were in place which ensured the management had a good oversight of service delivery.

The service was led by a management team which was approachable and respected by the people, relatives and staff.

The service worked to learn, improve and measure the quality of care and treatment people received.

Somerleigh Court

Detailed findings

Background to this inspection

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

The inspection took place on 19 February 2018 and was unannounced. The inspection continued on 22 February 2018 and was announced.

The inspection was carried out by two inspectors on the first day and by one inspector and an expert by experience on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience in dementia care and care home services.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority to obtain their views about the service.

We had requested and received a Provider Information Return. This is 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. We reviewed this information prior to the inspection.

During the inspection we spoke with 11 people who used the service and nine relatives. We also spoke with 10 members of staff, the registered manager and the head of care. We received feedback from three professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection, these included eight care records. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, meeting minutes and staff training records. We looked at three staff files, the recruitment process, complaints, training and supervision records.

Following our inspection visit, we requested further documentation from the service. This included an update about a complaints process and copies of some policies. This information was provided.

Good

Our findings

Care Home

People were protected from the risks of abuse because staff understood the potential signs and how to report any concerns. One staff member explained that they would be aware of any physical signs but also more subtle changes in people including "any flinching, facial expressions…anyone appearing frightened". Another staff member told us that they would look for "physical signs of bruising or marks....possible signs of agitation or fear". Staff understood how to report any concerns and told us that they would be confident to do so. If staff needed to whistle blow, they advised that they were confident that management would listen but knew how to report to external organisations if needed. The service had a safeguarding policy in place which provided guidance about types of abuse and included case studies to add context to the information. Where any concerns had been identified, these had been alerted appropriately and learning shared with staff.

People and relatives all told us that staff provided safe care and support. Comments from people included "I am happy as there are people around me all the time" and "I feel supported and there is always a button you can press somewhere to get help". Relatives were also positive about the safe care received by loved ones and comments included "My relative is safe as there is always people around at all times" and "my relative is safe as you need a key to use the lift and staff have to let you out to use the stairs". These security measures meant that people who had a dementia were cared for in an environment which was secure.

Staff understood their roles in managing the risks that people faced and these were clearly recorded with actions in place to guide staff. For example, one person was at risk of developing pressure areas. There was a plan in place to manage this which was regularly reviewed. When the person developed a pressure area, a separate plan was introduced to safely manage this which included an assessment of the wound, additional changes to take the pressure off this area and daily monitoring. The person's wound had improved with this action. Another person was at high risk relating to a medical condition. They could potentially have required an immediate response from staff and this had been reflected in a crisis plan which had been developed and shared individually with staff. Staff were all aware of this and aware of what immediate actions they would take if the person required this.

There were enough staff deployed to meet people's assessed needs in a timely way. We observed that call bells were answered quickly and when an emergency bell sounded, staff responded immediately. People told us "I get enough help when I need it" and "I ring the bell and staff come". The registered manager used a

dependency tool to consider staffing levels each month and used the information about call bell response times to identify appropriate staffing levels. Where there were times which were more pressured, these were identified and responded to. For example, more call bell responses in the evenings and higher numbers of falls at this time had resulted in an additional staff member for a 'twilight' shift to ensure that staffing levels were sufficient.

Recruitment at the service was safe with appropriate pre-employment checks in place. Staff files included identification checks, application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. Not all recruitment files included sufficient evidence of applicants conduct in previous employment. The registered manager introduced a risk assessment which they advised would be used to consider and manage any potential risks if they were unable to source sufficient evidence of previous conduct for applicants.

The service was fully staffed at the time of inspection and the registered manager explained that they also encouraged and used volunteers and apprentices. The service was also supporting a student nurse for their placement at the time of inspection and regularly offered this in conjunction with the local university.

Staff told us that they had access to enough suitable equipment to support people safely. We observed that staff had timely access to the correct equipment to support people and were confident in using different pieces of equipment safely. Five specialist 'floor beds' were in use where people were at risk of falling from their bed and the use of bed rails was not appropriate. These beds could be lowered to floor level while the person slept which removed the risk of injury if they fell. We saw this equipment in use for people and saw one person who had moved their legs out of the bed but were safely supported on a crash mat laid next to the floor bed. Staff fed back positively about this equipment and told us that it managed the risk of falls for people because if people rolled, they were on the same level as the mat next to their bed.

People received their medicines as prescribed and these were recorded safely. Where people had medicines prescribed to be taken 'as required', staff asked whether people wanted this before administering and recorded this accurately in the person's Medicine Administration Record (MAR). Additional guidance was in place for 'as required' medicines which included how these were to be administered and pain assessment tools were used where people may not be able to verbally express pain. We looked at the MAR for six people and found that these had been recorded accurately. Where people had prescribed creams, these had body maps to guide staff about where these needed to be applied and were recorded accurately in people's MAR.

The service had safe arrangements for the ordering, storage and disposal of medicines. Where medicines required additional security checks, these were in place and records of stock balances were correct. Some medicines required colder storage and this was provided with regular temperature checks in place.

Fire evacuation procedures were in place and each person had a Personal Emergency Evacuation Plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks of the fire alarms, fire doors and fire safety equipment. Fire drills were carried out and recorded to ensure that people could be evacuated safely in the event of an emergency. There was a fire risk assessment in place and the service had a 'fire box' which contained copies of people's PEEPs and other important information so that this could be quickly accessed in an emergency.

People were supported in an environment which was kept clean and safe with regular monitoring checks and cleaning. Checks were in place to ensure that all areas of the home were kept clean and there were visible stock of Personal Protective Equipment (PPE) on each floor of the home for staff to access. Staff told

us how they used PPE to prevent the spread of infection and we saw this being used throughout our inspection. One relative told us that they saw staff wearing gloves and aprons when they assisted their loved one and told us there was "never a smell, always clean. The cleaner is good and will help everybody". One person told us "I think the standard of cleanliness is quite high" and another said "I have never had any complaints about cleanliness". There was a malodour in one area of the home and the registered manager explained additional cleaning measures they had in place to try to manage this effectively. Staff received training in infection control and appropriate use of PPE and the service had a policy in place which included guidance for staff about their roles and responsibilities with relation to preventing the spread of infection. The service had not had any outbreaks of infection in the 12 months prior to our inspection.

Staff understood their responsibilities to raise concerns or report incidents and these were used to learn and drive improvements at the home. A previous safeguarding alert had been used to identify learning and actions which had been shared with staff. Staff had been given further guidance about ways to effectively monitor pressure areas if they were not easily visible and staff planned to complete further training in pressure areas.

Care at Home

Staff understood the risks people faced and how to manage these. One staff member told us about a person whose mobility had deteriorated. They had discussed with the person the best way to support them and were now using a piece of equipment the person was able to sit on to assist them safely. Risks were reflected in the care plans in people's homes and we were told that the provider would ensure that these risks were reflected in written care plans kept within Somerleigh Court so that the written information about risk management was consistent. Risk assessments were also in place to consider people's home environments and whether they needed assistance to evacuate their homes in an emergency.

Staff understood how to raise any concerns about potential abuse. One staff member explained that they would go to their line manager or the registered manager and would whistle blow externally if needed. There had not been any safeguarding alerts relating to the support provided to people in the extra care housing in the 12 months prior to our inspection.

People were supported by enough staff to meet their assessed needs. One person told us that they preferred to be supported at a particular time of the morning and that staff were consistently able to visit at this time. Another person explained "I can call them….they come quickly". People received safe support, one person explained that they felt safe and told us "If I start coughing when I am eating, they rush over to check I am okay".

People received their medicines as prescribed and staff told us about prescribed creams and how they ensured people were assisted to apply these. Staff understood how to administer medicines safely and people chose how they stored their medicines in their own homes. One person told us "they (staff) help me take my medicines and watch me take them, they are very good". We looked at the Medicines Administration Records (MAR) for two people and found that these were signed correctly.

People had previously attended a session arranged by the service around safety of electrical appliances in people's own homes. One person explained that this had been prompted by reports about a fire in a block of flats and had been helpful in providing handouts with information and formulating a plan to ensure that people's electrical equipment would be tested to ensure that it was safe.

Staff were mindful of infection control procedures and had access to appropriate Personal Protective

Equipment (PPE). One person explained that staff were "very respectful, they know what they are doing and wear gloves and aprons in my bathroom".

Good

Our findings

Care home

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 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people were unable to make decisions in relation to specific areas of their care and treatment, assessments of capacity and decisions in people's best interests had been made. Where people had legal arrangements in place to manage decisions about their support, these were recorded and copies included in their care plans. MCA assessments were decision specific and included clear reasoning where a person had been assessed as lacking capacity. Decisions in people's best interests involved those important to them and considered whether options were the last restrictive for the person. For example, one person had a best interest decision relating to the use of bed rails. The assessment identified that different approaches and times had been trialled to give the person the best opportunity to make the decision and where they had been assessed as lacking capacity to do so, the person's family had been involved in the discussions about what was in the best interests of the person.

No one at the service had any conditions attached to their DoLS authorisations. The head of care provided us with information about who had DoLS authorisations in place and who was awaiting assessment from the local authority.

People and those important to them were involved in pre-admission assessments about their support. Pre-admission assessments were in place which looked at support people required to ensure that Somerleigh Court would be able to meet their needs. On the day of admission, handover information for staff provided

details about the persons needs and their preferences had been shared with the kitchen with regard to meals and drinks. Information about their background and those important to them had also been recorded. This was important because it enabled staff to get to know the person and communicate about topics and people which were relevant to them.

Staff had the correct knowledge and skills to support people and received relevant training and development opportunities for their roles. Staff spoke positively about the training opportunities and explained that there were always topics and development options available and these were visibly posted on the staff noticeboard. Staff received training in some areas which the service considered to be essential. These included moving and assisting, safeguarding, mental capacity and dementia awareness. Other training opportunities were offered which were relevant to the needs of people receiving a service and included a range of methods including workbooks, practical sessions and quizzes. The staff notice board showed that a number of staff had signed up to attend a quiz relating to their knowledge of end of life care. Basic life support and Level 3 first aid was also planned and staff had also signed up to attend a virtual dementia workshop designed to provide staff with an understanding about how it might feel to have a dementia.

Registered nurses were supported to attend relevant training to maintain their competencies and were given support to complete their revalidation with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK. The registered manager and head of care had both completed revalidation and learning from themselves and other registered nursing staff was used to support and assist others when they were required to revalidate.

New staff to the home were supported through an induction and probation period and completed the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff completed shadowing as part of their induction and also completed a two day induction provided by the head of care and registered manager. It included basic information about nutrition, the values of the service, end of life care and a session around understanding the reality for a person with dementia. Staff told us that they had found the induction useful and had shadowed senior staff and asked whether they felt this was sufficient before starting to support people independently.

People were supported to have a balanced diet and where people needed foods prepared in a certain way to eat safely, this was accommodated. The chef was able to explain about people's particular dietary requirements and was aware of any allergies or intolerances. They had copies of safe swallow plans if these were in place for people and knew how people needed food to be prepared to ensure it was safe for them. For example, some people required a mashed or pureed diet. The chef also understood people's likes and dislikes and went onto each floor of the home daily at lunch time to speak with people and gather feedback about any changes or preferences. This information was then incorporated into future menu choices. People had a choice of a main meal daily and if people preferred to have their main meal at a different time or have something which was not on the menu, this was accommodated. One staff member explained that some people had expressed a wish to have a bacon butty for their breakfast and the chef had made these as requested. Another person was eating very little but had asked for a particular meal, this had been made promptly by the chef. Some people had different cutlery and plates to assist them to eat independently and we saw that people were supported to eat themselves rather than staff offering full assistance if this was not always required.

The kitchen had been awarded a five star food standards rating and all staff had received food hygiene training.

People had access to a range of health care professionals when this was needed. A local GP visited on both days of our inspection and we also saw another health professional popping in to deliver some prescriptions for people. People had regular access to chiropody and referrals were recorded for occupational therapy and opticians. Another person had a hospital appointment booked in to attend. One person presented as more drowsy than usual when we visited and the registered nurse on duty contacted the GP who visited the same day. On the second day a person had told staff that they felt unwell and dizzy, the registered nurse had taken their blood pressure and pulse and followed this up the same day with the GP.

Some changes to people's environment had been made since the last inspection to make sure that it met the different needs of the people living there. The second floor supported people who had varying types of dementia and work had been undertaken to ensure that colours and signage were used to help people orientate to particular areas. For example, hand rails were yellow to assist people to see these and use them when they walked. Toilets had pictorial signs to assist people to identify that this room was a bathroom. The registered manager explained that people's bedroom doors were painted in bold colours which had been most popular at a time when people lived in their own homes to assist them to identify that this was the front door to their personal space. Walls were decorated with different areas of textures and prompts for people to use touch to interact with them. For example, one board had soft knitted and sewn items for people to explore and another had mechanical items including locks and switches. People, relatives and staff had been invited to take and send in photographs of areas in Dorset which had been enlarged and used to make large canvasses around the home. This helped to orientate people and provided a basis for conversations if they were places people recognised. We observed a person discussing whether one image was of a local Dorset beach.

People had essential information recorded in the front of their care plans which would be used to ensure that important information about the person's needs and wishes would be known if the person went into hospital. Several people both in Somerleigh Court and the surrounding village had received some short term support at Somerleigh Court. The flexibility of the care home and domiciliary agency on one site meant that staff from both parts of the service worked closely together to offer adaptable support for people's changing needs. The head of care told us about one person who was currently living in the care home. They explained that the person had previously attended events at the care home and spoken with staff. This familiarity had meant that they were better able to manage the move into the care home on a temporary basis until they were able to return to their apartment.

Care at Home

People had person centred care plans which included what support they required and their preferences for receiving this. Staff knew people well, understood what support they needed and respected their preferences. One person told us "staff know what I need help with".

Staff sought people's consent before providing support and understood the principles of mental capacity. One person needed assistance with their medicines and staff understood that the person had capacity to make decisions about their medicines but needed physical assistance to take these safely. Consent forms were in place in people's care plans and one staff member explained that they "always ask people what they want and how they like care to be provided".

Staff were positive about the training they received and had the knowledge and skills to effectively carry out their role. In addition to mandatory subjects, staff received training specific to the people they were supporting including dementia and dysphasia. A staff member explained that quite a few people had a diagnosed dementia so this training had been helpful in understanding how this affected them.

Staff told us that they received regular supervisions and annual appraisals which enabled them to discuss practice, identify learning and development and discuss particular subjects or topics where appropriate. Staff told us that they felt supported and one commented that it was a "lovely team to work with".

People were supported where needed to have sufficient to eat and drink. Staff knew people's individual dietary requirements and where people needed meals to be cut up or pureed to be able to eat safely, this was provided. One person told us they "have to have food pureed, staff know all about it".

Three people who received support from the Care at Home service told us that they had lived in the care home for short periods of time. Feedback about this had been positive as it had enabled people to receive an increased level of support for a short while until their health had improved sufficiently to be able to move back into their apartments. This flexibility had been appreciated by the people we spoke with.

People were supported to access health professionals where needed and we were told that one person was awaiting a health diagnosis following appointments with health professionals. A different person explained that staff had helped them to access a different type of bed which they were currently waiting for. Another person had been referred for occupational therapy and was awaiting a visit.

Good

Our findings

Care Home

People and relatives told us that staff were kind and compassionate in their approach and we observed that interactions between staff and people were tactile and reassuring. One relative told us that the best part about the service was "kindness without a shadow of a doubt…from the top (the management team) right down (through all the staff)". Staff spoke with warmth about people and knew people well which was evidenced by their knowledge about people's personalities and characters. We observed a member of staff offering a person a choice about puddings after their main meal. They shared a joke with the person and noticed that another person had some food on their chin. They explained this to the person and quickly wiped this away for them.

Staff communicated effectively with each other throughout the inspection which meant that people received joined up, consistent support. Staff had a handover at each shift and any updates were added onto the written handover sheet to ensure that these were shared with staff. A copy of this was provided for a new staff member to ensure that they had easy access to the most important information about people. Verbal communication was used to provide proactive and timely support for people. For example, a staff member highlighted that the pain in a person's legs could be helped with the use of some pieces of equipment. Staff supported this suggestion and another staff member immediately sought a member of the domestic team who offered to find the equipment in the home to support the person.

Staff understood people's preferences and offered them choices in ways which were meaningful for them. One staff member explained how they sought consent to support someone with personal care. The person had requested that staff assist them with their hands and face only and staff had respected their wishes. Another person had limited verbal communication and staff explained how they used tactile contact and facial expressions to enable the person to make choices about what they wore. We observed a staff member arranging for a person to have their meal later because they had expressed a wish to go back to bed at lunchtime. This was respected. One care plan reflected that it was important for a person to be well dressed and included the persons favourite colours to wear.

People's religious and cultural needs were respected. People at the home received regular visits from a local church and staff explained how they were mindful about people's cultural and religious needs and would ensure that these were respected and that people were encouraged to maintain links with the community if they wished to do so. A member of the activities staff explained "we offer to take people to church if they

wish to go". Essential information in people's care plans included whether people had any particular religious or faith beliefs and whether they required any support to maintain this. The registered manager explained that they had worked with the local vicar to determine whether there was any further changes to ensure people's spiritual needs were met. This had led to the Vicar visiting to conduct a service at the home regularly which staff were able to attend if they wished. There were also plans to change an unused area of the home to create a spiritual space which would be available to support people's faith or spiritual beliefs as a private space.

Staff ensured that they were respectful of people's private rooms and maintained people's dignity. There were signs which staff used to indicate when they were assisting people with intimate care and we observed that staff consistently knocked and sought agreement before entering people's bedrooms and asked whether people wished to have their doors open or closed. One staff member explained that they "always knock when we enter, close the door and curtains and use the (do not disturb, care in progress) sign. We keep them as covered as possible". One person explained "we always have a laugh and then I don't feel embarrassed when they are doing something personal for me", another told us "staff are very discreet".

Staff had training in equality and the registered manager explained that where people at the home had protected characteristics under the Equality Act, they "would support the same as we support everyone….we treat people as individuals". They explained that they had considered how they might support people to ensure that they were not discriminated against and explained support that was in place for staff as well as people receiving a service.

People were supported to be as independent as possible and care plans were written with an emphasis on what abilities people had. One person had been visited by a physiotherapist and explained that their goal was to be able to walk again. Staff explained that they completed exercises with the person each day and we observed staff encouraging them and complimenting them about how well they were doing.

Visitors were welcomed at the home at any time and staff in the front office were available to greet people. All visitors signed in on arrival and visitors told us that they were able to stay if they wished for meals. We observed family members sharing meals with their loved ones at lunch time and saw that relatives and visitors were comfortable to access hot drinks from the small kitchenettes on each floor during their visits. One relative explained "staff keep me up to date with how (name) has been".

Care at Home

People told us that staff were kind and caring. One person said staff were "all lovely…always cheery. They check that everything is okay. I'm very happy with everything". Another told us "they (staff) are all very good".

People were supported to retain their independence. Care plans recorded people's abilities and focussed on what people were able to do for themselves. For example, one person's care plan indicated that they were able to wash and dry their face independently. Another person told us that they had a piece of equipment in their kitchen which "helps me to make tea".

Staff respected people's privacy in their own apartments. One person explained that staff always sought consent before entering their home. A staff member explained that they were mindful that they were visiting people in "their own flats…you (staff) are providing a service, I'm professional and human".

Good

Our findings

Care Home

Social opportunities and activities for people were person centred and promoted community links for people. Since our last inspection, the home had increased the support from activities staff, considered opportunities in the local area and planned creative ways to provide increased flexibility and opportunities for people. A staff member explained that group activities were planned for different floors of the home and that people were asked, encouraged and supported to attend these. There were monthly activities plans which included musical and creative options, some of which were provided by external resources. We saw some people involved in an art activity and saw that staff were available and engaged in supporting and talking with people about their pictures.

Innovative options for offering personalised interactions through the use of technology had been effective in engaging people. Staff had spent time understanding people's histories and interests and designed innovative activities to incorporate these in ways which were appropriate for people. For example, one person had an advanced dementia and was not able to verbally communicate. Staff had used a handheld device to find and play noises from a person's previous place of work. They told us that the person had responded positively to hearing these familiar sounds. Another person had expressed an interest in learning a foreign language and staff had used this interest to engage the person through an application on the handheld device to enable them to progress this. Another person had moved to the home from another part of Dorset and spoke with staff about where they used to live. Staff had considered ways of using the person's past to engage further with them. They sourced a map of the local area where the person used to live and the person had been able to identify where they used to live and pick out other local landmarks and discuss this. A professional who had involvement with the home told us that Somerleigh Court was "one of the most interactive and proactive homes" that they visited.

The registered manager had considered how to engage people with advanced dementia and had purchased a 'tovertafel' for people to use, we saw this in use during the inspection. This is described by the inventor as a fun care innovation that connects older people in the late stage of their dementia journey with each other and with their surroundings, all the while stimulating movement. We saw one person using this to complete an interactive puzzle. The person had limited movement and advanced dementia but were able to interact with the puzzle independent of staff assistance. Staff told us that another person enjoyed a game which was based on connecting well known phrases and another person enjoyed games where they could pop

bubbles and sweep up virtual leaves. This piece of technology was able to be moved to different floors of the home which made it accessible for everyone and was used regularly as another opportunity to engage with people in groups and one to one. When this equipment arrived at the home, the registered manager invited other local services to visit and try the 'tovertafel' to see whether it may be of benefit to other people in other services. Some people from another local service visited to try the technology out to see whether it might benefit them in their own service. We saw a thankyou card from the people who had trialled the 'tovertafel' which indicated that they had enjoyed trying it and were considering this innovation. This was an example of how the service was taking a key role in the community to share innovation and ideas.

Somerleigh Court arranged different events throughout the year which were open to people in the home, people who lived in the surrounding village, families and friends. Some of these were held in Somerleigh Court and others were planned and held in the communal areas of the Close Care village. People from Somerleigh and the village were invited and supported to attend these events in whichever location they were held. This provided opportunities for social interaction outside the nursing home. People were supported to attend local community groups including a local memory café and a regular group which used singing to bring people together run by the Alzheimer's society. The home also held regular 'knit and natter' sessions which were open to the local community as well as people in the home and surrounding village. This encouraged people to learn or practice this skill and provided a further link with the local community. Another person liked to access talking books from the local library. Staff supported the person to go to the library regularly so that they were able to independently choose what books they wanted to borrow. People were also supported to attend the local market in Dorchester each week which enabled them to see, choose and purchase items and to have further links with the local community.

The service had taken a key role in the local community to try to build links with local schools. They had regular visits from a secondary school who visited regularly, particularly for pupils to engage people with musical performances. Staff brought their children in to the home to visit people and the registered manager explained how people had benefitted from seeing and interacting with them. One person had been able to hold a baby and this had such a positive impact that the registered manager had considered opportunities for building relationships through local pre-schools. They had linked with a local school and planned regular visits for children to attend the 'knit and natter' sessions and visit the home on a regular basis. This would provide people with the opportunity to engage with children and form further social networks outside the home. The registered manager explained that they had linked with primary schools in another service which had been mutually beneficial for people and children. They were in the process of setting up to 'twin' with a local first school to develop opportunities for people and local children to engage and socialise through a range of activities. They explained that the 'tovertafel' had also been enjoyed by children who visited the home and was a resource that people and children could engage with together.

Somerleigh Court had several volunteers who visited at different times and spent one to one time with people. A staff member explained that the volunteers held a 'befriender' role and would spend time with people who preferred one to one contact and also support people to go out into the community and assist at events in the home and surrounding village. We saw volunteers spending time with people in the ways described during our inspection.

People and those important to them were involved in reviews and decisions about their care and treatment. Care plans were person centred and included detailed information about people's likes and dislikes for each area of their care and treatment. For example, one person had expressed a preference for a particular gender and age of staff. A staff member was aware of this preference and confirmed that the person was

always offered this preference when they needed support.
Care plans included information about people's backgrounds and what was important to them. Details included people's spirituality, life experiences and current and past interests. They also included information about what helped people if they were upset or anxious. Care plans were reviewed monthly or sooner if people's needs changed and we saw that people's families were invited to arrange more formal reviews about people's support on a regular basis. This meant that changes were reflected in care plans and shared with staff to ensure that care was responsive to people's needs.

The service met the Accessible Information Standard for people. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff understood and communicated with people in ways which were meaningful for them. For example, one person had a sight impairment. Their care plans identified this and gave guidance for staff about how to communicate effectively, this included where staff should stand to enable the person to best see them. Another person had a hearing loss but chose not to wear any aids to assist with this. We observed that staff were aware of this person's choice and ensured that they spoke clearly and loudly to assist the person to communicate. This was effective and the person was able to understand and communicate their wishes to the member of staff. The service had visual communication cards available. Staff told us that these were not used with anyone at the time of inspection, but they were available as another method of communication if this would have been of benefit for a person.

When people first moved into Somerleigh Court, they were provided with an information booklet. This included information to help people feel at ease and orientate into the home. For example, photographs of the registered manager, head of care and managers of other departments including housekeeping and maintenance were included with information about each one. Useful local phone numbers were also included for people, for example banks, dental surgeries and taxi firms. This meant that people were provided with relevant information to enable them to settle into their new environment.

Somerleigh Court had started to introduce an electronic care planning system in to the home and Close Care services. At the time of inspection this was used by all staff to record daily notes and observations about people, but was planned to make all recording electronic. Staff used smart phones to record daily notes and we saw that these handsets were available and charging for staff use on each floor of the home. The registered manager explained that they wanted to make recording more efficient at the home and to reduce the time staff needed to spend writing to enable them to spend more time engaging with people. Staff spoke positively about the new technology and were seen using it throughout the inspection to record information. People all had call bells in their rooms and some who were at a high risk of falls when mobilising also had sensor mats in place which alerted staff. We observed that this technology enabled staff to respond quickly when people needed assistance and when the emergency call bell sounded, staff responded immediately.

People and relatives told us that they would feel able to raise any concerns or complaints and were confident that these would be listened to and acted upon. Somerleigh Court had a complaints policy in place which detailed the process of making and responding to a complaint and included timescales for each stage. The service had received two complaints in the previous 12 months and both had been responded to in line with the policy. The registered manager discussed one complaint with us and explained the actions they had taken as a result of the issues raised. This demonstrated that complaints were listened to and that the service worked with people to try to find resolutions.

Somerleigh Court had been awarded Beacon status with a national framework for providing end of life care. People at the home received personalised end of life care which was respectful of their wishes and preferences. We saw that end of life care plans were in place and that end of life wishes were discussed with people and those important to them to ensure that their preferences were understood and recorded. We saw that people's pain was effectively managed by staff who were attentive and responsive to people's changing symptoms. One person was feeling nauseous on the first morning of our inspection. Staff had reported this to the registered nurse on shift who had administered medication to assist with this. This had worked effectively as the person was no longer feeling nauseous later in the day and had been able to eat something. The service held regular meetings to discuss and identify where people were approaching end of life. There were effective processes in place to work with the GP surgery to provide joined up, timely support when someone was approaching the end of their life. People had health decisions in place around end of life care and the GP explained that medicines were prescribed and available for people who required end of life support so that symptoms were effectively managed.

Staff were supported to discuss and reflect on people's deaths and there were regular reflective sessions to discuss and share emotions and experiences around end of life support for people. Any learning was used to make improvements and changes. Somerleigh Court help an annual memorial service for people and invites were sent to families and those close to people who had died at the home. Families were also supported when a person died. We saw that staff were all writing in a card sending condolences for one family. We observed a staff member asking after the family of a person who had recently died. Staff had said that they would be ringing the family to see how they were coping and offering support. The service had received several compliments from families about the end of life care their loved ones had received. Comments included "I have had a card from your staff which I will treasure, such lovely, caring people", "it made a huge difference to know that (name) was being looked after with such great care and affection". Another relative told us that staff had been compassionate when their loved one was receiving end of life care and in the last few hours had "quietly came in and sat with (name)" if the relative had needed to leave the room. They went on to explain if staff "saw (name) was in pain in their face, they gave them medication and saw the pain fade away".

Care at Home

Support people received was responsive to their changing needs. One staff member told us about a person whose mobility was variable. They explained they were "assessing each day….can bring another carer" if the person needed two to assist them.

Close Care had the same complaints policy as Somerleigh Court which detailed the process of making and responding to a complaint and included timescales for each stage. There had been no complaints made in the previous 12 months prior to our inspection, however people told us that they would be confident to speak with staff if they had any concerns, or to approach the registered manager.

People who lived in the apartments told us that they were able to attend events within Somerleigh Court and that events held within the communal areas of the village were also attended by people from Somerleigh court as well as the apartments.

People's care plans included whether there were any DNAR or living wills in place for people. A DNAR form is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation (CPR). After the death of one person, staff reflected and discussed additional support for people living in the surrounding apartments. The registered manager explained that a session was arranged which provided people with information and understanding about advance decisions for end of life care and

included how to request a DNAR and options for making legal decisions. Two people explained that they had found this useful and helped them to start to think about their wishes for their end of life support. The head of care explained that another person had sought advice about ensuring their wishes would be understood if they were to become unwell while out in the community. They had been supported to develop a plan to manage this concern.

Good

Our findings

Care Home and Care at Home

At our last comprehensive inspection on 10,11 and 17 November 2016 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems did not effectively and consistently assess or monitor the quality and safety of people using the service or identify areas for improvement. Records were not always accurate or reflect the risks that people faced. At this inspection we found that improvements had been made.

The registered manager had a clear vision for Somerleigh Court and had an inclusive approach to driving changes and improvements within the service. People, relatives and staff were involved and encouraged to make suggestions and comments about planned changes. There were improvements in the service since the last inspection and the registered manager told us that they had invited staff and relatives to be involved in an exercise to provide feedback about any potential changes to improve outcomes for people. Small groups had been set up and asked to look at the characteristics set by CQC of safe, effective, caring, responsive and well led to drive changes. The registered manager told us that this had been useful and they were planning using this system again to review the changes CQC had made to the mandatory characteristics which came into effect on 1 November 2017. This demonstrated that the management of the service was using innovative and inclusive approaches to improve service delivery.

Somerleigh Court had effective systems in place to monitor and identify gaps or areas for improvement and there were action plans in place to drive changes. Audits were completed on all areas of the service including medicines, accident/incidents, care plans and health and safety. There was an overall tracker used to identify which audits needed to be done and by whom and confirmation when they had been completed. Where actions were required, plans were put into place to identify who was responsible for each action and a timescale for completion. For example, an updated fire risk assessment had identified that evacuation chairs were required. This had been included on an action plan and the date of completion had been entered when this equipment had been put into place. Action plans were colour coded to identify anything which required urgent action in red. The registered manager told us that this enabled them to effectively monitor and prioritise changes at the service. Quality assurance information was also displayed on boards for staff to view, the information was presented in coloured charts and enabled staff to be able to see what information had been gathered and any trends or actions planned.

The registered manager told us that they were in the process of reviewing their values to reflect the

approach to care and treatment which they referred to during the inspection as 'The Somerleigh Way'. There was a draft version of the new values which the registered manager explained would be shared with staff, people and their relatives for their feedback before considering whether the updated values would be formally accepted. Staff, people and relatives told us that the registered manager and head of care were a strong team who had a good oversight of the service and worked effectively together. The service had a statement of purpose which stated that the service was 'committed to offering a safe, comfortable and friendly home to give our service users a sense of well-being and contentment'.

The registered manager told us that they received regular support from the provider and was given autonomy to use innovative thinking and make changes to improve outcomes for people. They explained "they give me the space to work and create something….there is not only one way to do things". They also had good local links with other services and registered managers and attended hubs to discuss practice and share ideas. They received good practice updates from a range of national organisations to ensure that they were up to date with best practice guidance.

Somerleigh Court had an inclusive approach which was respectful of people's individual beliefs and promoted equality. The registered manager welcomed and supported people from the LGBT community (lesbian, gay, bisexual and transgender) and explained how they supported people and staff as individuals. They gave us examples of this approach and told us how they would support a person living at the service to ensure that their equality and human rights were understood and respected. Information for people when they moved into the home included local places of worship for people of all faith's to enable them to make local links if this was important to them.

Staff told us that they felt supported and valued in their roles. One staff member described Somerleigh Court as "the best place I've worked in care". Another explained "we can always ask questions….I'm clear about my responsibilities". Staff had clear roles and responsibilities and systems were in place to ensure that shifts were organised. For example, allocations were made at each shift so that staff understood what they were responsible for. Staff handovers were used to update and discuss people's changing needs and we observed staff recording daily notes about people onto the mobile devices throughout the inspection.

The service worked in partnership with other agencies to provide good care and treatment to people. A professional told us that the home was proactive about treatment for people and gave us an example of partnership working for one person with other external professionals including a dietician and consultant. They explained that staff had advocated for the person and the person had received good care and been able to move back into the community. The professional told us that they did not think that this would have been possible without the partnership working which had taken place.

The registered manager and head of care had an open door policy. They both had offices which were located by the main entrance, this meant that they were visible to people, visitors and staff. In addition to informal feedback, the service also used surveys to gather peoples' views. The last satisfaction surveys had been completed by people and staff in August 2017 and responses were overwhelmingly positive. Staff had been offered an incentive of being entered into a prize draw if they completed the staff survey. This was an innovative way of trying to improve response rates to the surveys sent. The service received 27 surveys out of the 98 which were sent out to staff. The survey had gathered feedback about working for Somerleigh Court and had included questions about how staff felt about their role, views about the registered manager and training. Staff had fed back that staffing needed to be reviewed. The registered manager explained that they had taken action following this and had worked to expand the staff team.

A resident's survey had been sent to 68 people living at Somerleigh Court and the surrounding care village.

29 responses were received and again, the responses were overwhelmingly positive. Questions about the service included satisfaction levels with the service, feedback about staff, meals and events. An action plan was formulated from the feedback and used to drive changes. For example, some people had fed back that it was not always easy to identify staff. The registered manager explained that new uniforms had been introduced to clearly show staff roles and name badges were also in place.

The service had a clear development plan in place. This had been shared with people who used the service, relatives and staff and included a range of planned changes for 2018. These included converting some rooms to better suit people and staff, the development of a sensory room for people and an improved staff room. Feedback had also indicated the disabled access to the front of the home needed improvement and the registered manager told us that this was also planned.

The head of care had introduced a notebook at reception to encourage visitors and relatives to tell the service about good practice. This had been a suggestion from the KLOE exercise and we saw that it was being used with comments including 'thank you for making (name)'s room look lovely today', 'it was so nice to sing with my relative today' and 'it was wonderful to see such kindness and interest in each individual in their care'. The registered manager maintained a record of improvements since the last CQC inspection. This meant that they were able to demonstrate what had changed and provide us with information about the successes and changes which they had undertaken.