Sunrise Operations Purley Limited

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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 13 and 14 September 2016, the first day was unannounced. At our last inspection in July 2014 the provider met the regulations we inspected.

Sunrise Operations Purley Limited provides residential and nursing care for up to 119 older people. Accommodation is spread over four floors with passenger lift access. A separate specialised reminiscence neighbourhood is situated on the second floor for people living with dementia. Some people use the service for respite care breaks. There were 112 people using the service at the time of our inspection.

When we inspected, there was no registered manager at the service. A new manager had been appointed in August 2016 and was in the process of applying to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and well cared for. There were robust systems and processes in place to protect people from the risk of harm. Staff knew how to recognise and report any concerns they had about the care and welfare of people and how to protect them from abuse. People's safety was promoted because risks that may cause them harm had been identified. Suitable risk assessments were in place to keep people safe.

People lived in a safe, clean and comfortable environment that was designed and equipped to meet their needs. The reminiscence neighbourhood promoted engagement and wellbeing for people living with dementia, using decoration, signage and other adaptations. Appropriate checks of the building and equipment were undertaken to ensure health and safety for people and staff was maintained.

The provider's recruitment and employment processes were robust and protected people from unsafe care. When we inspected, there was enough staff to meet people's needs although continuity of care was affected by staff turnover and the use of agency staff at times. The provider was taking action to improve this.

Staff received a structured induction and essential training at the beginning of their employment. This was followed by ongoing refresher training to update and develop their knowledge and skills. Staff also undertook training specific to the needs of people they cared for and to keep up to date with best practice. Staff were supported in their roles and the standard and quality of their work was kept under review through ongoing supervision and performance appraisal.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This legislation is intended to ensure people receive the support they need to make their own decisions wherever possible. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process to

make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Conditions on authorisations to deprive a person of their liberty were being met. Staff had completed training and understood their responsibilities where people lacked capacity to consent or make decisions.

People's health needs were monitored and they had access to health care services when they needed them. Any advice from external professionals was included in their care and acted on accordingly. Medicines were managed safely and people had their medicines at the times they needed them. New audit and monitoring systems had been introduced to further ensure that people received their medicines as prescribed.

People's care needs had been fully assessed prior to moving to the home and these were regularly monitored and reviewed to make sure the care was current and relevant. Care records contained information about the care and support people required and were written in a way that recognised individual needs and preferences. Staff worked well with external health and social care professionals to ensure people received the care and support they needed.

People were treated with kindness and respect and made decisions about their care and support, with family members involved where appropriate. Staff were mindful of people's privacy and dignity and encouraged people to maintain their independence as much as possible. The service worked closely with families and relevant professionals so that people received dignified care at the end of their lives.

People were provided with a choice of food and drink that met their nutritional needs. Mealtimes were unrushed and people were encouraged and supported to eat a healthy diet that also recognised their choices. People received the assistance they needed to eat and drink well and staff involved other relevant professionals when people were at risk of poor nutrition or dehydration.

There was a varied range of activities and entertainment for people, which included group activities or one to one outings. Staff understood the importance of preventing social isolation and ensured that they offered companionship and interaction with people where necessary. People were supported to maintain relationships with family and friends who were important to them. Relatives and friends were welcome to visit when they wished and invited to participate in social events at the home.

Systems were in place that encouraged feedback from people who used the service, relatives, and staff and this was used to improve their experience at the service. People knew how to complain and told us they would do so if required. Procedures were in place to monitor, investigate and respond to complaints. There was monthly auditing to make sure that lessons could be learnt.

The registered provider had values for the service, which were known and followed by the staff team. Staff were clear about their roles and responsibilities and felt supported by management.

Consistent audits were undertaken to monitor the quality and health and safety of the service. Where improvements were needed or lessons learnt, action was taken. Records supported that audits were effective and supported the provision of safe and appropriate care. The provider worked in partnership with other agencies and professionals to support care provision and service development.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe and staff knew about their responsibility to protect people from the risk of abuse and harm. Risks to people's health and welfare were identified and steps were taken to minimise these and keep people safe.

There were adequate numbers of staff to provide safe support although staff turnover meant people did not experience continuity of care at times. The provider was taking action to address this.

Appropriate arrangements were in place for the recording, safe keeping and administration of people's medicines. The provider had taken action to improve practice around medicines management following a recent audit.

Is the service effective?

Good

The service was effective. People's rights were protected because staff understood and followed the principles of the Mental Capacity Act 2005. Staff sought consent from people before providing care and knew their responsibilities should a person be unable to make a decision independently or if someone was being deprived of their liberty.

People were supported to eat and drink well and received the support and care they needed to maintain their health and wellbeing. People were provided with a healthy diet which took account of their preferences and nutritional needs.

The service worked well with health and social care professionals to identify and meet people's needs. Staff sought healthcare advice and support for people as required.

The environment was designed and equipped to meet the needs of people using the service, including those living with dementia.

Is the service caring?

Good

The service was caring. People told us that staff were caring. Staff were kind and compassionate in their approach and had developed positive relationships with people.

People were involved in making decisions about their care and support. Staff were knowledgeable about people, the support they required and how they wanted their care to be provided.

Staff respected people's choices and supported them to maintain their privacy and dignity.

The service worked closely with families and relevant professionals so that people received dignified care at the end of their lives.

Is the service responsive?

Good

The service was responsive. People's needs were regularly assessed, monitored and reviewed to ensure they received appropriate care and support. People's care records were personalised in line with their needs and preferences and staff knew these well.

There was a variety of activities and entertainment. People could choose where and how they wanted to spend their day. Staff encouraged and supported people to participate in the activities to promote their health and wellbeing and reduce the risks of social isolation.

There were arrangements for people and relatives to raise any issues or concerns they had about the service. The provider had a complaints procedure to support this and responded to concerns in a timely manner.

Is the service well-led?

Good

The service was well-led. People, their relatives and staff told us they found the new manager to be approachable and supportive.

The atmosphere in the service was open and inclusive and there was effective communication within the staff team. Staff were aware of their role and felt supported by the new manager and their immediate line managers.

The provider used a range of audits and checks to monitor and assess the quality and safety of the service. Where issues were identified action was taken to improve the service people received.

Sunrise Operations Purley Limited

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.

Prior to our visit we reviewed the information we held about the service. This included notifications we had received from the provider and other information we hold about the service including any safeguarding alerts and outcomes, complaints and inspection history. Notifications are information about important events which the service is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return (PIR).The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection took place on 13 and 14 September 2016 and was unannounced. The first day was unannounced and the inspection was carried out by two inspectors, a specialist advisor in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with twenty people using the service and two visiting relatives. Due to their needs, some people were unable to share their direct views and experiences. We therefore spent time observing how care and support was provided to people. Along with general observation, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed records about people's care, including 16 files of people who used the service.

We spoke with five nurses, eight care staff, the activities co-ordinator, a chef, three domestic staff, the reminiscence coordinator, the new general manager, the deputy manager and a registered manager from

one of the provider's other homes who had been providing extra management support to this home. We also spoke with a visiting operations manager. We checked ten staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance systems, audits and health and safety records. We also reviewed how medicines were managed and the records relating to this.

Following our inspection, the manager also sent us information we had requested about quality assurance findings and planned improvements.

Good

Is the service safe?

Our findings

People consistently told us that they felt the home was a safe place to be. A relative felt their family member was safe and told us, "There are no issues of ill-treatment." Staff had a good understanding of how they kept people safe within the service. They were aware of the different types of abuse, how to report concerns, the escalation of concerns and understood whistle blowing procedures. They were confident that any safeguarding concerns raised would be dealt with appropriately by colleagues and management. We saw staff completed safeguarding training and were supported with clear policies and procedures. Safeguarding referrals had been made to the local authority safeguarding team where necessary in respect of people's care. CQC records showed that these safeguarding matters had been reported appropriately and the provider had cooperated with the local authority and other professionals to investigate events. At the time of this inspection one safeguarding investigation was still in process.

We found that the service was a safe place for people, staff and visitors. The building was purpose built over four floors to provide nursing and residential care for people. One floor was dedicated to people living with dementia. The building was well maintained as were the surrounding gardens. Maintenance was carried out when needed by two permanent staff, supported by external contractors.

Risks to people's health and welfare had been assessed. Care and support plans for people using the service were supported with relevant risk assessments. These risk assessments reflected the needs, goals and preferences of people and covered a wide range of risks. People's health needs were assessed for areas of risk such as falls, moving and handling, nutrition and pressure area care. We saw they clearly identified the risks, stated the aims and provided clear guidance to staff. For example, where people were at risk of developing pressure ulcers, this was assessed and pressure relieving equipment such as cushions and mattresses were used. Care plans included reference to the checks and records which should be maintained by staff. Staff told us that they would contact the tissue viability nurse and GP if required. We saw records in people's care plans to support this. Risk assessments were periodically reviewed or in response to any changes or incidents.

Staffing levels were planned based on the number of people at the home and their level of dependency. At the time of our inspection, we found that staffing levels were safe although staff turnover and the regular use of agency staff had an impact on the continuity of care. Some people felt there were particular times when staffing could be improved such as at weekends. A relative told us, "Agency staff come in at weekends and they don't know the residents." The PIR told us that 63 staff had left employment in the last 12 months. We saw that the provider was making efforts to improve staff retention and ensure staff vacancies were recruited to. For example, the HR department had visited the home to meet with staff and discuss their work experiences. As a result of feedback, new staff across all departments were provided with a more in depth induction.

We examined staff rotas which reflected staff on duty over the two days of the inspection. Nurses and care assistants were supported by domestic, catering and maintenance staff. Additional clinical support was available to nurses from the manager and care coordinator. This enabled nurses and care assistants to

concentrate on providing safe and appropriate care and support. The service regularly used agency staff. Wherever possible, planned absences for training and leave were accommodated within the staff rota. Short notice absences, such as sickness, were usually covered by staff staying on or agency staff being called in.

The registered provider followed robust recruitment and selection processes to make sure staff were suitable and appropriately employed. Records confirmed that the required checks were undertaken before staff started work. These included checks with the Disclosure and Barring Service to ensure applicants were not barred from working in this environment. There was also evidence of identity documents, references and full employment histories.

People we spoke with confirmed that they received their medicines when they needed them. A few people told us they had experienced occasional difficulties with their medicines supply. We brought this to the attention of the manager who looked into the issues and provided evidence that these were resolved.

Medicines, including controlled drugs, were safely managed and securely stored in appropriate conditions clinical rooms on each floor. All of the clinical rooms were clean and tidy with sufficient storage and hand wash facilities. Temperatures of the room and the medicines refrigerator were recorded daily to ensure medicines were stored at the correct temperatures.

We found medicines were administered by nurses and dedicated staff who had completed medicine's training and had their competency assessed. Medicines Administration Records (MARs) were up to date. Each MAR was preceded with a clear information sheet identifying the relevant person by photograph, name and room number and how people liked to take their medicines. They also contained essential, clinical information. Topical creams were recorded on MARs to ensure they were applied when needed.

We checked a random selection of medicines against records on each floor. The records we check tallied with the quantity of medicines held by the service. We also checked controlled drugs and medicines returns. We found the records accurately reflected medicines.

Where people were taking medicines that required regular medical checks or observations, this was referred to in medicines records and care plans. For example, where people were prescribed blood thinning medicines and those prescribed for a heart condition.

We found the service was administering medicines covertly to people when it was in their best interests. We checked records to ensure the service had completed mental capacity checks, held best interests meetings and involved relevant representatives and healthcare professionals.

The PIR told us that an independent audit of the medication systems had been carried out to reduce the risk of medicines errors. This resulted in a review of processes and procedures and updated training for every nurse and medication technician staff.

The service was following the Department of Health Codes of Practice for the prevention and control of infection in care homes. We checked communal areas and rooms which were clean and tidy. We examined bathrooms and toilets on all floors. The floors, walls, tiling, toilet pans, baths and shower areas were clean. We looked at cleaning schedules which clearly identified what was expected of each member of domestic staff each day and there were regular checks to ensure work was completed.

The main laundry was relatively small for such a large nursing home. The service had compensated for this by installing mini laundries on each floor that were used to launder people's clothing.

The service met the requirements of the Control of Substances Hazardous to Health Regulations (COSHH). Such substances were stored in locked COSHH cupboards. Domestic staff were provided with training and guidance in the use of these products.

Good

Is the service effective?

Our findings

People received effective care and support from staff who had completed a wide range of training relevant to their roles and responsibilities. The provider had a training and development programme for staff that included a structured induction and mandatory learning. This included core subjects such as manual handling, infection control, health and safety, food hygiene, safeguarding, fire awareness, first aid and privacy and dignity. Staff told us they were expected to refresh these key areas of training regularly. The provider used the Care Certificate, introduced in April 2015, which is a nationally recognised framework for good practice in the induction of new staff working in the care sector. As part of induction, staff told us they shadowed experienced members of staff before supporting people independently.

Since our last inspection, the home had accessed a range of local authority training to keep up-to-date with best practice. This had included training in person centred care, diabetes management, nutritional care and monitoring, record keeping, incident and accident reporting and continence awareness.

Staff spoke positively about the range and quality of training. One staff member told us, "There are very good opportunities for training." Staff told us they had been on training courses relevant to the needs of the people they supported. In the reminiscence neighbourhood staff had been enrolled on the dementia pathway scheme. This training took staff through six modules covering a wide range of skills for communicating and engaging with people living with dementia. Staff were in the process of completing the course and described the training as "very good."

Our discussions with staff showed they had knowledge and awareness about people's needs and how to support them. This included pressure ulcer prevention and the importance of using appropriate equipment, maintaining turning charts and involving the tissue viability nurse when necessary. One staff member explained that people living with dementia "need more time and more understanding."

The provider used an electronic training and development plan for the staff team to monitor training attendance and identify any gaps. The record showed all completed training as well as where staff were due to attend refresher courses. This helped ensure that staff kept their knowledge and skills up to date and at the required frequency. Records were kept of induction and the training courses and qualifications staff had attended and achieved. The PIR told us that there were plans to create and train a quality team of staff champions to support other staff in managing aspects of care such as continence, falls, nutrition and hydration, MCA and DoLS, dignity, dementia, skin integrity, medication and moving and handling.

Staff were provided with ongoing support and supervision to enable them to fulfil their roles effectively. Staff received a yearly appraisal to discuss their performance, identify training needs and areas for development. Registered nurses received clinical supervision and were supported to update their nursing skills, qualifications and competencies. Supervision records were detailed and included discussions about people using the service and feedback from staff. Staff training attendance and learning was monitored through supervision meetings and assessments were carried out with staff to check and confirm their practical competency and knowledge. This included observations of their moving and handling practice and

medicines administration. Other opportunities for support were given through meetings and informal discussions with colleagues. Handover meetings took place for staff between shifts to support continuity of care. There were also daily 'huddle' meetings between management and senior staff to discuss any relevant issues such as risks, changes to people's health and well-being as well as actions for the day.

Staff consistently told us they felt supported in their role and that help and advice was always available from their line manager or the deputy. One member of staff said, "We are very well supported" and another staff commented, "[My manager] is very hands on and I can approach her about anything."

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent and choices were taken into account and included in their care plans. Staff understood their responsibilities and people's right to refuse. Staff said they always explained what they were going to do before support was provided. People's feedback confirmed this. Our observations and discussions with staff showed they encouraged people to make choices when they could. For example, staff asked people's permission before providing support with personal care and assistance with meals. Staff knew their responsibilities and what to do if a person could not make decisions about their care and treatment. Staff said these would be done in people's best interests with people who knew them well and were authorised to do this. This included involving the person's family as well as other professionals such as an advocate or GP.

Where people lacked capacity to consent to care this was documented in their care plans. For example, one person received their medicines covertly and another person needed bed rails. Care records showed these decisions had been made in line with the principles of the MCA. We looked at a selection of DoLS applications and found that these were appropriate to keep people safe. Applications under DoLS had either been authorised or were awaiting assessment by the supervisory body. The manager kept a tracker to account for applications that had been made to deprive people of their liberty. The tracker enabled the service to monitor when authorisations expired and assess whether they should be reviewed.

We observed lunch time in the main dining room and the reminiscence community. The lunchtime experience was calm and unhurried. Staff supported people in a relaxed and dignified manner. They asked people if they needed any assistance and made sure that they were comfortable. Menus were planned in advance and displayed on tables. The options included two starters, two mains (with alternatives including a vegetarian option) and a choice of desserts and drinks. People had a choice of drink to accompany their meal, red or white wine, beer or a selection of fruit juices were offered. People were supported to make their own choices about what they wanted to eat and drink. Where people could not communicate verbally, staff helped individuals choose by showing them the two plated meal options. Where people required soft diets, items on the plate were pureed separately so the person could taste the different flavours. People had appropriate aids to promote their independence such as adapted cups, plate guards and grip handled cutlery.

A range of hot and cold drinks, fruit and snacks were available day or night from the twenty four hour bistro on the ground floor. People could help themselves and during the day, care staff were available to support those who needed assistance. Tea or coffee and biscuits were served to people throughout the day. There were 'hydration stations' throughout the home where people could help themselves to bottled drinks or juices, fruit and mini snack items. The weather was particularly warm on the day of our inspection and we observed that people were encouraged to drink regularly.

People told us they could choose to eat in the main dining room or their rooms if they preferred. Many people were complimentary about the food. Their comments included, "The food's excellent. Tasty and well cooked", "There is variety", "There is enough choice of food", "If I did not fancy the menu, they would do something else" and "I've seen enough to know that the meals are properly managed." A relative told us, "The meals are excellent, tasty and nutritional." A few people however told us the meals did not always meet their tastes or preferences and felt there was not enough variety. We discussed this with the manager who agreed to undertake a themed survey with people about their dining experience. Records showed that people were regularly asked about food quality and menus through resident meetings and speaking regularly with the chef. There was also a comments book for people to share their views.

People's nutritional needs were assessed, planned for and monitored. Staff used a recognised assessment tool to check whether people were at risk of malnutrition. Where people were found to be at risk, staff kept records of their food and fluid intake and weight, additional high calorie drinks and snacks were provided and referrals were made to other professionals such as the GP and dietician. Where concerns about a person's food intake or swallowing ability were identified, these were referred to a speech and language therapist (SALT). One person's care records recorded how appropriate actions were taken on the recommendation of the SALT such as preparing food in a way which was safe for the person to eat. Dining staff had undertaken dysphagia training which enabled them to support people's physical needs and manage any risks. (Dysphagia is the medical term for swallowing difficulties). Information about people's specific dietary needs, allergies, likes and dislikes was posted in the kitchen and accessible to the chef and catering staff.

People had access to the healthcare services they required and were supported to maintain good health by the nursing staff on site and other health and social care practitioners when needed. Comments from people included, "If I was unwell, they would get the doctor, no question", "If I'm not well, they would call the doctor" and "The medical services from outside are good." A relative told us, "The doctor checks on [my relative] every Monday and they [the home] have a good relationship with the surgery." People told us they also found the chiropody service beneficial.

Nursing staff told us that as people's health needs changed a referral would be made to the relevant professional for advice and guidance. This included GPs, occupational therapists, physiotherapists, tissue viability nurses and dentists. Records of all health care appointments were kept in people's files. These records detailed the reason for the visit or contact and details of any treatment required and advice provided by professionals. Monthly 'wellness' checks were carried out by staff to monitor people's general health and weight. Nurses and care staff had received training related to skin integrity and management of pressure ulcers.

There were accessible toilets and bathrooms situated throughout the building. Facilities were equipped with sufficient aids and adaptations to meet people's physical needs such as raised toilet seats, adjustable beds and hand rails for support. People had mobility aids and other specialist equipment to promote their independence and there was passenger lift access to all floors. People living with dementia were cared for in an environment adapted to their needs. The reminiscence neighbourhood was designed and arranged to

promote engagement and wellbeing using decoration, signage and other adaptations. Corridors were well lit to aid orientation and furnished with pictures from a bygone age and tactile wall coverings for people to touch. People had access to an outside terrace area which included seating and planted flower pots.

Good

Is the service caring?

Our findings

People consistently told us that staff were caring, kind and treated them with dignity and respect. Feedback comments included, "The staff are friendly and helpful", "Staff are nice and caring", "The staff are very good, nice people", "I have to say the staff here are wonderful" and "I can confidently say the care is good." One relative told us, "The staff are lovely" and "They always ring with any matter about [my relative's] health."

During this inspection, there was a friendly, welcoming atmosphere and we observed positive interactions between staff and people. In the reminiscence community, staff showed patience and compassion when supporting people living with dementia. Staff were caring and attentive to people's individual needs, using touch and facial expression to interact with those who found it difficult to communicate their needs verbally. During our observation at lunch staff frequently checked if people were enjoying their meal or needed a drink and engaged in conversation with them. Staff gave encouragement by saying, "You're doing well" and "How is the soup, would you like to try some more?" Staff supported people in a dignified manner and provided reassurance about what they were doing. They sat next to people and asked their permission to undertake tasks such as putting on an apron or wiping a person's face. People were gently reminded or assisted to continue eating in an unhurried manner. Staff described the food before supporting people to eat it. Throughout lunch people were chatting and smiling with each other and staff.

People told us that they had comfortable bedrooms and we saw they had been able to personalise them with items of personal value, such as photographs, memorabilia and other possessions that were important to them and represented their interests. In the reminiscence neighbourhood, memory boxes and signage helped people to orientate in their surroundings. Memory boxes contained photographs, personal belongings and other objects of reference to help individuals recognise their own private rooms. People also had rummage baskets which contained favourite sounds, smells and items that represented the person's life. The baskets provided comfort to people and helped them and their families interact through sharing memories and evoking nostalgia.

Conversations we overheard were friendly and relaxed and demonstrated that carers were on good terms with the people they were caring for. Staff we spoke with were knowledgeable about the care and support people required and their preferred routines. We observed that their approach was patient and personalised. Staff provided clear explanations to people before they intervened, for example when people were supported with their personal care or helped to mobilise. When staff used hoisting equipment to assist people to move or transfer, they checked at each stage of the process that people were comfortable and knew what to expect next. One person complained of feeling sick and staff provided reassurance whilst regularly checking if they felt any better.

Care plans explained what people could manage on their own and what level of physical support people needed. They included information about what equipment people needed to support their independence and guidance for staff about what support each person needed with their mobility. Plans were person centred with good detail about people's likes, dislikes, personal history and preferred routines and comforts. One example included, "Always has lights on, even in the day." There was a 'life story' which documented

people's upbringing, early life, education, career and work, social and recreational interests and important occasions in their life. There was a section about life skills which gave information about the person's interest for activities such as sewing/ folding clothes, gardening and carpentry/fixing things. Staff told us these details helped them understand a person's background and organise appropriate activities.

People were supported to maintain relationships with their families and friends. One person told us, "Visiting from family and friends is quite open" and another person said, "I do have visitors and they can come when they like." A relative told us they were made to feel very welcome and another relative reported that staff communicated with them on matters of their relation's health and care. There were a number of quiet areas and rooms where people and their visitors could meet in private. We also saw a number of complimentary letters from relatives thanking the management and staff for the care their family members received.

People looked well cared for and were supported to dress in their personal style. People told us that staff supported their privacy, dignity and independence. Comments included, "They are very good at dignity and respect", "The staff do treat me privately" and "Yes, they do give us all respect". Staff addressed people by their preferred names and demonstrated a courteous and respectful attitude. People received personal care in the privacy of their bedroom or bathroom with doors closed. Staff knocked on people's bedroom doors, announced themselves and waited before entering. Some people chose to have their door open or closed and their privacy was respected. We saw that people were provided with protective clothing when eating and drinking.

Staff were provided with training on confidentiality and information about people was shared on a need to know basis. We saw that people's files were kept secure in locked areas and computers were password protected. Handovers took place in private and staff spoke about people in a respectful manner.

People were fully involved in the advanced planning of their own care and these discussions and agreements were recorded. Staff had undertaken training which gave them the skills and knowledge to provide compassionate care for people nearing the end of their lives. This training was facilitated by the local hospice team, who also provided advice and support to the home about end of life care. Information about people's advanced decisions about their care was included within their care plans. This recorded if they wished to stay in the home or be transferred to hospital and meant that staff and their GPs were aware of how the person wanted to be supported at the end of their life. Pain and symptom control and any nursing or caring interventions were fully recorded so that all staff were kept up to date with any changing needs. Staff said they were confident when discussing advance care plans with people and involved their families and carers where possible. The PIR told us that two senior carers were due to enrol in the Namaste programme which is designed to improve the quality of life for people with advanced dementia.

The service had achieved Beacon Status for end of life care through the Gold Standard Framework (GSF). Beacon status is the highest award given by the GSF for end of life care practice in care homes. The GSF coordinator for the home told us that staff were very proud of this achievement.

Some people had DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) agreements in place. These are decisions made in relation to whether people who are very ill and unwell would want to be resuscitated or would benefit from being resuscitated, if they stopped breathing. The forms we checked had been completed correctly in consultation with the person, doctors, and family, where appropriate. This ensured that people's wishes would be carried out as requested.

Good

Is the service responsive?

Our findings

People told us they received a personalised service and felt that staff knew what care they needed. One person told us, "I do believe I get the care I need" and another said, "I do get the care I expect." People's views and preferences were taken into account. One person told us, "They do ask my permission before attending to me" and another said, "They always ask me if I want a shower or whatever." Staff were able to describe the best way to engage with different people. For example one individual often refused assistance with their personal care in the mornings. To alleviate any anxiety, the person's keyworker told us they always gave the person time and asked which carers they would like to be supported by. We saw that another person had a preference for particular members of staff and their choice was respected.

People's needs were assessed before moving in to the service, with relatives and health and social care professionals supporting the process wherever possible. Nursing staff told us that a pre-admission assessment was carried out by two members of staff, including a registered nurse or the deputy manager, to determine if the placement was appropriate. The assessment considered all aspects of the person's life, including their background, hobbies, social needs, preferences, past medical history, health and personal care needs and areas of independence. It included details of specific care areas such as nutrition, skin care and mobility. There was evidence of discussion with family about people's care, including their likes, dislikes and life history or background. The provider had effective tools in place to assess, monitor and review people's nursing care needs. This included nutritional screening documentation and assessments for skin integrity and moving and handling. Staff told us they were provided with information that prepared them to meet a person's needs at the point of admission. This included making sure specific equipment was in place and that the correct level and skill mix of staff were available.

The needs assessment was then used to complete an individualised service plan (ISP) which was personalised and focussed upon the support the person required. Care records reflected how specific health conditions might impact upon people's care and how living with dementia affected people's daily lives. There was information about what action staff should take to ensure care remained appropriate and met their needs. For example, how a person living with dementia communicated and how staff should respond when a person became upset or disorientated. Guidelines about diabetes or management of pressure sores were available to support staff to provide appropriate care.

People's care plans reflected their current needs as these were reviewed and updated appropriately. Nurses or team leaders, overseen by the care coordinator, reviewed people's care plans on a monthly basis, or as soon as needed. For example, following an illness, an incident or accident, a medicines review or a period of hospitalisation. A named nurse and key worker system meant that each person had a dedicated registered nurse and carer to support this process. People's files were completed in a consistent format and were up to date. Records about people's care were held electronically and in paper format. A copy of the electronic care plan was then printed for the person's file so that staff had up-to-date information on the care and support individuals required. At the time of our inspection nurses told us they had identified that some people's plans had not always been reviewed each month and were checking all care plans for accuracy. We noted an action to support this in the provider's quality assurance improvement plan.

People's diverse needs were understood and supported. Care plans included details about people's needs in relation to age, disability, gender, race, religion and belief and sexual orientation. Staff had completed equality and diversity training and were aware of people's cultural, religious and personal needs. Representatives from local churches visited the home on a regular basis and held services for people. There were activities and events which celebrated different cultures and people's cultural food preferences were accounted for.

Staff also completed daily records which reflected people's day to day experiences and gave a good overview of their health and wellbeing and any other significant issues. Where needed, monitoring sheets for weights, food intake and positional changes were maintained for people. Staff shared information at each shift change to keep up to date with any changes concerning people's care and support. Our observation of a handover supported this.

People had opportunity to take part in activities based on their interests. Activities were available for people every day and planned in advance by the activities co-ordinator and people using the service. Activities included arts and crafts, bingo, gentle exercises, hand massages, quizzes, bridge club, baking, flower arranging, knitting and tea dances. Additional entertainment was sourced externally and there were frequent visits from singers, local school choirs and musicians. A mini bus was available to take people out on a one to one basis or in groups. Pub lunches and trips to parks, garden centres and places of interest were organised. We observed some people taking part in an 'Oomph' session with staff. The 'Oomph!' programme is designed by a national social enterprise to enhance the mental, physical and emotional wellbeing of older adults. It includes a range of activities and exercises for people using music, dance, props and storytelling.

Many people were complimentary about the activities. One person said, "There is always something going on, a good variety and I have choice about what I do." Another person said, "There's enough entertainment for me, they do a good job." Some people told us they preferred to stay in their rooms and not join in with activities. They told us, "They do try to promote the activities" and "I choose not to take part in the activities….The staff do ask me if I want to go to them." Our discussion with the activities coordinator and staff showed their understanding of the importance of activities to promote people's well-being and avoid social isolation. This included offering one-to-one pastimes with people that were reluctant to engage in group activities. We observed that staff also spent time with people who preferred to be on their own.

In the reminiscence neighbourhood, people were provided with suitable activities to meet their needs. There were 'life skills' stations with objects and accessories that provided people with links to past memories and activities. One room had been designed as a 'reflection room' and included books and items from a bygone age. We observed staff sitting with people engaging in conversation and supporting individuals to join in activities such as singing and art and craft.

Written information about the programme of activities was advertised around the home. In the reminiscence neighbourhood we discussed the use of additional photos or pictures to help people recognise and choose from the day to day activities.

There were opportunities for people to share their views and experiences of the service. Residents meetings and family support meetings were held on a regular basis. These gave people and their relatives an opportunity to express their views, make suggestions and ask questions about care provision. All meetings were recorded and any action agreed to be taken was monitored until completion. Records showed that people were encouraged to give their feedback and opinions about aspects of the home, such as quality of care, catering, activities and the premises.

The provider also circulated a monthly newsletter to keep people informed about activities and developments in the service. This included photographs of events, activities and celebrations and information about staff achievements. To help people reminisce, there were details about historical facts and dates each month. The provider also held regional 'resident council' meetings every quarter and a representative from the home attended.

Each person received a copy of the complaints policy when they moved into the home. People and their relatives told us they knew how to complain and would do so if necessary. One relative told us, "If I'm really annoyed, I go to the manager, I feel happy about that." Another relative reported a communication problem by the management was resolved.

Records showed complaints were managed in line with procedure and a clear audit trail was available. We saw that complaints were investigated thoroughly and where appropriate, lessons had been learnt. For example, additional monitoring of people's specific care needs had been implemented when concerns were raised in regard to their care and welfare. When complaints were raised, people were provided a written response to the concerns. This included offering people an appropriate apology when they had experienced poor care. At the time of our inspection one complaint was being investigated.

Complaints were also logged and monitored at provider level to check for themes or trends. These were analysed and reviewed for learning opportunities and service improvement. The PIR told us that call bell responses and communication were common themes for complaints. The home had acted on this and improved the systems for communication with relatives and monitoring call bell responses floor by floor. The PIR included, "We are also looking at the way we manage our daily work to ensure we have staff available for peak times, which was a particular problem for response."

Good

Is the service well-led?

Our findings

As part of the provider's conditions of registration, the service was required to have a registered manager. There had been a change in leadership since the last inspection. The previous registered manager left in April 2016 and the new manager had recently started at the service. As part of their induction, they were supported by another registered manager from the organisation. The manager confirmed they were in the process of submitting their application to register with CQC.

People were aware of the change in leadership at the home and were complimentary about the new manager. Their comments included, "I've met the manager and she seems very attentive from what I can see", "The manager is very affable" and "The manager is a nice person. She is very approachable." One person told us, "When we were managerless, it was a nightmare. Now it's fine." One staff member told us, "We weren't kept in the lurch, the new manager came and introduced herself." Another staff member told us the manager had organised a complimentary breakfast to thank staff for their good work.

We asked people what they thought the service did well. One person told us, "The ambience and the environment here is the best thing" and another person said, "I think the attitude of staff is the best thing here." Other people spoke about the good care, feeling safe and being able to choose what to do.

Staff had clear lines of accountability for their role and responsibilities and the service had an effective management structure in place. One member of staff said, "Communications are good and there is an open culture within the home." Another staff member told us, "There is good team working and supportive managers." One person told us, "The home seems to be well managed, quick and good laundry, rooms attended to and maintenance." We observed effective team work and communication between members of staff during our inspection. The manager and senior staff often spent time with people in communal areas and were available to offer advice and support where necessary.

There were consistent staff meetings where staff shared learning and good practice so they understood what was expected of them at all levels. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health and social care professionals, and any changes or developments within the service. We joined the daily huddle meeting and observed that there was effective information sharing between all departments. We also observed a handover between outgoing and incoming nursing and care staff. Information was passed on about how people were feeling and behaving, any concerns about people and incidents that may have occurred in the preceding shift.

Staff were enthusiastic about their work and said they wanted to provide a high quality service for people who were living at the home. "I have been working here for some time and I thoroughly enjoy it." Staff told us they felt involved in developing the service and could share their views. One member of staff told us, "[My manager] takes everything on board." Staff were aware of the values of the service and applied them in their practice. Values were displayed in the home and included encouraging independence, enabling choice, preserving dignity, celebrating individuality, nurturing the spirit and involving family & friends.

The provider had a reward scheme recognising employees for achievements in the workplace. People, staff and others were also able to nominate staff for 'heart and soul awards' when it was felt they had made a significant difference in their work. These awards were presented at a monthly team forum. Staff told us there was also 'employee of the month' and a yearly national award ceremony.

Quality assurance systems, developed by the provider, were in place to formally assess and monitor the quality and safety of the service. Audits were undertaken by staff and management within the service and also by clinical and governance staff from head office. These focussed on areas such as medicines, infection prevention and control, cleaning, the environment and health and safety. The deputy manager completed a monthly Quality Indicators (QI) audit. This audit covered areas such as nutrition, pressure damage, infections, reasons for hospital transfers, accidents and incidents, safeguarding events, DoLS, medicines management, information about complaints and meetings.

All accidents and incidents were recorded, analysed and reported to the provider every month. This enabled the service to identify any patterns or trends in accidents such as falls. It also gave an indication of where people's general health and mobility was improving or deteriorating. Where appropriate people's care plans and /or risk assessments were updated. The provider used learning from events and incidents involving people to make changes and improvements to the service.

A 'team action plan' had been created for the manager and staff to apply in the service. This identified where improvements were needed, the actions to be undertaken and timescales for completion. We saw the current plan was detailed, progress was kept under review and actions were monitored until completion. We found that learning occurred as a result of audits and feedback. For example, people's experiences had improved in the reminiscence neighbourhood by the increased activities and ensuring staff were available at each table during meal times. In another example, the service had recognised the requirement for a designated member of staff to be available in the bistro area. Our observations and records confirmed this had been actioned.

People and relatives were provided with satisfaction questionnaires every year. Results from the last survey in 2015 were positive and there was information about the action taken in response to the few comments raised. This had included improving communication between relatives and staff. We noted there had been a low response rate to the survey although the service organised regular meetings to capture people's feedback and experiences.

The provider had oversight of how the service was performing and was aware of its strengths and weaknesses. Action plans were in place and steps were taken to implement change. The new manager understood their role and responsibilities in providing a good quality service and to sustain continuous improvement. They showed us they were open and accountable and wanted to develop the service. This included the organisation's expectation of working towards exceptional and excellent care for senior people. The PIR also gave us information about how the service performed and what improvements were planned.

The provider worked in partnership with other professionals to ensure people received appropriate support to meet their needs. Care records showed how the service engaged with other healthcare agencies and specialists to respond to people's care needs and to maintain people's safety and welfare.

Registered persons are required by law to notify CQC of certain changes, events or incidents at the service. Our records showed that since our last inspection the registered provider had notified us appropriately of any reportable events.