Bupa Care Homes (CFHCare) Limited

Priory Mews Nursing Home

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

The inspection took place on 01 and 02 September 2016 and was unannounced. Priory Mews Nursing home is a large nursing home providing nursing and personal care for up to 156 older people, some of whom have palliative and dementia care needs.

The accommodation comprises of five separate houses adjacent to each other. Beaumont and Berkeley provide residential and nursing care; Marchall and Mountenay provide care for people with nursing dementia needs and Cressenor House cares for people with residential dementia requirements. A separate house accommodates the main reception, the kitchen, the senior management team, and the administration team. There were 136 people living in Priory Mews at the time of our visit, 95 of whom lived with dementia.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

At our last inspection in July 2014, we found a breach of Regulation 21 Health and Social care Act 2008 (Regulated Activities) Regulations 2010. Accurate and appropriate care records were not consistently maintained. At this inspection we found that improvements had been carried out and that the Regulation was being met.
We had also identified that improvements were needed to ensure that the Mental Capacity Act 2005 requirements were implemented correctly to make sure that people's rights were protected. At this inspection we found that improvements had been carried out.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered.

Staff sought and obtained people's consent before they helped them. They knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

At our last inspection in July 2014, we found a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Adequate training had not been provided to ensure that the prevention and treatment of pressure and leg ulcers was effective. At this inspection we found that improvements had been carried out and that Regulation was being met. Staff received essential training, additional training relevant to people's individual needs, and regular one to one supervision sessions.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People's feedback was positive about the food. Staff knew about and provided for people's dietary preferences and restrictions.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

A range of suitable activities and entertainment was provided. People were involved in the planning of activities that responded to their individual needs.

Staff told us they felt valued and supported by the registered manager, the management team and the provider. The registered manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service and promoted links with the community.

There was a robust system of monitoring checks and audits to identify any improvements that needed to be made. The management team acted on the results of these checks to improve the quality of the service and care.

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. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to make decisions and were asked to consent to their care and treatment. The principles of the Mental capacity Act 2005 were followed to protect people's rights. Appropriate applications in regard to the Deprivation of Liberty Safeguards were made to keep people safe.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people. The staff pre-empted ways to ensure people's wellbeing and comfort.

People's independence was promoted and staff encouraged them to do as much for themselves as they were able to. They respected people's privacy and dignity.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments. There was a suitable amount of daily activities that were inclusive, flexible and suitable for people who lived with dementia.

People and their relatives' views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted an open and positive culture which focussed on people.

The provider and the management team sought feedback from people, their representatives and staff about the overall quality of the service. They welcomed suggestions for improvement and acted on these.

Emphasis was placed by the management team on continuous improvement of the service. A robust system of monitoring checks and audits identified any improvements that needed to be made and action was taken as a result.

Priory Mews Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out 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.

This inspection was carried out by a team of seven on 01 and 02 September 2016. On the first day the inspection team included three inspectors, a specialist nurse and two experts by experience; on the second day, there were three inspectors, an inspection manager and one 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 care service.

The manager had completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report. Before our inspection we looked at records that were sent to us by the manager and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report.

We looked at 13 sets of records which included those related to people's care and medicines. In 11 of these records, we looked at people's assessments of needs and care plans and observed to check care and treatment were appropriately and consistently delivered. We reviewed documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 19 people who lived in the service and 11 of their relatives to gather their feedback. Although several people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the regional director, the clinical lead, three units managers, two deputy unit managers, nine

nurses, nine care workers, three activities coordinators, the chef, the housekeeping manager and one member of the housekeeping staff. We also spoke with a GP who visited the home regularly to provide medical care, a local authority safeguarding assessor and two local authority case managers who oversaw people's care in the service. We obtained feedback about their experience of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "I do feel safe", "I get my meds on time", "When I call for help they come pretty quickly" and, "I've absolutely no complaints, I'm very happy and safe here." Relatives told us, "As much as they can keep my father safe, he is safe here; he does have falls but they help him as much as possible and deal with any falls very quickly", "There seem to be enough staff even at weekends" and, "There is always someone around."

There was a sufficient number of staff to meet people's needs in a safe way. Staffing rotas indicated sufficient numbers of care and nursing staff were deployed during the day, at night time and at weekends. Levels of support required were calculated as part of the pre-admission process and were reviewed once the person had moved into the service. Additional staff had been deployed when necessary, such as when people needed particular one to one support and at the end of a person's life. The provider employed a number of bank staff who were available for covering short and long term sickness and annual leave. A unit manager told us, "We can get extra care workers in for the mornings if we are particularly busy." People's requests for help were responded to without delay and the registered manager maintained an overview of the call bell system by checking response times.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. All care and nursing staff had received training in the safeguarding of vulnerable adults. There was a detailed safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. Staff were aware of the whistleblowing procedure in the service and staff we spoke with expressed confidence that any concerns would be addressed.

The premises were safe for people because all equipment in use and fittings were regularly checked and serviced. Safety checks were planned, carried out throughout the service and monitored effectively. The fixed electrical circuit was tested every five years. Equipment that was used by staff to help people move around, specialised beds, adapted baths, oxygen, suction machines and nebulizers were checked and serviced regularly. Repairs were carried out within one or two days of having been reported. Environmental risk assessments were in place for all of the units. The assessments included actions that were being taken to protect people from harm and any actions that had been identified as steps that would need to be taken. As a result of an assessment, large glazed areas such as patio doors were conspicuously marked to make them visible. Quarterly health and safety audits were also used to identify possible hazards. For example, floor cleaning methods were checked to ensure that they were suitable and did not create slip hazards for people.

Systems were in place to ensure the service was secure and visitors were identified by reception staff before they accessed the units. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they wished to access other units.

Staff had received appropriate training in fire safety and were familiar with the steps to be taken in case of a fire. There was appropriate signage about fire exits and fire protection equipment throughout the service. Regular checks on fire equipment were carried out and fire drills were completed in accordance with the service's policy. There were detailed plans in place concerning how the service would manage an emergency, such as the loss of utilities, adverse events and evacuation. People had individual personal emergency evacuation plans in place which detailed the level of assistance they would require if it was necessary to evacuate the service. These plans were updated regularly and were included in 'grab bags' on each unit for quick access if needed.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. There was a system in place for reporting accidents and incidents and the management team had an overview of the system. This meant that changes were made when it was identified that preventative measures could be introduced to reduce any risk for people. For example, it was noted by managers that a particular person was having falls consistently at the same time in the day. The managers looked at the factors that could be causing this to take place and made changes to this person's morning routine to ensure that they had eaten and had stable blood sugar levels before they got up in the morning. This had reduced the person's falls.

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. There were specific risk assessments in place for people who may experience choking, skin damage and who were at risk of falls. Each risk assessment included clear measures for staff about how to keep people as safe as possible, taking into account people's individual circumstances and preferences. Staff applied these measures in practice, for example following specific instruction for repositioning a person in bed, and checking bed rails and mattresses on a daily basis. Staff helped people move around safely and checked that people had the equipment and aids they needed within easy reach. When people were taken out by their family, a risk assessment had been completed and families were shown how to administer medicines if required during the outing.

All aspects of people's medicines were managed safely. People had their medicines at the time they were to be taken. Systems for ordering, stock controlling, storing and returning medicines were orderly and easy to follow. Medicine cupboards were connected to an alarm system and the temperatures of the refrigerators where medicines were kept was monitored daily. The nurses who administered people's medicines completed the medicines administration records (MARs) appropriately. Medicines to be taken 'as required' such as pain relievers were administered appropriately in line with individual protocols that detailed signs of pain to observe and respond to when people may not be able to communicate their discomfort. Topical creams were appropriately applied according to individual body maps. Staff were trained and competent in administering medicines safely to people. Competencies had been checked in the administration of medicines for all administering staff. This included the use of syringe drivers (portable pump which allows medicines to be administered by slow release over a period of 24 hours). Palliative care medicines were in place in readiness for when people reached the end of their life, with input and guidance from the local hospice palliative team.

The units were clean and tidy. All units were pleasant smelling although we noted an unpleasant odour in one of the units on the first day and discussed this with the registered manager. This odour was no longer present during the second day of our inspection. A housekeeping manager showed us the systems, procedures and routines for cleaning across the five units. In addition to dedicated cleaning staff, each unit identified 'corridor staff' who were responsible for patrolling and checking cleanliness. Cleaning schedules included daily cleaning; deep cleaning of every room every six weeks; and responsive cleaning when a

person left the service or when a problem had been identified. Carpets were steam-cleaned and a unit's flooring was due to be replaced as its surface was worn and did not facilitate effective cleaning. Laundry was segregated appropriately and soiled items were cleaned at the required temperature. A monthly and quarterly audit process for the laundry covered a comprehensive range of checks and actions. Relatives confirmed to us that laundry was processed on the same day.

There was an infection control policy in place that provided clear guidance for staff concerning the steps they should take to protect people from the risk of infection. The staff were knowledgeable of the policy, had been appropriately trained in infection control, wore appropriate personal protection equipment and followed good hand hygiene practice. Four members of staff described to us the correct steps they would take, should there be an illness that needed contamination control.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate and current professional registration. Disciplinary procedures were followed and action was taken appropriately by the registered manager when any staff behaved outside their code of conduct. Therefore people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "They [staff] know what needs to be done", "The staff do the best they can for me", "The staff are good at their jobs" and, "The staff here are competent." Relatives told us, "The staff are very good at their jobs; and, "Communication with the staff is very good."

Staff received essential training to enable them to carry out their roles effectively. New staff received a five days induction that incorporated initial training on food hygiene, manual handling, safeguarding, introduction to dementia care and the principles of the Mental Capacity Act 2005. Essential training was further provided beyond the induction that included dementia and cognitive issues, mental capacity, safeguarding, infection control and manual handling. On average, 90% of staff were up to date with their training. There was an effective system to record and monitor staff training and highlight when refresher courses were due. Staff were reminded to attend scheduled refresher courses.

Additional training that was relevant to people who lived in the service was offered and delivered to staff, such as enhanced dementia training 'Person first dementia second', behaviours that may challenge others, end of life care and pressure ulcers care. The staff we spoke with were positive about the range of training courses that were available to them. A member of staff said, "There is a lot of training available; the training on dementia is particularly interesting and it helped me understand why residents may find it easier to remember what happened years ago rather than the present." Some of the nursing staff had requested training on Tracheotomy (an incision in the windpipe made to relieve an obstruction to breathing) and this had been provided in Guy's Hospital.

Staff received one to one supervision sessions every two months and were scheduled for annual appraisal of their performance. Staff were well supported in the carrying of their roles and told us they felt valued by the management team and the provider.

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 are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in July 2014, we had identified that although staff undertook Mental Capacity Act (MCA) 2005 and Deprivations of Liberty Safeguards (DoLS) training, improvements were needed to ensure that MCA requirements were implemented correctly to make sure that people's rights were protected. At this inspection 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. We found that improvements had been carried out.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual. The CQC had been appropriately notified when DoLS applications had been authorised.

Staff were trained in the principles of the MCA and the DoLS and were able to tell us of the main principles of the MCA. They had been provided with a card that reminded them of these principles so they could refer to the guidance when needed. Assessments of people's mental capacity were carried out when necessary. When people did not have the mental capacity to make certain decisions, meetings were held with appropriate parties to decide the best way forward in their best interest. An assessment of a person's mental capacity had been carried out for a person who chose to have bed rails in place, for a person who wanted to walk independently when this presented a risk, and for people whose consent was needed to remain in the service.

The regional director had identified shortfalls in the provider's documentation used to record mental capacity assessments and had introduced an interim form that better evidenced the steps that were taken during the assessment process. Since our inspection, the provider ran a pilot in several sister homes to introduce a new template that fully met the legal requirements and that was easier for staff to use.

Staff sought consent from people before they helped them move around, before they helped them with personal care and with eating their meals. A person told us, "They do ask me if it's Ok for them to do this or that and they do listen to me." The registered manager had addressed staff about the importance of obtaining and recording people's consent about all aspects of their care and this was carried out in practice. People signed consent forms about their care when they had been assessed as having the relevant mental capacity. People's legal representatives had been invited to attend reviews of people's care plans with their consent, and requested to sign on people's behalf when appropriate.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. Each person living in the service had been allocated a named care worker and a named nurse so they could quickly identify them and communicate with them should they have any problems. One person told us, "I helped set up my care plan, we have a review once a year, and I also know my care worker." A relative told us, "I am well aware of the care plan." A 'resident of the day' scheme was in place that meant that staff focused on and celebrated that person during a particular day of the month, and checked all aspects of their care and relevant documentation.

There was an effective system of communication between staff to ensure continuity of care. Staff handed over information about people's care to the staff on the next shift twice a day in each unit, in the way of clinical handovers. Care workers attended the handovers alongside nurses. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. The handovers we looked at provided clear information about a person who was appearing unwell, and of the actions that had been taken as a result. Follow up action was taken from one staff shift to another. There was an effective system of recording admissions, discharges, deaths, and staffing issues in each unit, where unit managers reported daily to the registered manager. Staff used a diary to record people's appointments and recorded outcomes of visits from health care professionals in dedicated visit sheets.

People told us they were satisfied with the standards of meals. They told us, "The food's OK" and, "Meals are OK." Two relatives who came regularly to support their loved one at mealtimes told us, "The food is

excellent; they do alternatives and they are very helpful." We observed lunch being served in two units. People chose whether to eat in the dining area, in the lounge or in their bedrooms. The lunch was freshly cooked, hot, well balanced and in sufficient amounts. People were offered choices of main courses and two desserts, and were shown the plated food to help them make their choice. People told us that staff were providing them with alternatives when they wanted something else. One person told us, "I don't like fish so they are doing something else for me." One person was not hungry at mealtime and their food was kept hot for them to have later if they wished.

People were supported by staff with eating and drinking when they needed encouragement and care workers respected people's pace. Aids were used when people needed them, such as plate guards and beakers to help people drink and prevent spillage. Current records of people's dietary needs, preferences and allergies were displayed in the kitchen and known by the chef and kitchen staff. As a result, people received meals that had been specially prepared for them, such as vegetarian, soft or pureed diet, or diabetic.

People were weighed monthly or weekly when there were concerns about their health or appetite. Weighing records were audited every month and people's food and fluid intake was appropriately recorded and monitored. When fluctuations of weight were noted, people were referred to the GP, a dietician or a speech and language therapist (SALT) and their recommendations were followed in practice, such as providing them with thickened fluids or helping them sit in a particular position when eating.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with one of two local GP surgeries. A chiropodist visited every six weeks or sooner to provide treatment for people who wished it. An optician service specialised with treating people living with dementia visited every six months or sooner when needed. People were escorted to visit a dentist when necessary. People were offered routine yearly vaccination against influenza or shingles when they had consented to this. When people had become unwell, they had been promptly referred to healthcare professionals, such as GPs, consultants, tissue viability nurses and a mental health team.

At our last inspection in July 2014, we found a breach of Regulation 21 Health and Social care Act 2008 (Regulated Activities) Regulations 2010 in regard to care records not being consistently maintained. At this inspection we found that improvements had been carried out to meet this Regulation. A system was in place to ensure an effective management of wounds, supported by appropriate documentation. Staff we spoke with had been trained in pressure wounds care and were knowledgeable about the steps they had to take to promote the healing of wounds and monitor their progress.

There was some pictorial signage in the home to help people gain information. However the menus and the activities programme were not provided in a format that helped people living with dementia understand. An improvement plan that included re-decoration of the premises, further personalisation of bedroom doors, a pictorial menu and a visual panel to describe activities on offer for people who lived with dementia was in place, and scheduled to take place shortly.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "They [staff] are fantastic, caring and kind", "The staff do treat us with respect", "The staff here are very good and kind." Relatives told us, "The staff are wonderful, angels", "The staff are great; we have a god laugh and a joke with them", "The staff are kind, attentive and firm but in a gentle, compassionate way" and, "All the staff are definitely kind, they have endless patience." A GP who visited the home regularly to provide medical care over the last 11 years told us, "The care is really very good; there are always some issues but hand on heart I'm very happy with the home." A local authority case manager who oversaw several people's care in the service told us, "Definitely a good home, very caring and attentive staff."

Visitors were welcome at any time without restrictions and were warmly greeted by reception staff. A flat was available to accommodate up to two family members who may have to stay overnight when they visited. We spent time in the communal areas and observed how people and staff interacted. There was frequent friendly and appropriately humorous interaction between staff and people whom staff addressed respectfully by their preferred names. Staff were vigilant, checking on people's wellbeing while respecting their space and privacy. People went from one unit to another, mostly escorted by staff, to either visit others or take part in activities. We overheard staff interacting with people in their bedrooms and found that all staff were attentive, kind, respectful and patient.

The staff approach was pro-active as they pre-empted ways to ensure people's wellbeing. A unit manager responded to a person who displayed signs of anxiety and asked them, "Would you like to come into the garden for some fresh air?" They gently guided the person and helped them walk around the garden, taking off a garment as they were feeling hot, before wrapping it gently around their shoulders to preserve their dignity. Another unit manager was helping staff while they encouraged a person to eat. A member of staff conversed with a person and reminded them of the day and the date so they could be oriented.

Staff knew how to communicate with each person. They spoke clearly and smiled to engage people. They showed interest in people's response and interacted positively with them. A member of staff was singing softly with a person to distract them when they became agitated, maintaining good eye contact and smiling at them. When people had hearing impairment, their communication care plans indicated how best to talk with them and be understood. People' care plans highlighted individual methods of communication and included specific instructions to staff, such as using simple words for one person, repetitions for another person, and the importance to enunciate clearly face to face and lower their position for people with hearing impairment. We observed staff following these instructions in practice. Staff ensured people's hearing aids were functioning and replaced batteries when necessary.

People were assisted discreetly with their personal care and bathing needs in a way that respected their dignity. A person told us, "They wrap me in a blanket before using the hoist." Bathrooms had privacy curtains so to prevent any intrusion that may disturb their sense of dignity while bathing. Staff told us people could have 'as many baths or showers as they liked' and people we spoke with confirmed this. People were encouraged to personalise their bedrooms as they wished and bring their own articles of

furniture to make them feel at home from the beginning of their stay. One person had requested their bedroom to be redecorated in pink and this had been implemented.

Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People were given the choice of having their doors open or closed; people's records were kept securely in an office equipped with a code system to maintain confidentiality. When appropriate, independent mental health advocates (IMCAs) had been enlisted to help represent people's views at best interest meetings when families were not available.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, remain in their bedrooms, or stay in bed. At mealtimes and during activities, people chose where they liked to sit. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence. One person used a mobility scooter to go out and occasionally went to their own home for the day; one person used a taxi independently to visit their relative several times a week; another person was escorted by staff to local shops; and another who enjoyed doing housework was helping staff with wiping tables.

Clear information about the service and its facilities was provided to people and their relatives. A folder containing information on the service and its facilities included a welcoming letter from the registered manager. There was a ''Welcome to Priory Mews' brochure written in large format to assist people with sight impairment. It described the history of the site, introduced key members of staff, the service's philosophy of care, the activities, and how to complain. There was a website about the service and sister services that was informative, well maintained and user-friendly.

Clear information of people's key workers, of who was the 'resident of the day' and of the team on duty was displayed on each floor. A new member of staff told us how they had been formally introduced to a person's family so they could develop a good rapport centred on the person's care needs and wellbeing. The service produced a seasonal and pictorial newsletter that informed people and their relatives about forthcoming events, the refurbishment programme, and invitations for them to provide feedback or any ideas they may like to see included in the next edition.

People could be confident that best practice would be maintained for their end of life care. People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When appropriate, people were invited to take part in 'advance care plans' (ACP) and were supported by staff during the process. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. Staff were aware of people having stated their wishes regarding resuscitation. The service was well supported by a local hospice palliative care specialists who offered guidance when needed.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their needs. They told us, "The staff take me to the lounge; I go to all the entertainment", "I have never needed to complain", "We have residents' meetings so we can have our say." Relatives told us, "We feel very welcome here; there are relatives meetings; we feel involved, definitely." A GP who visited the service regularly to provide medical care told us, "The care is good, personalised, which makes ours and the residents' lives easier. I find that people are admitted when they are poorly and they recover well."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments gave a clear account of people's needs and associated risks in relation to their medicines, communication, nutrition, continence, skin integrity and mobility. They were person centred and noted people's family history, their interests and special requirements about end of life care when people wished to talk about this. People were invited to stay for short periods before they made an informed decision about coming to live into the service.

An initial care plan was completed within 72 hours when people moved into the service. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. Equipment to reduce possible risks was put in place before or soon after a person came to live in the service, for example special mattresses or sensor mats to alert staff when people got out of bed and may need help.

People's care plans reflected their current needs as these were reviewed and updated appropriately on a monthly basis, or as soon as needed, for example following an illness, any incidents, a medicines review or a period of hospitalisation. Staff sat with people to involve them during the reviews of their care, when they were able and willing to contribute. Relatives' comments and contribution were clearly stated in their relatives' care plans. Two relatives told us that staff communicated with them on matters relevant to their relative's health and care. They told us, "We are invited at annual reviews but can also be involved in between at each monthly review if we wish" and, "We get informed and get involved when there are any changes or decisions to be made."

The delivery of care matched the instructions for staff to follow that were in people's care plans and risk assessments. When people had wounds such as pressure sores, they had healed satisfactorily as correct procedures were followed. This included the completion of body maps and repositioning charts, close monitoring of their healing progress with measurements and photographs, the use of appropriate equipment and dressings. Care plans were also in place for the prevention of pressure wounds. Staff consulted tissue viability nurses for guidance and followed their instructions.

People's likes, dislikes and preferences were taken into account. Staff enquired with people and their relatives about their preferences about all aspects of their routine, activities and food. Individual interests, hobbies and lifestyle were recorded in a dedicated form titled 'My Day, My Life, My Story', such as, 'Prefers to sit in an upright position with a pillow under left arm and a blanket', 'Likes crosswords, puzzles and Bingo',

'Likes sweetened in her tea', 'Dislikes noise but enjoys country music and Nat King Cole'. This helped staff appraise each person's individuality, taste and preferences. When people had requested to be cared for by only female or male staff, to go to bed late or to have certain food, this was implemented. We asked members of staff to tell us about several people's preferences and they were aware of these.

A sufficient amount of activities that were suitable for older people and people living with dementia was available. There was one activities coordinator in each unit and activities were provided twice daily. At weekends, care workers provided the activities. One to one activities were provided for people who remained in their bedrooms and may not be able to join group activities.

The activities coordinators researched people's interests to inform the planning of activities. For example, individualised interventions included getting prints out and posters from a bakery that one person used to work in, to decorate their bedroom; a one to one activity for a person who was particularly fond of cats included discussing articles in cats magazines. Cards games and 3D games were simplified to enable all people to participate, so people could benefit from activities that were inclusive. Two pet rabbits had been purchased at the request of residents who enjoyed petting them. People were encouraged to meet others whom they may share interests with, such as knitting, 'gossiping' or reading. These people were invited to sit together and this had led to friendships being formed.

Activities included Bingo, pampering, board and card games, 50's and 60's reminiscence games, art and crafts, singing along, flower arranging, light exercise and a 'pub quiz' held in a small sitting room that had been converted to resemble a pub. There was a juke box, fruit machines, a traditional-looking bar with beer pumps, mirror and glasses optics. While the pumps and optics did not dispense alcohol, people could have a beer or glass of wine from a fridge behind the bar as well as crisps and snacks. People appeared to enjoy this activity as they said, "Oh I love this" and, while showing their glass of wine, "That's alright that." During the activity, people told the staff, "Thank you very much for doing this for us and helping us here" and, "You are very good people." The provider commissioned external performers to enhance the activities programme and keep people entertained. This included singers, dancers, musicians and a 'Pat the dog' service. People appeared to enjoy petting dogs during our visit and a member of staff was taking photographs to create good memories for people. Events such as people's birthdays, the Queen's birthday, St George's day and the Olympic Games were celebrated.

People, relatives, staff and visitors were given several opportunities to provide their feedback about the service, the staff, the environment, the food, activities and about the running of the service. People's feedback was sought at residents meetings, relatives meetings, by annual satisfaction questionnaires, and collected weekly from a suggestion box. The annual satisfaction survey for people, carried out in December 2015, had highlighted that 89 % of people who took part were 'happy and content' living in the service. As a result of the feedback, a re-decoration programme had been initiated; all flooring and fitted carpets had been replaced; and staffing levels had been further assessed and increased in two units. Relatives had suggested a coffee shop to be installed with bistro tables and chairs; staff had suggested a beach theme for a garden area and these suggestions had been included in a refurbishment plan.

Complaints were investigated and responded to in line with the provider's policies and procedures. People and relatives we spoke with were aware of how to make a complaint. Detailed information on how to complain was provided for people in the 'Residents guide' and displayed in the entrance. One relative said, "We don't need to lodge official complaints, if we have any problems we talk to the staff and it is dealt with right away; we can always see the manager if it is not done but it hasn't happened." One relative had requested a food and fluid chart to be completed for their personal information and this had been implemented. A person told us, "If I am not happy I talk with my favourite care worker and she puts it right."

Good

Is the service well-led?

Our findings

People were complimentary about the way the home was run. They told us, "It is well organised", "I know the manager, she is very good" and "The manager is fine; she makes sure everything is done properly" and, "The management listens and acts on what we say." Relatives told us, "I have had dealings with the unit manager; it seems to be well run", "I do feel they listen to the residents and to the comments made by relatives."

The current registered manager had been in post for five and a half years and was supported by a regional director who visited the service regularly. Management responsibilities were clearly defined and relatives were complimentary about the structure of the management team, telling us, "There is one main manager in each of the units who manages all the staff in that unit and this is the person we talk with if we have any problems; otherwise, the registered manager in the office."

The registered manager operated an open door policy and anyone who lived or worked in the service were able to visit her in her office and discuss any problems they may have. The registered manager was very visible in the service and visited each of the units several times a day, taking time to talk with residents and observe staff practice. She knew most of the people's names and interacted with them with appropriate humour and respect. During our visit, two people who lived in the service came to her office 'for a chat and candy'. One said, "I am a regular visitor to the office, they are lovely people."

Staff were positive about the support they received from the registered manager. They reported that they could approach the registered manager and the management team with concerns and that they were confident that they would be supported. They described them as, "really lovely", "personable", "understanding" and, "very approachable and efficient."

The registered manager encouraged the staff to be involved with the running of the service. They held daily meetings every morning with the units' managers and the heads of departments including kitchen, maintenance, housekeeping and activities. We attended such a meeting and noted how tasks were clearly delegated to ensure staff delivered care and met people's individual needs for the day ahead. All aspects of care in regard to the 'resident of the day' were discussed, as well as any people whose health and safety may be compromised, such as by illness or a fall. One person had been hospitalised and the registered manager had discussed with staff how to support that person at the hospital. Quarterly staff meetings were held to discuss new staff, safeguarding, health and safety issues and the results of a wide range of quality assurance audits. All meetings were recorded and any action that was agreed to be taken was monitored until completion.

The registered manager participated in monthly meetings with the regional director and other sister homes' managers to discuss policies, procedures and practice. They told us, "This is where we exchange ideas and experiences, and share our plans for improvement." There was a robust system in place to monitor the quality of the service and drive improvements. In each of the five units, staff updated a 'Home manager Quality Metrics' report on a daily basis and forwarded it each month to the registered manager, the deputy

manager, and the Clinical Services Manager. This included updates on wound care, medicines, GP reviews, safeguarding, infections, accidents and incidents, and people's feedback. The data was inputted in a computerised system and a report for the service was generated, checked and scrutinised by the management team and by the Head Office to identify trends and patterns. This system complemented regular audits that were carried out by the management team and designated staff, which included accidents and incidents, weighing charts, medicines, infection control, complaints and satisfaction surveys. When an audit had identified a shortfall, the registered manager checked that an action plan was set up, monitored the plan until completion and signed it off when satisfactorily completed.

The regional director carried out monthly inspections of the service and compiled a 'monthly home review' that checked all aspects of the service including the quality assurance systems. The checks either 'passed' or 'failed' different domains and the number of 'passes' determined the urgency of remedial action needed. As a result of internal audits and of the monthly home review, the registered manager wrote a 'home improvement plan' that detailed the actions required, the timescales for completion, and an update on their progress. Their report was based on the CQC methodology looking at evidence of the service being safe, effective, caring, responsive and well-led. A recent monthly home review had indicated the registered manager needed to devise a system to evidence overall management of the supervision and appraisal tracker system; that the training matrix needed to be updated; and that in one unit repositioning charts had not been signed by the person in charge. These actions had been implemented.

The provider had established an annual system to regularly gather the views of people, their relatives and staff through satisfaction survey questionnaires, analyse the results and act on implementing any improvements that may be identified. Feedback from people and relatives was also collected at each residents and relatives' meetings and acted on. When relatives had queried why the service had erected an outside fence that restricted the view, they were provided with an explanation and invited to discuss this further if they wished. When staff had suggested an improvement of the gardens, this had been included in the registered manager's home improvement plan and scheduled to take place. When two relatives had complained to a unit manager about cleanliness, this had been reported immediately to the registered manager and action had been taken without delay.

The registered manager ensured the home maintained links with the local community. The service had opened its doors to the public during the National Care Homes Open Day and held a summer fete where there were singers, a band, tombola, a buffet and a show. They had advertised this event in the community with posters and a banner to invite members of the public and explain what the service could offer. Sixth formers from a local school spent work experience days in the service. The service was actively recruiting volunteers and had established a positive rapport with an external Community Liaison Officer.

The provider's philosophy of care statement was divided into four key areas: 'being passionate about delivering personalised care in a safe environment; giving the personal touch that recognises people's unique needs; providing a place to call home; and providing helpful advice that is easy to access'. Our observations confirmed that the management team and staff shared this vision. The registered manager told us, "We want to give the very best of care to our residents in the best possible environment; it is their home at the end of the day, we are here to make sure they enjoy the best possible quality of life."

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept

securely and confidentially. They were archived and disposed as per legal requirements.