Bupa Care Homes (CFHCare) Limited

Manor Court Care Home

Inspection report

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27 June 2018

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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

We undertook an unannounced comprehensive inspection of Manor Court Care Home on 26 and 27 June 2018. As part of our inspection we checked that improvements to meet legal requirements planned by the provider after our focused inspection on 4 and 5 December 2017 had been made, which we found they had.

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

Manor Court Care Centre accommodates 111 people across four separate units, each of which had separate adapted facilities. Three units were open at the time of the inspection. One of the units catered for people living with the experience of dementia, the second unit was for younger adults with a physical disability and the third unit accommodated older people and those who required end of life care. At the time of inspection one unit was closed and there were 73 people accommodated over the other three units.

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

Since our last inspection there had been significant improvements made with the auditing and monitoring of the quality of the service. Quality assurance systems were robust and being used effectively so shortfalls were being identified and addressed in a timely way. Record keeping had improved and we also found that people were receiving the care and support they wanted. Work was ongoing to identify further improvements.

People said they felt safe living at the service. Staff understood the procedures to follow to protect people from the risk of abuse and to report any concerns. Risks for individuals and for the service were assessed and action taken to minimise them. Systems and equipment were checked, maintained and serviced at the required intervals to keep them in good working order.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed. There were enough staff available to meet people's needs and staffing levels were kept under review in line with changes in people's needs.

Medicines were being managed safely at the service. Infection control procedures were in place and being followed. The registered manager used reflective practice to consider all aspects of the service including events so where shortfalls were identified lessons could be learnt.

People were assessed prior to coming to the service to identify their needs and wishes, which were recorded and were being met. Staff undertook induction training programmes and received ongoing training to provide them with the skills and knowledge to provide good care and support.

People's dietary needs and preferences, including those to meet people's religious and cultural needs, were being identified and met and a range of meals were provided. People were referred to healthcare professionals when needed and received the healthcare input they required.

The environment provided a homely place to live and each unit was appropriately decorated and furnished to meet the needs of the people who lived there.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). People were encouraged to have choice and control of their lives and staff supported them in the least restrictive way possible.

People and relatives were happy with the care and support people received. Staff treated people in a caring and gentle manner, with dignity and respect. Staff understood and respected people's individual wishes and did what they could to enable people to live the lives they wanted to.

Care records were clear, person centred and reviewed regularly to keep the information up to date. Activities were varied and took place each day and people enjoyed taking part. People and relatives felt able to express any concerns so they could be addressed. Where people were happy to discuss their end of life care wishes, these were recorded so they were known and could be met.

People and relatives knew who the registered manager was and said she was visible, approachable and responsive. They were well supported by the deputy manager and encouraged good teamwork throughout the staff team.

The registered manager and the deputy manager kept up to date with current legislation and good practice, and had implemented auditing and monitoring processes effectively to ensure all aspects of the service were kept under review.

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 living at the service. Staff understood the procedures to follow to protect people from the risk of abuse and to report any concerns.

Risks for individuals and for the service were assessed and action taken to minimise them. Systems and equipment were checked, maintained and serviced at the required intervals to keep them in good working order.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed. There were enough staff available to meet people's needs and staffing levels were kept under review in line with changes in people's dependencies.

Medicines were being managed safely at the service. Infection control procedures were in place and being followed. The registered manager used reflective practice to consider all aspects of the service including events so where shortfalls were identified lessons could be learnt.

Is the service effective?

Good

The service was effective.

People were assessed prior to coming to the service to identify their needs and wishes, which were recorded and were being met. Staff undertook induction training programmes and received ongoing training to provide them with the skills and knowledge to provide good care and support.

People's dietary needs and preferences, including those to meet people's religious and cultural needs, were being identified and met and a range of meals were provided. People were referred to healthcare professionals when needed and received the healthcare input they required.

The environment provided a homely place to live and each unit was appropriately decorated and furnished to meet the needs of

the people who lived there.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). People were encouraged to have choice and control of their lives and staff supported them in the least restrictive way possible.

Is the service caring?

Good

The service was caring.

People and relatives were happy with the care and support people received. Staff treated people in a caring and gentle manner, with dignity and respect.

Staff understood and respected people's individual wishes and did what they could to enable people to live the lives they wanted to.

Is the service responsive?

Good

The service was responsive.

Care records were clear, person centred and reviewed regularly to keep the information up to date. Activities were varied and took place each day and people enjoyed taking part.

People and relatives felt able to express any concerns so they could be addressed.

Where people were happy to discuss their end of life care wishes, these were recorded so they were known and could be met.

Is the service well-led?

Good

The service was well led.

People and relatives knew who the registered manager was and said she was visible, approachable and responsive. They were well supported by the deputy manager and encouraged good teamwork throughout the staff team.

The registered manager and the deputy manager kept up to date with current legislation and good practice, and had implemented auditing and monitoring processes effectively to ensure all aspects of the service were kept under review.

Manor Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 26 and 27 June 2018 and was unannounced. This inspection was carried out to check all the five questions we ask the service and to check that improvements to meet legal requirements planned by the provider after our December 2017 inspection had been made.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. Before the inspection, we also reviewed the information we held about the service including the action plan the provider had sent us in response to our last inspection, notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection was carried out by four inspectors including a pharmacist inspector plus 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 care service.

During the inspection we viewed four staff recruitment files, care records and risk assessments for six people, personal care records and/or mental capacity information for 19 people and the medicine administration records and associated care plans for 15 people. We looked at risk assessments for systems and equipment used to support the delivery of care and staff working practices, maintenance and servicing records, complaints, safeguarding and accident and incident records, meeting minutes, staff rotas and training records, auditing and monitoring records and a sample of the provider's policies and procedures.

During the inspection we spoke with 14 people using the service, five relatives, the registered manager, the deputy manager, the regional director, the regional support manager, four registered nurses including the unit leaders, the administrator, the maintenance man, two activities organisers, two senior care workers,

three care workers, two catering staff and a housekeeper. We carried out the Short Observational Framework for Inspection (SOFI) on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed an activities session with a visiting entertainer and carried out observations of other activities and generally throughout the inspection. Following the inspection, we requested feedback from four visiting healthcare professionals and received one response.

Good

Is the service safe?

Our findings

People and relatives said they felt people were safe at the service. Comments from people included, "I feel safe. I don't worry about anything really because they look after me and everything really", "I am very safe here and all my things are too. We all are" and "They do a great job here. Everyone is safe." Staff told us people were cared for safely in the service. Their comments included, "Yes, people are safe here. We are well trained and we know what to do" and "[Relatives] trust us to keep their loved ones safe. They shouldn't have to worry when they leave people here."

Staff were able to tell us about the provider's policy and procedures for safeguarding people from abuse and what actions they would take if they had any concerns. Their comments included, "Abuse should never happen. If I thought someone living here was being abused I would report to the manager straight away. If they did nothing I would tell CQC or the local authority," "I have done my safeguarding training. I would tell the nurse in charge or the manager if I thought anyone was harming one of the [people using the service]" and "Abuse of any kind is not permitted. We are told to report any concerns to the manager and we have a whistle blowing number if we think nothing has been done." We saw that any safeguarding concerns that were raised were reported to the local authority and to CQC and they were investigated and appropriate action taken to address them.

We saw that risk assessments were carried out for individuals to include risks associated with falls, skin integrity, mobility and nutrition and where risks were identified associated care plans had been developed to address the risks. These documents were updated monthly and whenever a person's needs changed. Risk assessments for equipment and safe working practices were also in place and we saw these in the kitchen, laundry and maintenance areas of the service. These had been reviewed in the last 12 months and were clear and up to date. The fire risk assessment had last been completed in April 2018 and staff received training in fire safety and took part in fire drills to keep their knowledge of fire safety up to date. Water safety was also being maintained and the risk assessment for legionella had been recently completed. This recorded that action had been taken to address the findings of the previous years' report, to maintain water safety.

Pre-employment checks were carried out to make sure only staff who were suitable to work with people using the service were employed. Work histories were obtained, including explanations for any gaps in employment. Records for each member of staff contained two references including those from the last employer, a Disclosure and Barring Service (DBS) enhanced disclosure, a completed health questionnaire and proof of identity information including photographic identification, passports and evidence of people's right to work in the UK. Nurses are required to be registered with the Nursing and Midwifery Council (NMC) and the provider had carried out checks on the NMC website to confirm the nurses' registrations were up to date, so they could work as registered nurses. Where agency staff worked at the service profiles had been obtained from the agencies and the information included a photograph, confirmation that the required pre-employment checks had been carried out, details of qualifications and training and a short pen portrait of the person.

During the inspection we saw there were enough nurses and care staff to provide people with the care and support they needed. We saw people did not have to wait for support and where they needed care and support from two members of staff, this was provided promptly. The majority of staff felt the staffing levels were suitable to meet people's needs, however, care staff on one unit told us that at times during the day and night, they were not always able to respond as quickly as they felt they should. We discussed this with the registered manager, the clinical lead for the service and the provider's regional manager and regional director. They told us there had recently been a review of staffing levels on the unit and as a result they were increasing the night staffing by one care worker to ensure people's needs were met. Following the inspection, they informed us the day staffing levels on the unit had also been increased by one care worker on both the morning and the afternoon shifts. The management said they kept the staffing levels throughout the service under review as part of the auditing and monitoring process, to ensure there were enough staff on duty to give people the care and support they required.

The provider employed one full-time and two part-time maintenance staff to complete repairs and carry out checks in the service. Nurses and care staff on each unit recorded jobs for the maintenance team and they told us repairs were usually completed quickly. The provider carried out checks and audits to make sure the service was safe. We saw the maintenance team carried out tests on hot water temperatures, electrical safety, fire safety equipment, emergency escape routes, window opening restrictors, laundry equipment and food trollies. The maintenance team also kept records of regular servicing of equipment used in the service. All the checks, audits and service records we saw were well maintained and up to date. We saw that when staff used equipment to assist people with moving, for example transporting people in wheelchairs or transferring them using hoist equipment, this was used safely and correctly.

We looked at policies, storage, records, training and systems for medicines management at the service and found the provider was managing medicines safely. People and relatives confirmed they knew what medicines people took. One person said, "I know what it is for and I always have it with my food or just after." A relative told us, "I know everything [person] is on. They discussed everything with us and they quickly got all his medication sorted out and the right dosages when he first came. They were very good."

We looked at medicine administration records (MAR) and care plans for 15 people. The provider had recorded important information such as the name, photograph and medicine sensitivities to help staff give people their medicines safely. We found that not all care plans for people had an up to date medicines list, however there was always an up to date list of medicines in the MARs. Some people were prescribed medicines on a when required basis. There was guidance in place to advise staff when and how to give these medicines and these were kept with the MARs. Some people were prescribed creams and ointments to be applied to their body. These were securely stored in people's own rooms and recorded when applied by staff on separate charts.

We saw nursing staff proactively checking medicines that had been delivered from the supplying pharmacy, over a period of three days. This was to ensure that the medicines received were in line with the medicines on the MARs. The nursing staff on Larch unit had identified a number of dispensing errors from the supplying pharmacy, including missing medicines for people, incorrect dosage of medicines and missing MARs. This information was shared with the supplying pharmacy.

Some people were given their medicines disguised in food or drink (covert administration). This was carried out in their best interests following an assessment under the Mental Capacity Act 2005 (MCA) and a documented best interests review, which included an advocate for the person. We saw staff members were caring and they tried to gain permission from the person to give the medicines, when this would fail the staff member would follow the agreed covert protocol. They signed for each medicine after giving it on the MAR.

Medicines including controlled drugs were appropriately stored in accordance with legal requirements. Controlled drugs had daily and weekly audits of quantities by two members of nursing staff. We found staff checked and recorded room and refrigerator temperatures daily and these were within the required range. Staff recorded and disposed of unwanted medicines using medicine waste bins.

We saw evidence that people's medicines had been periodically reviewed by their GP. This meant people were being prescribed medicines appropriate for their health condition. We saw people with mental health conditions had their medicines reviewed more frequently with the GP. People who were on medicines for diabetes had their blood sugar levels monitored at regular intervals. This assured us that people were getting the correct doses of medicines for their condition.

We found the home had the necessary systems in place to manage medicines safely. The home had a medicine policy about these systems. Staff received annual medicines training and the provider assessed the competency of staff to ensure they handled medicines safely. There was a process in place to report and investigate medicine errors. Medicines systems were regularly audited for service improvement.

Infection control procedures were in place and being followed. The service was clean and smelled fresh and domestic staff were available on each unit to carry out cleaning throughout the day. The staff wore gloves and aprons when cleaning, when serving food and when assisting people. These were disposed of after each use. People using the service were offered hand wipes to clean their hands before their midday meal. The staff assisted people with this when they were unable to do this themselves.

When untoward events occurred, there were processes in place for identifying, investigating and reflecting on them so that lessons could be learned and improvements made. We asked people what happened if they raised any issues. One told us, "They listen to me whatever it is and make time to sit with you to talk. They give me feedback on any queries and if they can't help they find a way to. The [registered manager] is always available and so are the rest of the management." We viewed the incidents file and saw examples of where an event had been reviewed and lessons learned. For example, where there had been a medicine error this had been investigated, a root cause analysis had been carried out and action to minimise the risk of recurrence taken by providing the staff with supervision and additional training, plus the opportunity to reflect on the event and to say what they would do differently in future.

Another example was the timeliness of answering call bells. This was being monitored and any calls over five minutes were recorded and then discussed with staff during the managers' daily 'take ten' walk around meetings on the units. We saw there had been a significant reduction in the number of bells ringing for over five minutes, from instances earlier in 2018 of several in a day to three single instances in the first two weeks of June. This was also backed up by comments from people we spoke with including, "They are very quick if you push the bell. I never wait too long" and "I push the bell and they appear quickly." Weekly clinical risk meetings took place and the registered manager said that any events that had occurred were discussed at these meetings and reflected on so the information was shared and an action plan put in place to address the issue.

Good

Is the service effective?

Our findings

The provider had completed assessments of people's needs before they moved to the service. They had met with the person and their representatives to ask them about their needs and preferences. They had also consulted with relevant healthcare professionals. The assessments included information about the person's expectations and understanding of the care they would receive, as well as details about their health, cultural and social needs, how to keep them safe, how they communicated, their skin integrity and their nutritional needs. These assessments had been used to help plan their care, and records of these were stored along with other care notes.

We asked people and relatives if they felt staff were well trained. Their comments included, "They do make me feel safe and they are confident, there is no dithering about", "They seem to know what they are talking about with me and know all about what help I need which I'm pleased about", "Most of the time. I get a bit confused with things and they always reassure me and give me the correct information" and "I'm very happy with the level of expertise. They are very knowledgeable when you ask them things."

Staff working in the service told us they had access to the training they needed to care for and support people. They told us, "The training is good, I have done all my mandatory training and they tell me when I need to do refresher training," "I have done a lot of training, if there is anything I think I need I would speak with my manager," "We all know when we have to do our training and managers make sure we complete it" and "The training has been helpful, I had done a lot of it in other jobs but it is good to keep up to date." We viewed the staff training file and saw that several different training sessions had taken place recently including fire safety, care plan writing, skin care, moving and handling and training from Dementia Friends. The training record reflected the training that had taken place in topics including nutrition and hydration, medicines awareness and management, food safety and dementia care and behaviours that challenge. After training sessions staff completed feedback forms, so the effectiveness of the training could be assessed and any suggestions taken on board for future trainings.

The staff had good systems for communicating effectively with each other. These included daily verbal handovers of information about the people they were caring for. In addition, the information was recorded in an easy guide so that the staff were aware of any changes in people's needs since they last worked with them. There was a communication book on each unit and the nurses in charge of the unit allocated duties to the other staff and oversaw whether these were being carried out. We also observed that staff communicated well together and with people, listening to each other and to people and there was a good atmosphere throughout the service.

People's hydration needs were being met. Throughout the inspection, people had access to a range of hot and cold drinks. Jugs of squash and water were available in communal rooms and occupied bedrooms. The staff regularly refreshed these. People were offered drinks throughout the day and the staff reminded people to have their drinks. Where people were assessed at risk relating to hydration, there were clear assessments and plans in place relating to this. The staff recorded people's fluid intake. We looked at a sample of records of fluid intake for June 2018. These showed that people had received suitable amounts of fluid.

People's nutritional needs were being met. The staff completed assessments of nutritional risks and these were regularly reviewed and updated. The assessments were designed to show when people were at high risk. We saw that each person had a care plan relating to their nutritional needs. These care plans included information about specialist diets, the texture of food which was safe for them to eat, whether additional fortification was required, cultural needs and preferences. Where people were considered at risk, and when changes in their diet took place, the staff had made referrals to relevant healthcare professionals so that they could receive support and guidance from them. The information and any specific plans from healthcare professionals had been incorporated into care plans. The information about individual needs was shared with the kitchen staff, who had a good overview and written information about these. There was clear guidance for the staff on how to support people with different specialist diets and those with a Percutaneous Endoscopic Gastrostomy (PEG) feeding system.

People were regularly weighed. Changes in weight were recorded and the information shared with the registered manager and provider so they could see if there were any significant changes which needed acting on. There was a choice of dishes for each meal. These included a vegetarian option and an Asian meal. Menus were displayed on the dining tables and included a picture of the main dish. People were given a choice of meals when they were served and if they wanted an alternative then this was ordered from the kitchen and provided promptly. There were snacks and fruit available between meals and during the night and we saw people being offered these.

People's healthcare needs were being assessed, monitored and met. Comments from people regarding the healthcare input they received included, "I tell [staff] and they organise the nurse to come and see me and they listen and call the GP or whoever I need to see. You see them regularly and immediately, sometimes that day", "I have seen everyone while I've been here, doctor, dentist, optician, foot lady, hairdresser regularly. You only need to ask and they arrange it and tell you straight away when they will come. I am happy with this" and "The staff arrange it. They help me to stay organised and remind me of the right days for my appointments and take me to them. I am waiting for transport now and they are keeping me updated because transport turn up when they feel like it."

Care plans included information about individual healthcare conditions and the support people needed with these. There was additional guidance in people's care files relating to specific conditions so that the staff had an understanding about these. The provider employed nursing staff who cared for people throughout the day and night. There was evidence they made regular checks on people's health and wellbeing and that they recorded these. Where people's condition changed or they became ill, the staff had taken appropriate action which included asking other healthcare professionals to see the person and, when needed, sending the person to hospital.
People could see their GP and other healthcare professionals whenever they needed. Care plans included details of healthcare professional consultations. There was also guidance from professionals incorporated into the planned care. The GPs visited the service regularly and the staff had good systems for communication with them which enabled them to share information about changes in people's healthcare needs.

The building was suitably designed to meet people's needs. The provider had made improvements to the environment and further improvements had been planned. For example, new flooring had been installed in all units and some of the bathrooms had been refurbished. We noted that some furniture in communal areas was damaged or broken, however, the registered manager told us that new furniture was on order and was due to arrive at the service the following month. Larch, a unit dedicated for people living with the experience of dementia, had features designed to orientate people and provide stimulation. There were also similar features in other units. These were enjoyed by people who lived there. The registered manager said

work was ongoing to further improve areas of the service, to help support people identify where they were and to be able to interact with the environment.

A number of people used wheelchairs to move around the home. The corridors were wide and furniture had been arranged so that people had easy access to the areas they needed. Bedrooms, communal rooms and corridors were light and well ventilated. The inspection took place over two hot summer days, but the staff had managed to keep the environment relatively cool with fans and open doors and windows. People could spend time in shaded areas of the garden and under gazebos.

People had personalised their bedrooms with their own belongings and furnishings. Everyone had access to the equipment they needed, such as specialist beds, hoists, their own individual slings, bedrails or sensor mats to reduce the risk of falling. There were proper assessments in place when equipment was being used and people, or their representatives, had been involved in the planning for this. Equipment had been regularly checked and serviced. For example, the staff undertook daily checks of air pressure mattresses and bed rails to make sure these were safe to use.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Care plans contained information about how people made decisions, their choices, communication and whether they had the mental capacity to consent to different decisions. There was an assessment which outlined how best to communicate with the person. For example, one assessment stated that an interpreter was needed to help the person make important decisions. Another assessment referred to the use of visual clues. Where people had the mental capacity to understand about their care and treatment they had been asked to sign or give their verbal consent to specific areas of their care and treatment. Where people lacked the mental capacity to do this, the provider had consulted with their representatives so that decisions could be made in their best interests and this was recorded. The assessments regarding people's mental capacity had been regularly reviewed.

Throughout the inspection we saw that care staff explained the care and support they gave to people and ensured they understood and consented to the care they received. When care staff supported people to move around the service, they made sure they explained to the person what was going to happen and ensured they used to necessary equipment to make sure people were safe and comfortable. We observed the staff administering medicines to some people. They sat next to the person, asked if they were ready to take their medicines, explained what they were for and gained their consent before dispensing the medicines from the container. This allowed people to understand what was happening and make informed choices. The staff also offered people a choice of drinks (where appropriate) to accompany their medicines.

Good

Is the service caring?

Our findings

People felt they were being well cared for. Comments included, "They [staff] are lovely and kind and look after me so well. They are just a bit busy sometimes and you get the ones that don't speak much English at night but they do care", "They are a good lot who know what they are doing" and "They really are reassuring and good at what they do. They have sat with me when I've been worried and helped me to do personal things and not made me feel like a baby."

During the inspection there was a calm and friendly atmosphere in all parts of the service. Staff, people, relatives and management all engaged easily with each other in a way that was cheery, respectful and polite. A relative told us they were always made welcome by staff and could visit at any time. They added, "We have been so lucky to find this place. The improvement in my [family member] is remarkable."

People using the service could see their visitors in one of the shared living areas or in their own room. On the day of our visit several relatives came into the service to visit people. Staff greeted them with a smile and showed genuine interest in their lives as well as updating them on the person living at the service. For people whose first language was not English, we heard staff communicating with them in their own language. Where someone was unable to communicate verbally we saw staff using a board so the person could indicate what they wanted and staff recognised and then met the need.

Staff we spoke with were passionate about their work and motivated to provide as good a service as possible for people. Their comments included, "It's important for me that people are treated the way I would want one of my family treated" and "We have a saying, people don't live where we work, we work in their home and I always try to remember that." Staff also spoke to us about their personal experiences of caring for others and how this had helped them to support people. They gave examples about how they shared their learning from working with health care professionals and thinking of new ways for supporting people at the service.

People using the service who were living with the experience of dementia had a positive experience at lunchtime. On Larch unit tables were laid with table cloths, condiments and flowers and there was a copy of the day's menu on each table. Where people needed help to read the menu, care staff did this patiently and ensured people understood the available options. Some people chose to eat their meal in the garden and care staff also respected the choice of those who decided to remain in the dining room. There were enough staff to serve people's meals and where people needed support to eat their meal, staff provided this in a patient and caring way. They offered people a choice of main course and dessert and made sure that everyone had enough to drink from a selection of cold drinks. Care staff gave people time to make choices and explained options to them to make sure they had the information they needed to choose.

We also observed mealtimes on other units and overall found that staff were caring, offered people choices and helped with meals at a pace that suited the individual. For example, one member of staff who went to support a person with lunch asked if they could do so, asked if they could reposition the chairs to make it easier to do so and was calm, unhurried and assisted the person at a pace to suit them. We saw that, where

possible, people had the support they needed to eat independently, although some people would have benefitted from adapted crockery or cutlery to enable them to continue to eat their meals independently. We discussed this with the registered manager, the clinical lead for the service and the provider's regional managers. They told us they would arrange to provide plate guards and adapted cutlery where people needed these.

Overall the care we saw provided was appropriate to people's needs and enhanced their well-being. Staff were patient and discreet when providing care for people. They took the time to speak with people as they supported them and we saw many positive interactions that supported people's wellbeing. We did note some issues where staff demonstrated a task orientated approach, for example, placing napkins under people's chins without consultation. We discussed this with the registered manager who said work was ongoing on personalising people's care and that she would monitor this as part of her work.

Staff told us they had worked with people and their relatives to develop their 'life stories' to understand about people's past lives and interests. This helped staff gain an understanding of the person's background and what was important to them so staff could talk to people about things that interested them. All the staff we spoke with demonstrated a good knowledge of people's life histories and could tell us about their backgrounds and significant places, events and people in their lives. We saw one member of staff on Willow unit conversing with people. They made each person feel special and included in the activity that was taking place, including those whose ability to participate was limited. They talked about things that interested people and showed an interest in each person. They were calm and inclusive and the way they spoke with people was like old friends having a chat rather than a staff member to someone they were caring for. A member on staff on Larch unit demonstrated a good knowledge of the people they were caring for and responded to each person in a calm and gentle manner, helping them to find their way when lost in thought or in the environment.

People confirmed they were treated with respect. Comments included, "They always knock on my door and ask if they can come in. I can lock my door and do at night which is fine. They are very respectful", "I feel they treat me with respect and it's all very dignified. They help me to cover up if I'm getting out of the bath and they turn their back. I asked them not to wake me at night for changes and they respect my wishes" and "I have complete privacy. They offer to help me with tidying my room but if I say no they don't touch anything. They sometimes say I can't leave things all over the floor because it's a trip hazard and that's fine. They joke with me about it and make me smile."

Relatives were also happy with the respect staff showed, telling us, "They respect [person] and listen to him and that makes him happy, he likes a joke and the banter", "They know he likes space and independence and he does what he wants really" and "It's all been very dignified for him and they have respected his wishes and beliefs continually. We can visit when we want, day or night and given all the information we need but they always check it's okay to talk about things to us with him first." We saw care staff respected people's privacy and dignity and promoted their independence whenever possible. They closed bedroom, toilet and bathroom doors when they supported people with their personal care and knocked on doors before entering people's rooms.

Good

Is the service responsive?

Our findings

At the last inspection we found that people were not always receiving the personal care they wanted. At this inspection we found that this had improved. We saw that most people had received support to wash and dress each day. However, records indicated that some people did not always receive baths and showers regularly and there was evidence that some people had been offered and had refused these. We noted that some people had consistently refused to have support to take a shower or bath and have their teeth cleaned. Staff told us that if people refused personal care then they would try again after an interval to see if they could encourage them to accept the care they needed.

People and relatives confirmed that people received assistance with personal care. Comments included, "I have a shower about twice a week and have asked for more and if there is enough staff you can and they help me" and "I can have one when I like and bath or shower but shower is better. I have been offered regular help with this daily but I don't need it. They know I like a shower." Comments from relatives included, "[Person] is always clean and his hair brushed. His nails always look nice and clean, they didn't before he came in here" and "He has regular washes and showers. he always looks clean." Throughout our inspection, we saw that people were clean and well presented in clean clothes.

We discussed the issue regarding refusals of personal care. The registered manager and deputy manager were aware of the situation and were doing some research on this, putting information together to provide staff with additional ideas of ways of approaching people who were resistant to care. They were also requesting training sessions for staff to help them improve their knowledge and skills in this area. The regional director told us they had developed a training course in dementia care around linking care to encompass the life history of individuals, to better understand ways to succeed with providing care. They said they would be rolling this training out for staff.

The staff had created detailed care plans for each person. These plans included information about their individual needs in respect of their mental and physical health, communication, mental capacity to consent, social and leisure needs, dietary needs and information about how they were supported to move. The care plans were divided into clear individual sections and additional care plans had been created for each specific need, for example, a health care condition, such as diabetes, and catheter care. Each area of need was accompanied by information about what the person could do for themselves and how they should be supported. There was a focus on supporting them to be independent and to develop their skills where they could. Care plans were personalised with details about individual preferences and things which were important to the person. The care plans had been regularly reviewed and updated where changes had taken place.

In addition to the care plans, the staff had summaries of essential information available in each unit. These outlined people's medical history, dietary and hydration needs, assisted moving and equipment needs, any allergies and whether 'not for resuscitation' agreements were in place. This information was updated each week and was available for visiting healthcare professionals as well as staff. This was a quick guide and a useful aide memoire for staff when supporting people. The staff also kept a daily handover sheet where they

recorded any changes in people's needs, such as new illnesses, wounds, injuries, medicines changes or weight loss.

Where people had developed wounds, there were detailed care plans to show how the wound had been assessed and treated. There was evidence that the staff had consulted with tissue viability nurses and that the treatment provided had helped to heal the wounds. The staff kept records of the care they had provided, both during the day and the night. These records showed that people had been supported with personal care and had their hydration and nutritional needs met. The records also showed how often people, who were at risk of developing pressure ulcers, had been supported to change position and alleviate the pressure on part of their skin.

People and relatives were happy with the activities provision at the service. Comments included, "I do chair exercise which I like and I like to watch movies. They do both those here. They do trips too here but I like to go out with my family. They are going to the garden centre next week. Sometimes they will come and sit in my room with me and we do a puzzle together, have a cuppa.", "There is a lot to do. I like the entertainers and flower arranging. I like art time too. I love to draw and paint and do regularly. Visitors can come anytime and I go on the trips to the garden centre or cafes sometimes" and "You can go out with [staff] or with visitors. I like listening to music and watching sport and I have sky in my room that my children pay for. They have a movie today and came to remind me. There is always a board with what's on and what food is that day." Relatives told us, "They come to [person's] room with music and they read the papers to her. I can visit anytime" and "They are kept entertained. [Person] likes to sit and watch the world go by and he likes the garden and they spend a lot of time out there in the summer. I sometimes find them reading to him or they put music on and hold his hand."

The provider employed four activity coordinators to organise and provide a range of social activities throughout the week and at weekends. During the week each unit had an assigned activities coordinator. They met with people using the service and their families to talk to them about their interests and hobbies. Care plans included information about people's social needs and interests. For example, there were details about the films, music and activities they enjoyed. Information about people's past experiences and life before they came to the service were included. In most cases, people's families had helped to develop these, so that information about things which were important to the person had been captured. Information about people's religion was recorded and festival days of different religions were celebrated at the service.

The activities coordinators told us that they planned several different group events each week based on the needs and wishes of people living in each unit. We saw that these were advertised on notice boards. During our inspection, we saw some of these activities taking place. For example, on the first day of the inspection we saw that some people were involved in a game of bingo followed by a discussion activity designed to help them remember and talk about past events, such as their favourite holidays. People enjoyed this and the activity was suitably paced to reflect their understanding. The activity coordinator encouraged people to join in and have fun. In another part of the service, people were sitting together in the garden supported by staff to have a discussion. The activity coordinators told us that they also visited people who remained in their rooms and those who did not want to participate in group activities and we saw evidence of this in people's care records.

People had had opportunities for individual discussions, massages and watching films or listening to music from their country of origin. The records completed by the staff to show how people had participated in leisure activities also recorded their enjoyment and participation so the staff could judge whether the activity was a success or not. There were a number of different resources available for people. These included dolls, games, books, newspapers and craft materials. One person told us they had opportunities to

visit the local library, and others spoke about visits to local shops. One person was able to watch the world cup football on the television, something they particularly wanted to do. The service was decorated with world cup themed bunting. The care staff sat and talked with people when they were not participating in a specific event or activity.

We observed a music session the activity coordinators had arranged. Activities and care staff supported 30 people in one of the unit dining rooms where a visiting entertainer sang songs from the 1960's and 1970's. Many of the people who attended the session knew the songs and joined in, singing along, clapping and dancing, encouraged by the entertainer and staff from the service. The session lasted for an hour and we saw all the people who attended were engaged and enjoyed the music and dancing. During the session, staff served hot or cold drinks and snacks for those who wanted them.

The service had a complaints procedure and we saw that any complaints were recorded, investigated and responded to in a timely way. People and relatives felt confident to raise any issues they might have and their comments included, "I feel any member of staff would take a complaint very seriously and act on it and get back to you quickly. I've never had to complain", "They listen to me whatever it is and make time to sit with you to talk. They give me feedback on any queries and if they can't help they find a way to. The manager is always available and so are the rest of the management", "The staff are very good at dealing with things quickly" and "You can chat with [registered manager] any time, day or night and they always have time to chat on the phone too. I've never needed to complain but I would if I had to. They do ask for any feedback. She is amazing and the directors are always on hand."

Some people were being cared for at the end of their lives. The staff worked closely with the external palliative healthcare teams to make sure people had the right care. Care plans included information about how to provide comfort and pain relief when needed. Relatives of some of the people who had been cared for at the service before they passed away had written cards of thanks which we saw displayed at the service. One person had written, ''Your [staff] devoted professionalism enabled [person] to pass with compassion and dignity.'' Another person had commented, ''I could not have wished for anything better.'' A healthcare professional told us that staff were caring and compassionate, had good communication skills and were proactive with the planning for people's end of life care.

Some people's care plans included a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order that were at the front of the care plan files. All the forms we viewed had been made in agreement with the person, or with the involvement of their representatives when they lacked the mental capacity to make this decision. There were clear reasons why the decision had been made and agreed by the person's GP. Care plans contained a section where people's future wishes were recorded, for example for people who were not receiving palliative care but to record how they would wish to be cared for when the time came. This part of the care plan had not always been completed, however there was often a note stating the family or person had said they did not wish to discuss this yet. The deputy manager said some people and relatives were very reluctant to discuss this area, however they said they would do more work on this to try and get people to give some information, for example, if they had any religious or cultural needs they wished to be respected in the event of their death. One relative told us, "I keep on top of them so yes I know everything and it's recorded and I check it when I come. I know all about his wishes especially his end of life and what he would like."

Good

Is the service well-led?

Our findings

People and relatives were positive about the way the service was being managed. One person said, "I feel I can talk to anyone of the management and they will get things sorted ASAP. This has changed recently and they are on the ball." Another told us, "I feel I would be listened to and taken seriously. Feedback I'm sure is welcome, they listen to us at resident's meetings." Feedback from relatives included, "We are reassured that the manager is kind and approachable and would go to her if we needed and feel our opinions and requests would be listened to" and "The management seems much better at getting their staff moving now. I feel more listened to."

At the last inspection we found that monitoring processes were not robust and did not always identify shortfalls in the service provision. At this inspection we found that this had improved. There were a series of meetings and reviews that took place to monitor the service. These included daily clinical walk arounds on all units to discuss any events, changes and to highlight any changes in people's conditions, and weekly clinical risk meetings to identify all areas of risk throughout the service, including highlighting risks to people, and taking action to address these. There was then a monthly clinical governance review carried out that covered all aspects of the service and fed into the provider's quality monitoring overview for the service. The regional director and the regional manager attended the home each week to provide input and support to the management team and monitor the progress of the service. They were supportive and alongside the registered manager and the deputy manager demonstrated a dedication to the continued improvement of the experience of the people living at the service.

Staff had received training in effective auditing processes and we saw that there had been significant improvements made with the auditing and monitoring of many aspects of the service including the completion and maintenance of care plans, 'do not attempt cardiopulmonary resuscitation' DNACPR records and recruitment records. Where shortfalls were identified in the auditing and monitoring reports, we could see that action plans with timescales had been set and then revisited and signed off once complete, demonstrating that the process was being used effectively to drive up improvement.

In each unit there was a monthly report which contained information about changes in people's weight, skin integrity, falls, health, medicines, coroner investigations and anyone on antipsychotic medicines. The monthly report in each unit was up to date and staff had included any changes. The report contained a detailed log of each of the areas. For example, the monthly nutrition review recorded people's weights, any changes in these and the action taken to address the changes. The summary and detailed reviews were shared with the registered manager and the provider so they were kept up to date.

There were regular resident's meetings and minutes were taken. People were encouraged to express their views so any issues, good or bad could be responded to. In each unit there was a board displaying how the provider had responded to specific requests made by people using the service for improvements. The board focussed on "What [people] said" and "What [the provider] did." These boards were regularly updated and the ones on display in each unit were individual to the unit and for the month of June. Examples of this were, "Ensure my food is hot" ……. "We spoke with the staff about ways to make sure food is hot when served"

and "Respect my privacy" …… "We make sure signs are placed on bedroom and bathroom doors to show when people are being cared for."

The registered manager said of the service, "We want our residents to feel loved, safe, cared for and content and happy in their home. It is their home and we just work for them." They told us about a scheme they had introduced called, ''The everyday hero.'' This was a scheme whereby people using the service, visitors and other staff could nominate a member of staff who they felt had worked particularly hard or done something special. The winners of the award each month received a gift as well as recognition and thanks for their work. The registered manager told us they felt the culture of the home had improved. This was reflected in our observations where people using the service and staff appeared relaxed and happy. The staff sat and talked with people, did not rush them and there was a calm and positive ambiance throughout the service.

Most of the staff we spoke with told us there was an open culture in the service and they could comment on the service and how it operated. Their comments included, "They are a good employer. We are supported and told what is happening. The manager is a good listener," "The manager is good, you can talk to her", "The manager is a very good communicator and listener, very supportive", "We are free to speak to the managers and they are so good, they listen to you and they do take notice and make sure action is taken straight away" and "They are the perfect employer. I enjoy my job, I get all the training I need and I get on well with the other staff." We received mixed feedback regarding the frequency of supervision sessions, some staff being happy with how often they received supervision stating this was every three to six months and others who said they rarely had supervision. Some staff said they had not yet had appraisals. We saw a log of objective setting meetings and appraisals for several staff and the deputy manager said she would ensure these were completed for all staff.

The registered manager and the deputy manager carried out night spot checks to see how the service was being run at night and to meet with the night staff and discuss any points. The management were aware of the importance of communicating with staff and regular meetings were held on the units with minutes taken and action plans to address any issues that were raised. We saw that staff meetings for heads of department, senior staff and full staff meetings were also arranged and minutes taken so any issues could be addressed. There had been a series of meetings with the activities coordinators earlier in the year to support them and ensure they were happy with the plans to increase activities. We saw there had been a marked improvement in the activity provision and communication was good.

The registered manager said they had involvement from the local community including using local shops, for example to order people's newspapers and to include neighbours in events such as a recent Fete and a planned barbecue. The registered manager was clear on the importance of the service being part of the local community and of working together and maintaining good relations. Students from the National Citizens Service, a voluntary personal and social development programme for young people, were visiting the service in July 2018 for an activities programme with people living at the service.

Corporate policies and procedures were in place, referenced relevant legislation and good practice guidance and were updated periodically to keep the information up to date. The registered manager had worked on the recent changes in the Data Protection legislation and we saw that information about the General Data Protection Regulation (GDPR) was displayed on all units and in other areas of the service so people, visitors and staff had access to the information and explanations of the changes in the law. Information Technology was in use and we saw two computers were available for people to use in Sycamore unit and people could have their own computer and internet connection if they so wished, so they could have independent access to the internet.