Medicare Corporation Ltd

Broadland View Care Home

Inspection report

147 Yarmouth Road
Thorpe St Andrew
Norwich
Norfolk
NR7 0SA

Tel: 01603432050
Website: www.broadlandview.co.uk

Date of inspection visit:
24 October 2017
25 October 2017

Date of publication:
01 December 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24 October 2017 and was unannounced. We returned on the 25 October 2017 to complete the inspection. The registered manager was given notice of the second date, as we needed to spend specific time with her and the provider to discuss aspects of the inspection and to gather further information.

We undertook an unannounced comprehensive inspection of Broadland View on 08 November 2016. We found continued breaches in Regulations 9, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was from a previous visit in September 2015. The service had failed to ensure that people's emotional and social needs were assessed and met. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. For the Regulation 17 breach of Good Governance, we served a warning notice informing the provider that they had to comply with this regulation by 3 March 2017.

At that inspection, we also identified additional breaches of Regulation 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the service had failed to ensure people consented to the restrictions put in place surrounding people's freedom of movement. The service had also failed to ensure that all peoples nutritional and hydration needs were met.

We undertook a focused inspection on 19 April 2017. This was to check the service had met the conditions in the warning notice and whether they now met the legal requirements for Good Governance. We found the service had made improvements and were no longer in breach of this regulation. We found that action had been taken to improve how the service assessed, monitored and improved the quality of the service provided. We did not improve the rating for well-led from requires improvement because to do so requires consistent good practice over time.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our 8 November and 19 April inspections had been made and sustained. The team inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well led. This is because previously, the service was not meeting some legal requirements.

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

Broadland View accommodates 25 people in one adapted building. There were 25 people living in the home on the day of our inspection. The home supported people who were over 65 years of age, some of whom were living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations.

At the inspection on 8 November 2016 we found there was a lack of knowledge and understanding in regards to when a Deprivation of Liberty Safeguards (DoLS) application was required. The service was therefore not acting in accordance with the Mental Capacity Act 2005/DoLS and seeking to reduce the restrictions as far as possible. These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always involved in decisions about what they wanted to eat. We found food looked unappetising. For people who could not have a conversation with staff about what they wanted to eat and drink, the management team had not considered other ways of gaining this information. These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive care which was person centred and responsive to their needs. This constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, the provider wrote to us to confirm that they had addressed these issues. At this visit, we found sufficient improvements in all of these areas. People's capacity to consent to care was properly considered and the home worked in accordance with current legislation relating to the MCA and the DoLS. This included training for all staff on both subjects. People appeared happy and were relaxed and comfortable with staff. People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. Observations of meal times showed these to be a positive experience, with people being supported to eat a meal of their choice and where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. People were supported by staff who understood their needs and abilities and knew them well. Staff were kind and caring towards people and upheld their privacy and dignity at all times. Therefore the actions had been completed and the provider had now met those legal requirements.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People who were able to said they felt safe at the home.

People's care records showed risks to their safety were assessed and the action needed to mitigate those risks. These assessments and care plans were reviewed and updated at regular intervals to ensure people's changing needs were met. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed. Newly appointed staff received an induction to prepare them for their work. Staff had access to a range of training courses and said they were supported to attend training courses.

People's health care needs were assessed monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff working in the home were caring and compassionate. Staff knew the needs and preferences of the

people they cared for and people were given reassurance and encouragement when they needed it. Where people needed support in order to make their own day-to-day decisions this was provided by staff. Where people had short term memory loss, staff were patient in repeating choices each time and explaining what was going on and listening to people's stories. People's rights to privacy, dignity and independence were taken into account by staff in the way they cared for them.

Each person's needs were assessed and this included obtaining a background history of people. Care plans and assessments were comprehensive and showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences.

People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. Staff were always visible to interact or sit with people. People were offered a wide range of both group and individual activities that were meaningful to them and which had a positive impact on their lives.

The home had been decorated and arranged in a way that supported people living with dementia. The service was brightly decorated and stimulating for the people living there. The communal areas of the service were clean and well-furnished with a homely feel. People's rooms were individualised, with personal items such as ornaments, photos and furniture. The outside area was accessible with paths and benches.

Complaints were listened to and managed in line with the provider's policy. Relatives felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

People and their relatives were involved in developing the service through meetings. People, relatives, healthcare professionals connected to the service and staff were asked for their feedback in annual surveys. All responses were positive from the recent quality assurance questionnaire. Their views were valued and they were able to have meaningful input into the running of the home, such as activities they would like to do, which mattered to them.

Staff felt the registered manager was supportive and said there was an open door policy. Relatives spoke positively about the care their family members received. There were effective quality assurance processes in place to monitor care and plan on-going improvements. The provider visited the home on a weekly basis and supported the registered manager.

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 had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

Sufficient numbers of staff were provided to meet people's needs. Safe recruitment systems were in place.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training as required to ensure they were able to meet people's needs effectively. Staff received supervision and appraisal.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to people. Equality and diversity were managed well and people were supported to follow their own religious and cultural preferences and beliefs.

Staff acknowledged, maintained and promoted people's privacy. People were involved with and included in making decisions about their care and how they wanted this to be delivered.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

People were able to take part in meaningful activities of their choice.

People were aware of the complaints procedure and knew what to do if they were dissatisfied with the care they received.

Is the service well-led?

Good

The service was well-led.

There was an honest and open culture within the staff team.

People benefited from a well organised home with clear lines of accountability and responsibility within the management team.

Staff told us that the registered manager was approachable and that they were encouraged to discuss any issues or concerns. The provider encouraged people and their relatives to express their views about the service and the provider was open to suggestions for improvement.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

Broadland View 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 and 25 October 2017. One inspector and an expert by experience undertook this inspection. 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 expert by experience at this inspection had expertise in dementia care.

Before the inspection, we received 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

We spoke with six people who lived at the service and contacted three relatives by telephone for their feedback on the quality of care provided. We spoke with the provider and the registered manager. We spoke to head of care, two senior care staff and one carer. We also spoke with one visiting district nurse.

We looked at the care plans and associated records for four people. We looked at four people's medication records and four people's weight records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menus, relative questionnaires, and health and safety checks. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

People who were able to tell us they felt safe and our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed. One person said, "I feel safe because if you want anything you just ask, they [staff] are very good." Another person said, "I feel safe because I have company, staff and people to talk to." A third person said, "Having people around makes me feel safe." Without exception all the relatives we spoke with told us they felt their family members were safe. One relative told us, "[Person] is safe and very well treated, he feels safe with them." Another relative told us, "My mum is definitely safe it is such a high standard of care." A third relative told us, "Mum is safe at the home, I visited a lot of homes and this was by far the best, the people are friendly and happy, the home smells good."

When we inspected last November, we observed some unsafe moving and handling techniques. This was an area requiring improvement. At this year's inspection, we found moving and handling assessments gave staff clear guidance on how to support people when moving them. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

At the inspection on 8 November 2016, we looked at people's risk assessments and care records and found these were not always robust, updated, or offered clear guidance for staff. This was an area requiring improvement. At this inspection, we viewed four peoples care records which included risk assessments regarding nutrition, possible falls, diabetes, activities and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. For example, one person's care records described the hazards and measures to control risks regarding going out, preventing falls and nutrition. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff.

We found risks regarding developing pressure areas on skin due to prolonged immobility were completed. Appropriate referrals had been made to health care services. These included referrals for assessment by the tissue vitality service for pressure area care. People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas. One person had a record to show they were repositioned at regular intervals to relieve the pressure on their skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment

and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

The registered manager demonstrated understanding of her responsibilities to protect people from abuse and to provide safe care. We asked the registered manager about the systems and processes in place to ensure appropriate action was taken when incidents and safeguarding situations occurred to reduce risks to people. The registered manager explained that all individual incident and accident reports were seen by her, that she then compiled a monthly report, which was reviewed by the provider. We were told a trend analysis was then completed. We spoke with staff about the safeguarding of people and each staff member had a good awareness of the principles of safeguarding procedures and who to report any concerns too. Records showed staff were trained in safeguarding procedures and this was included in the induction for newly appointed staff.

Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although staffing levels remained flexible. Staffing could be changed if required, for example if people became particularly unwell. We saw that people received care and support in a timely manner. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. One person told us, "I feel safe in here, the carers are so good, I hate having to be dependent on people, and I like to do as much as I can for myself. I have my bell which I press when I do need help, I do not have to wait long as a rule. They are very good at night at answering the bell considering there are only two of them."

Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the entrance hall where relatives were visiting and staff discreetly assisted them, ensuring they were comfortable in a quieter environment. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice.

The rotas reflected each day that at least four care staff and one senior carer were on duty from 8am to 8pm, each working a 12 hour shift. At night-time one carer and one senior carer were on duty 8pm to 8am. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed. In addition to the care staff, the service had a team of domestic staff, a chef and one activity coordinator who worked 25 hours per week. This enabled the care staff to attend to people and their needs. A head of care worked four shifts a week and one admin shift per week. The head of care was responsible for ensuring care plans were up to date and worked alongside carers offering support, advice and guidance.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.

People's medicines were safely managed. There were policies and procedures for the safe handling of medicines. Medicines were administered by trained staff. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.'

The senior carer was observed administrating medicines on the day of the inspection. We observed medicines were administered safely and the medicines administration record charts were seen to be signed

and dated. However, we found in some records that there were gaps in these records. Where this had happened, the registered manager had suspended staff from administering medicines until they had been retrained and their competency assessed. Staff were also met with the registered manager on a one to one basis to discuss any errors or additional support to be offered. The registered manager then discussed any medicines administration errors at team meetings to help prevent any recurrence. The senior carer was observed explaining to people what she was doing, gaining their consent and explaining what the medicine included. The senior carer ensured that the medicine was given in accordance with the wishes of the person, that it was given safely and that the person was comfortable.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

Good

Is the service effective?

Our findings

At the inspection on 8 November 2016 we found the provider had not ensured care and treatment was always provided with the consent of people. Where people were able to consent, the provider had not acted in accordance with the Mental Capacity Act 2005 and its Code of Practice. We made a requirement for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and this regulation was now met.

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs. One staff member told us, "We must never assume a person does not have capacity. Capacity can change from day to day depending on how a person is feeling or if they are physically well. If we are questioning a person's capacity we complete a capacity assessment and if needed involve relevant professionals for a best interest meeting. This could involve the use of advocacy services." An advocacy service is provided by an advocate who is independent of social services and who is not part of a person's family.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People and their relatives said staff consulted people and gained their consent when providing care where this was possible. We observed staff gained people's consent before supporting them using their assessed communication method. One staff member told us, "The MCA is there to protect people. Capacity can fluctuate especially if a person has a urine infection. Therefore, it is really important how we communicate with people. Listening to what they [people] tell us, but also visually how do they appear when making decisions. I ask questions and if needed rephrase the questions to ensure that they have understood." Our observations confirmed people were able to make choices and were in control as much as they could be in the day-to-day decisions being made. For example, what people wanted to wear, where they wanted to sit, what activity they wanted to do and what level of interaction they wanted with staff. Records confirmed that staff had completed training in the MCA and had a good understanding of this topic.

Appropriate DoLS applications had been made and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care,

where they lacked capacity, these had been made in the person's best interests.

At the inspection on 8 November 2016 we found food looked unappetising. For people who could not have a conversation with staff about what they wanted to eat and drink, the management team had not considered other ways of gaining this information. We made a requirement for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and this regulation was now met.

One person told us, "The food is very good, I have a small portion, it is cooked well, and I have no complaints of the food." Another person told us, "The food is very good, it is the sort of food our generation would like cereal and toast at breakfast, meat and two veg and a sweet at dinner time and sandwiches for tea. It is the sort of food we are used to, not fancy, no complaints with the food what so ever." A third person told us, "The food is beautiful, I am ever so full today, they asked me if I would like some more gammon, I couldn't possibly have eaten anymore." One relative told us, "The food is lovely; I have had the food and they can have as much as they like and if they don't like what is offered they will always get them something else." Another relative told us, "The food is good; they give cakes, biscuits and tea to all. My mum is well hydrated."

People were supported to have sufficient to eat and drink and to maintain a balanced diet. We reviewed the records kept by the chef, which explained how they catered for people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. We observed good communication between kitchen staff and care staff. The staff advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and speech and language therapists.

People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Induction training was followed by a minimum of four shadow shifts. New staff shadowed more experienced colleagues and did not work on their own until they were competent and confident to do so.

The provider maintained a spreadsheet record of training in courses completed by staff, which were considered mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people and the Mental Capacity Act (MCA.) Additional training was available to staff in specific conditions such as end of life care, dementia and diabetes. Records confirmed all staff who had finished their induction, had received this training. Staff confirmed they received training

which they said was of a good standard and that they were able to suggest relevant training courses which were then provided. One staff member told us, "I love training. I have been here just over a year and learnt so much." One person told us, "I feel confident in them [staff], they seem to all know what they are doing." Another person told us, "From what I see they [staff] have the skills, they are all very helpful."

Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard.

Staff received supervisions with the registered manager approximately three times per year and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. One staff member said, "I get regular supervision. [Head of care] and [registered manager] are so supportive. They are good meetings." We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

We found records demonstrating other ways staff were supported. This was through handovers during the day, staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to.

We looked at documentation related to staff handovers. We noted these revealed the focus was person centred rather than task oriented. There was clear information concerning important aspects of people's care and how this affected them day to day. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse or optician. If needed, staff would support people to attend their hospital appointments. One relative told us, "My husband had to go to hospital, he had some sort of seizure they [staff] called the ambulance. Staff noticed he had a sore eye so they called the GP out for that, they don't just leave things, they do sort things out, they do as much as they can. When he first arrived he wouldn't let them touch him, They found it hard to deal with him so they called the psychiatrist in and together they sorted a plan out, it was implemented and it worked. He sits in the lounge now instead of hiding away in his room. He is happy with the people."

The colours and décor of the home supported people living with dementia to orient themselves in their surroundings. For example, there were objects placed around the home for people to pick up and engage with. We observed people walking around with various items that were of interest to them, such as knitted items, which some people enjoyed holding and putting on. There were handrails along the corridors for people to steady themselves and rest if needed.

Good

Is the service caring?

Our findings

At the inspection on 8 November 2016 we found the staff approach towards people who lived in Broadland View was not always caring. This was an area requiring improvement. Following the inspection, the provider sent us an action plan. At this inspection we found improvements had been made. All of the people and their relatives we met spoke very highly about the caring and compassionate nature of the service, staff and management team. They told us that every member of staff demonstrated this approach consistently and without fail.

One person told us, "The staff are very caring without exception. They tell me to stop apologising when I have had to ring my bell, telling me that is what they are here for to help me. It is a real team effort. I feel I am listened to." Another person told us, "I think the staff are very good, sometimes I wonder how they keep their patience." Another person said, "All the staff are very nice, they bring my sandwiches up to my room at night." A fourth person told us, "The staff are lovely I don't need them to do anything for me as I can do it myself but they are kind." A fifth person told us, "They're good girls, they look after me well."

One relative told us, "All the staff are caring, they make you feel so welcome when you visit. All the staff even the new ones call the residents by their names, they are all treated with respect. They never pass any resident without saying are you alright, there is always someone keeping an eye on the lounge even if no one is sitting in there with them."

We observed the lunchtime meal in the dining room on both days of our visit. On the first day we observed three people on the same table, left unsupported who were struggling with their meals. We were informed the same three people sat together each day on the same table. All three people had been identified as needing verbal encouragement to eat or support to cut food up. One person struggled to cut up their food, resulting in them picking a large piece of meat and trying to chew on it. Another person was using a knife as a fork; they appeared confused and prodded at their food before eventually leaving it. Another person on the same table, attempted to pick their food up with a fork but due to not having a plate guard, it was pushed onto the table. A plate guard helps a person to eat their meal more independently. This person's food eventually went cold before a staff member intervened and offered support. After lunch had finished we shared our observations with the registered manager and provider. The registered manager immediately arranged for all three people to be offered another meal with one to one staff support to ensure they were not hungry. The provider immediately ordered a number of plate guards to be delivered the same week. As a temporary solution people who were seen struggling with a flat plate, were offered large pasta bowls which had large rims, this kept the food on the plate and not on the table.

On the second day of our visit, we observed improvements at meal times. We observed lunch and evening tea. Between the first and second day of our visit, the registered manager had called a staff team meeting to discuss our observations from the first day. The registered manager reminded staff of people's needs and the care plans to support people's needs at meal times. The registered manager had also identified that the people who sat at the same table each day needed a carer to be present sat at the table with people to offer, support and encouragement, at the time people needed it. We observed this in practice on our second day.

The atmosphere was calm and relaxed and there was music playing which people told us they enjoyed. Tables were nicely laid with condiments and sauces. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Staff assisted people who required support with eating their meal in a discreet and unhurried way. Staff made sure they carefully wiped people's mouths after eating and drinking to protect their dignity. Staff spoke to people warmly and interacted well with those who needed help. The staff made eye contact with people and crouched down so people could see them when they spoke to them rather than standing over them. Staff made sure people were safe when they were eating and drinking. A person was eating their meal independently, a staff member made sure they did not eat too much food each time to ensure they could swallow safely. Staff took care to treat people in a way which made people feel they mattered.

People were treated as individuals and with care. For example, one staff member said they treated people according to their cultural needs and offered them appropriate choices. Another staff member said they treated people as they would treat a member of their own family. Staff knew each person's needs and preferences. The staff induction included instructions for staff in treating people with dignity, maintaining people's independence and treating people as individuals, which we observed in practice. Each person had a person centred care plan which was personalised to reflect people's preferred routines and choices in how they spent their day and how they wished to be helped. People who were able told us they were able to choose how they spent their time. Care plans also included details of how staff should support people with emotional needs. Staff told us care was provided based on what the individual needed and that choices were available to people.

Staff said they knew how to respect people's dignity and privacy, which we observed taking place. For example, one person was confused with their clothing, which resulted in them raising their top, exposing their bra. We observed a staff responding immediately, taking the persons hand and stroking it. The staff member offered reassurance and positioned themselves in front of the person to maintain the person's dignity. With their other hand they quickly lowered the person's top. They continued to sit with the person making conversations and using this as a diversion. We observed staff knocking and waiting before entering people's bedrooms. We observed staff supporting people discretely in going to the toilet and cleaning their hands before and after meals as they wished.

People's abilities to express their views and make decisions about their care varied. To ensure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed to help give people a normal life.

Good

Is the service responsive?

Our findings

At the inspection on 8 November 2016 we found a continued breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was from a previous inspection in September 2015. We found the service had failed to ensure that people's emotional and social needs were assessed and met. We also found people did not always receive care which was person centred and responsive to their needs. We made a requirement for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and this regulation was now met.

One staff member told us, "Its homely here, people are well cared for. It's not a clinical place, we are personal. It's really nice for people. All staff are friendly. We all get on. All of the families are happy with the care people get here. We make it as comfortable and personal as we can."

People's needs were comprehensively assessed at the time they were admitted to the service. This included communication needs, personal care, continence, mobility and nutrition. Further assessments were carried out regarding moving and handling and any risks to people. They were legible and securely stored. They were person centred and people's choices and preferences were consistently documented. The care plans we looked at contained meaningful information about people's social and personal histories. It was possible to 'see the person' in these documents. One person told us, "The manager came to see me at home before I came in and we discussed then what help I wanted. I like to get up at around 6.45, which I do, and I have two carers when I have a bath. I have my meals in my room and that is my preference."

Each person's care plan contained detailed information about people's care needs and actions required in order to provide safe and effective care. Some people had diabetes. Their care plan's contained clear and concise information for staff concerning the management of this. For example, we noted people were assessed as being at risk of developing a pressure sore due to immobility. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration. They had been provided with an air mattress, the pressures of which were calibrated and regularly checked. The District Nurse told us there was no one with pressure sores greater than grade 2 (superficial) and that the "staff are very prompt and quick if they need advice. Things have improved immensely since their last inspection. The staff are on the ball which has resulted in our visits reducing. We only do this when we are happy and satisfied people's health needs are being fully met. It is turning around." Care plans and risk assessments were reviewed at regular intervals and were updated to show changing needs were addressed.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way, for example, in relation to chiropody, eye care or GP. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

Most people were able to be directly involved in their care planning and relatives confirmed they were able to be involved if they wished. One person told us, "I look after myself but the staff help me when I have a bath. They always talk to me about my care plan and ask for my input." Another person told us, "I am involved in my care plans. We agree together what help I need from staff. I like to get up at 6.30am. This is my choice and that is when they come to help me. We do review this and they do check with me each day to make sure I want to get up at that time." Two relatives said they did not need to be involved as they were able to chat to staff or the registered manager at any time. However, the opportunity was there. People had consent forms in their care plans, which asked when people would want their loved ones to be contacted. People who used the service had monthly meetings where they discussed topics that were relevant to them and the service such as social activities and meals.

We observed people and staff together in the communal areas. They chatted and joked with each other continuously. Staff responded well to those who gestured for help because they did not have verbal communication. There was laughter and free communication between staff and people. Each person had a communication care plan, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, angry or in pain and how staff should respond. Care workers and the registered manager communicated with people in an appropriate way according to their understanding.

The activity coordinator managed a mixture of external and internal activities for people including word and puzzle games and regular visits from companies offering entertainment. There was a full timetable available with dates and times of what activities were available and when. On the day of the inspection, we observed people looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. Records demonstrated that people attended a wide variety of activities, for example Church, bingo and musical events. Some records reviewed had daily activity charts completed and daily records recorded activities that people had participated in that day. One person told us, "I am happy staying in my room, when I was at home I lived alone. I am a regular Church goer. I have my television to watch if I want to." Another person told us, "I like to join in whatever they are doing, it isn't every day. I watch a bit of television in the evening. In the summertime, we go outside and play hoopla and different things. A friend's family visited and they came and asked me to join them as they know I like to be outside. My friends and family take me out for a cup of tea or for a ride out." Another person told us, "I like to watch The Jeremy Kyle Show. The staff make sure I don't miss any episodes. I really enjoyed the belly dancers when they visited and the music is good. The old songs I know, they make all of the entertainment very comfortable for us.

Due to people choosing to spend most of the day in the communal areas, they were able to interact with staff and watch what was going on; this meant there was a low risk of isolation. The small number of individuals who chose to remain in their bedrooms received one to one time with the activity coordinator or staff. Activity records demonstrated they chose to relax in their rooms, listening and watching their preferred radio station and television programmes. Activities such as art, exercises and memory games, were also supported in people's bedrooms. This ensured the risk of people being socially isolated was minimised.

The registered manager and her team had made every effort to ensure that the environment was as conducive as possible to supporting people who lived with dementia in having a structured, meaningful day. The ground floor lounge area had been well planned making it very suitable for people. It had many interesting objects that could be picked up and interacted with. We also saw seating areas along the hallways where people could rest and where dementia friendly activities were placed for people to engage in.

The complaints policy included clear guidelines on how and by when issues should be resolved. It contained details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The provider responded to complaints effectively and in line with their complaints procedure. There was an accessible complaints procedure in place and on display in the communal areas. People knew who to speak with if they had any concerns or complaints. People confirmed they could talk to staff and felt listened too. Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the registered manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was discussed with the person as part of their monthly resident' meetings in a format the person was able to understand.

We noted the provider had received a number of compliments, in the form of cards, letters and e-mails, from people and their relatives since our last visit. All expressed a high degree of satisfaction with the care provided.

Good

Is the service well-led?

Our findings

We asked staff about the vision and values of the service. One staff member told us, "It is to provide a safe service. To treat people as individuals." Another staff member said, "To offer a home from home experience for people. This is their home and we should respect this." Staff demonstrated the importance of offering each person a personalised service and each person being highly valued.

Staff said that they felt fully supported and that the registered manager was approachable. Staff confirmed that the registered manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence. One staff member told us, "I feel if we have a problem we can go to [registered manager]. If you go to management they listen and they act on what you tell them. They put things right." Another staff member told us, "They [management] are amazing. I cannot compliment them enough. If there are any issues, you can be open and honest. They are really good at what they do and are approachable."

One person told us, "On the whole the home is comfortably managed. There has been nothing I would want to make a formal complaint about." Another person told us, "I think the home is well managed." Another person said, "If I had worries I would speak to the manager, I have to say everything is lovely here." One relative told us, "I would speak to the manager if I was concerned. If anything changes in the home they [registered manager/head of care] call me in and keep me updated. There was a broken wall at the front of the home it didn't bother the residents but I felt it didn't look nice, I mentioned it to the registered manager and within two weeks it was fixed. There was a statue that my husband could see from his bedroom window. He kept thinking it was a person staring at him, I mentioned it to the staff and they went and spoke with the private residence. They moved it for us." Another relative told us, "I would like to see an extra carer occasionally, they are always so busy with residents, it would be nice to see staff with them rather than doing for them, they all work so hard." One relative commented that the general ambience of the home had improved since the last inspection.

The head of care completed a range of quality monitoring audits. These included medicines, accidents, incidents, safeguarding, pressure wounds, complaints and health and safety. In addition to these, the registered manager completed monthly quality audits. On the audit form there were details in relation to injuries with date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details, outcome i.e. closed, on-going, no further action. The form also included a section for recording any details of any trends developing and noted actions taken. Records demonstrated that information from the audits was used to improve the service and information recorded used to reduce risk of untoward events occurring.

The registered manager and provider had an action plan in place to review compliance with CQC standards and regulations. This has been reviewed on a weekly basis and shared with Norfolk County Council and CQC on a regular basis. This has formed part of the home's internal quality monitoring programme. All recommendations had been addressed by the registered manager. Therefore quality assurance measures had been implemented effectively to ensure the service continuously improved and addressed concerns in a

timely way. The provider visited the home on a weekly basis and supported the registered manager.

Staff told us they attended staff meetings where they could discuss the care of individuals and any updates to policies and procedures. Staff said they felt supported and said there was a culture where they could ask for support and training to enhance the standard of care they provided.

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose, the last CQC report and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in September 2017. We noted all expressed a high degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.