Queensbridge Care Limited

Queensbridge House

Inspection report

63 Queens Road
Cheltenham
Gloucestershire
GL50 2NF

Tel: 01242519690
Website: www.queensbridgecare.co.uk

Date of inspection visit:
04 February 2019
05 February 2019

Date of publication:
09 April 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Queensbridge House is a residential care home. It specialises in the care of people who live with dementia and mental health needs. It can accommodate up to 27 people, although at the time of the inspection 26 people were receiving care (a bedroom which can accommodate a couple where needed was being used by one person).

People's experience of using this service:
•□The service demonstrated a strong, visible person-centred culture and followed a model of dementia care called the 'Butterfly Approach'. People therefore received highly personalised and exceptionally caring, kind and empathic care from staff
•□People's feelings, wishes and wellbeing were at the centre of their support. People were afforded time and emotional support to help them maintain their wellbeing. Staff were particularly 'tuned into' people's moments of illbeing and distress and provided positive and emotional support at these times.
•□Staff demonstrated exceptional compassion, understanding and kindness towards people when supporting them. A nurturing culture helped people to feel safe and to develop meaningful and beneficial relationships.
•□Staff were developed and supported to be skilled and motivated in helping people to live well with dementia. Improving people's quality of life was at the centre of all interactions and activities provided by the staff.
•□Activities were meaningful and fun, they were person - centred and were aimed at maintaining individual skills and achieving a sense of purpose and achievement. They were used to support social connections between people.
•□People and staff lived and worked as one supportive 'household' caring for and valuing each other's contribution. Staff recognised and valued the importance of those who were close to people; family and friends. They were supported to feel part of the 'household' and to remain part of people's lives.
•□People's representatives (where appropriate) contributed to people's care and the decisions made on their behalf.
•□The home's environment was domesticated and adapted to help people orientate and connect to their surroundings.
•□People's care records had improved. Records reflected people's needs, the care people received and gave detailed guidance to staff on how to meet people's needs.
•□Risks to people were identified, assessed and managed effectively. We have made a recommendation in relation to guidance available to staff when supporting people following a fall who have also sustained a head injury and who are on a blood thinning agent.
•□People and their relatives benefited from the home being managed in an open and transparent way. There had been a change of manager in August 2017 when the deputy manager became the registered manager of the service.

Rating at last inspection:
At the last inspection on 26 and 27 October 2017 the service was rated Requires Improvement. This report was published on 2 February 2018.

At our last inspection we found people's records were not always comprehensive and the provider's quality assurance systems had not identified this concern. Following the last inspection, we asked the provider to complete an action plan to show us what they would do and by when to improve the key questions, Is the service responsive and well-led? The overall rating for the service has improved from Requires Improvement to Good.

Why we inspected:
We inspected this service as part of our ongoing Adult Social Care inspection programme. This was a planned inspection based on the previous Requires Improvement rating. We also followed up on progress against agreed action plans to address the breaches in regulation we found at our previous inspection in October 2017. Previous CQC ratings and the time since the last inspection were also taken into consideration.
The overall rating for the service has improved from Requires Improvement to Good.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Queensbridge House

Detailed findings

Background to this inspection

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

Inspection team:
This consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, caring for someone who lived with dementia.

Service and service type:
Queensbridge House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provide, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before inspection: We reviewed the Provider Information Return (PIR) as part of the provider information collection. This was received on 10 January 2019. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed all notifications received from the service since the last inspection. This information is required by law and informs us about incidents and events which have had an impact on people who use the service.

During the inspection:
We spoke with seven people who used the service and eight relatives. We reviewed four people's care records, which included care plans and risk assessments. We reviewed four people's medicine

administration records. We observed the support provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager and five members of the team. We reviewed one staff recruitment record, maintenance records, a selection of quality monitoring audits, which included an analysis of all accidents and incidents. We reviewed the staff training record.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse.
•Staff had received training on this subject and knew how to recognise potential abuse. They knew who to report concerns to and took action when needed to protect people.
•Managers adhered to the provider's safeguarding policy and procedures; they shared relevant information with other professionals to help safeguard people.
•Staff knew what poor care and unsafe practice looked like; they were confident enough to challenge this.

Assessing risk, safety monitoring and management.
•Risks to people were assessed and managed effectively. These included risks relating to people's behaviours, falls, malnutrition, choking and the development of pressure ulcers.
•A falls protocol (guidance) was in place to help staff take the correct action following a person's fall.
•Regular safety checks of the environment took place; potential risks to people inside and outside of the home were reduced.
•Actions taken to reduce risks were reviewed so they remained appropriate and effective.
•Information, in line with the Herbert Protocol was held by staff. This information is used by the police to help them locate a vulnerable missing person.

Staffing and recruitment.
•Enough staff were available to support people's needs. There were two staff vacancies; applicants so far had not been considered suitable. Familiar agency staff had been used during this time so people's needs were met in a consistent way.
•One member of staff had been recruited since the last inspection. Recruitment records showed safe recruitment processes were followed to protect people.

Using medicines safely
•People received their medicines as prescribed. People's medicines were requested and ordered in time for their use.
•Medicines were stored safely and in line with pharmaceutical guidance.
•Medicine administration records were well maintained, giving clear instruction to staff so medicine errors were avoided.
•People received the support they required to take their medicines. GPs kept medicines under review. One relative said, "[Relative] takes a pain killer in liquid form and they [the staff] know exactly when she has it."

Preventing and controlling infection.
•People lived in a clean home where measures were in place to reduce the risk of infection. Staff wore

protective aprons and gloves when delivering personal care to prevent cross contamination between people.
•□Laundry was managed safely; soiled items of laundry were managed separately to avoid the spread of germs.
•□People and staff had been supported to have the Flu vaccine.

Learning lessons when things go wrong.
•□An open and transparent culture was promoted; staff felt comfortable and able to discuss mistakes, concerns or near misses.
•□Staff meetings were used to reflect on and discuss areas for learning and improvement.
•□Duty of Candour was met; people or their representatives, were provided with explanations of incidents and kept informed of actions taken to avoid reoccurrences. One relative said, "We are very happy with the care here and are always kept up to date with how [name] is."

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•□People's needs were assessed prior to them moving into the home. An ongoing assessment process enabled staff to identify changing needs and alter their care accordingly.
•□People's choices and preferences, about their care, were explored with them (or with their representatives where appropriate) and respected.
•□Care was delivered in line with good practice guidance, for example, Dementia Care Matters, Gloucestershire's Dementia Strategy – learning and training strategy, the Alzheimer's Society and guidance from the National Institute for Health Care Excellence (NICE).

Staff support: induction, training, skills and experience.
•□Staff were provided with the training and knowledge they required to work safely and within the law with people who lived with dementia.
•□Additional training and support was given so they could work in line with the 'Butterfly Approach'; person-centred care, positive and enabling interactions and how to support people emotionally.
•□Managers supported and promoted the use of reflection and learning through experience. They worked alongside staff to help improve practice.

Supporting people to eat and drink enough to maintain a balanced diet.
•□Staff were skilled in helping people who lived with dementia to make choices about what they ate and drank. Verbal and visual support was provided.
•□People's individual nutritional risks were assessed and known to the staff.
•□Main meals were provided by a company who specialised in the nutrition of older people and other health related dietary requirements.
•□Eating and drinking was a social activity for many people; a relaxed and unrushed atmosphere was promoted by the staff at mealtimes.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support.
•□People were fully dependent on staff to support them to access the right support, at the right time and in a way which took their dementia needs into consideration. Staff worked closely with people's families when planning reviews and assessments with health and social care professionals, so people were well represented.
•□Staff supported people and their representatives to understand the information given to them and their treatment options.

•□People were reviewed by GPs on a regular basis. People's nursing requirements; wound care and the monitoring of conditions such as diabetes and Parkinson's Disease, were met by other community health practitioners.
•□NHS dental and optical services visited the home when required. Regular chiropody arrangements were in place.
•□Staff contacted and worked with the emergency services when needed; NHS 111 and the NHS Rapid Response teams to meet people's health needs.

Adapting service, design, decoration to meet people's needs.
•□Adaptions were made to meet people's physical care needs; a new and updated assisted bath and bath chair were being fitted at the time of the inspection.
•□The homes environment had been designed in line with the 'Butterfly Approach'. Bedrooms had 'Front door' style doors which helped people identify their personal space as their own home. Corridors were themed; pictorial signage, use of colour and familiar items helped people to orientate.
•□We saw one person, who was new to the home, be disoriented but when they saw the garden themed corridor they recognised the decoration and knew their bedroom was close by.
•□Communal rooms were domestic in style and provided a choice of visual and sensory stimulation. A different mood and ambiance could be created in each. The people who liked to watch television during the evening were made to feel cosy and at home by staff switching on a wood burner effect fire and lamps.
•□In one lounge, four out of five people were fully engaged in and laughing at a programme on the television. The programme had been popular when it was televised in the 1970's and was accessed through a special TV Programme for use in care home's supporting people with dementia. A member of staff said, "They love it and remember it."
•□Personal effects, paintings and crafts (made by the people) personalised the areas they used. Positive quotes, sayings and inspirational thoughts were decoratively written on walls and provided triggers for conversation, reflection and reminiscence.
•□The garden was enclosed, easy to access and had covered and uncovered areas to sit. Amongst the plants and on the fences and sheds were items providing visual stimulation; colourful garden bunting, garden lights and ornamental windmills.

Ensuring consent to care and treatment in line with law and guidance.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•□DoLS applications had been appropriately submitted to the local authority (the supervisory body). There were no conditions applied to those which had been authorised.
•□People's mental capacity to make particular decisions had been assessed; fully completed mental capacity assessments were seen completed.
•□Best interests decisions were recorded; a record held of the decision to be made, the outcome of the

decision and who was involved in the decision making. This process had included people's legal representative/s and involved health and social care professionals.

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Outstanding: People were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; respecting equality and diversity.
•There was an exceptionally strong and embedded person-centred culture; rigid routines and task-led working did not exist.
•The home followed a model of dementia care called the 'Butterfly Approach'. One of the core values being 'Feelings matter first'; not only did people matter but they were supported to 'feel' as if they mattered. The registered manager told us "We nurture people."
•This nurturing and inclusive culture had a direct impact on people's quality of life. It supported those who had difficulty in, remaining connected with their surroundings, connected with the people around and whose perception of the world around them could at times, cause them distress.
•One person told us how they had felt after leaving their own home and needing to be cared for. They said, "When I first came in here it was horrible but now they [staff] have got to know me and I have got to know them it's okay and they always find the time to talk to me."
•Staff worked in a flexible and relaxed way around people's individual routines, needs and preferences. The home was managed in such a way to achieve this; staff were rostered according to need, they worked as one team and supported each other and they took their breaks when it best suited the people.
•One family member confirmed their relative's choices were respected. On one day of the inspection their relative was not up at the usual time. They said, "If they don't have a particularly good night [which had been their relative's experience] they are able to have a lie in."
•People were treated equally. We observed, without exception, staff to be consistently thoughtful, caring and compassionate towards people, irrespective of age, disability, mood or behaviour, gender or personal beliefs.
•The registered manager explained that all staff were recruited and supported, in such a way, to develop a team with the skills and emotional ability to support those who lived with dementia. Referred to in the model of care as having 'Emotional Intelligence'. One member of staff said, "We know each other's strengths and weaknesses because we talk about these and we support each other." Another member of staff said, "I can't come to work, which is in other people's home, if I'm feeling upset or stressed. I had to learn ways of leaving this behind."
•People and staff lived and worked as one 'household'; everyone's contribution and presence was valued. A member of staff said, "People have a richness in what they can offer."
•Staff were highly motivated to learn about the 'individual' who lived with dementia. Time and effort went into gathering detailed information about people's life histories, who and what was important to them and learning about their core values and beliefs.
•This knowledge was used to help staff make meaningful connections with people and to build positive relationships. We observed, what were clearly well developed, relaxed and trusting relationships between

people and staff.
•□One person's mood was fluctuating between being settled and unsettled and the staff were very aware of this. The person requested a hug from a member of staff who provided this. There was a visible settling down of the person's mood, which was seen in a smile and a repositioning of their body to make themselves comfortable.
•□We witnessed the use of terms of endearment such as "alright lovely" and "okay sweetheart". The registered manager told us that an appropriately used physical connection and the use of terms of endearment, with the right person, can provide an acknowledgement that they are loved and cared for.
•□People experienced periods of illbeing (exhibited by confusion, disturbances in perception, anxiety, distress) which were responded to quickly and effectively by the staff.
•□Some people were prescribed medicines which could be administered 'when required' to reduce their illbeing. Medicine records showed limited use of these. The registered manager explained that people's illbeing was often successfully reduced through the application of person-centred care, skilful nurturing and staffs' abilities to connect with people. Records showed that the home had very few incidents of challenging behaviour.
•□One person experienced sun downing (late-day confusion); exhibited through heightened confusion, anxiety and pacing. We spoke with two staff about how the staff team supported this person during these times. Staff knew the person's pattern of behaviour, the triggers for distress and when to provide support and when to give them space. When we observed this pattern of behaviour starting we spoke with staff who, as they said, were "already tuned into" the person's feelings and reactions to things around them. This person's periods of illbeing were managed successfully by using the approach described above.
•□A comment made by a member of staff, about how this person was when they were in a state of wellbeing, summed up the level of understanding, connection and appreciation staff had of people. They said, "When you are with [name] you can feel an extraordinary peacefulness from them."
•□In understanding people, staff were very aware, that although people lived as members of the 'household' and, with dementia, they were usually, still the other half of a marriage, civil partnership or other significant relationship. Staff provided support to both people, their spouses, partners and other significant people to help maintain their relationships.
•□People's relatives and visitors were made to feel very welcomed and included. At special times of the year (and at other times) those close to people were welcomed and included in meals, activities and other celebrations.
•□Sometimes, people had been left with feelings of loss [grief] when it had not been possible to maintain close relationships, but without the ability to remember why. Staff were exceptionally understanding, kind and compassionate in the way they supported these people. We observed staff exhibiting these qualities when taking time to talk with people who experienced these feelings. In one person's case, staff made time, at the time it was needed, to 'just be with' the person and help navigate them through the emotions they experienced.
•□Extra thought and consideration went into reducing triggers which may cause distress. Simple things such as the sound of a front door bell, could potentially trigger feelings of anticipation or distress in a person who may be looking for someone they know or knew. At Queensbridge House the doorbell sound had been removed and replaced with a burst of jazz music, which people did not connect with someone being at the front door.

Supporting people to express their views and be involved in making decisions about their care.
•□Staff were present and available to give explanations and support to people to enable them to express their views to make simple daily decisions.
•□One person's ability to verbally communicate; to find the right words, had been made more difficult by their dementia. We saw that it took time and patience to connect with this person and to help them express

themselves. We observed one member of staff lower themselves to their knees when this very frail looking person approached them. This enabled better eye contact and presented a less threatening figure. The member of staff tenderly took hold of the person's hands, which the person offered to them. The topic of conversation was what the person was going to have for lunch. Although what was verbally said by the person was disjointed to the listener, it was obvious from the person's body language and facial expression, that they, felt nurtured and cared for by the way the member of staff had interacted with them. We later observed this person being provided with two visual food options to help them decide, what is was they wanted to eat.

•□Barriers to communication and developing relationships had been removed, for example, staff did not wear uniforms; any visual association with authority was dispelled. Staff had the freedom to wear clothing they felt comfortable in and which was colourful and fun.

•□To help initiate conversation with people one member of staff had drawn cartoon characters on the equipment they used at work. They said, "They help to open up conversation, act as an ice-breaker, people find them funny and start to talk to me about them." This had been the case when they had first met a person who was new to the home. On a subsequent day they had found the person to be tearful. The person remembered (through the images) that they had met the staff member before and felt comfortable enough to share with them, why they felt sad.

•□The staff member told us they felt confident and able to support this person because, whatever role a staff member had within the team, they had the same aim and were given the same support, to be able to care for and nurture people. They said, "The way [name of registered manager] runs the home enables us to be ourselves with people and to spend time with them."

•□Where people were unable to express their feelings verbally staff used the Cornell Scale for Depression. This tool helped staff to review other signs which may indicate possible depression in an elderly person who lives with dementia. For example, mood or behavioural changes, changes in day and night routine and physical changes such as loss of energy or appetite.

•□People who could make decisions, but who required support to do this, were supported by the staff but also by the involvement of the person's legal representative/s or an independent advocate if needed.

Respecting and promoting people's privacy, dignity and independence.

•□People's dignity was supported exceptionally well in the effort staff made to find out what people's choices were and how they ensured these were met. Choices, which helped to maintain quality of life; choices about what to eat, drink, wear and how to socialise.

•□Dignity was maintained by addressing people in their preferred way; terms of endearment only being used when it was preferred by the person or was a recognised way of helping a person feel loved.

•□People's privacy and their right to private family life was respected. Staff knocked on people's front doors before entering. There were no visiting restrictions (unless part of a best interest decision to safeguard a person) and people could see their visitors in private.

•□A sense of self-worth and achievement was promoted and supported by the staff which helped people to retain their dignity.

•□People's independence was supported by helping people retain simple skills; washing and dressing, independently eating and drinking, walking, socialising and finding and using the toilet independently. One relative said, "It can take [relative] up to two hours to eat her food but nobody worries about it they [staff] let her get on with it, she hates someone trying to help."

•□The 'Breakfast Club' was a good example of this in practice. A designated member of staff supported those who could do so to prepare their own breakfast; use the toaster, spread their own butter and marmalade and get their own cereal. Breakfast time was used as another opportunity for positive and meaningful interaction with people.

•□People had access to the kitchen as they would have had in their own homes. They were supported to

wash up and sometimes to bake. Again, the activity itself, the smells and conversations all used to help people feel involved, connected and to safely reminisce.

•□Sometimes it required vigilance and understanding from the staff to see what was needed to help maintain a person's independence. Simple changes sometimes made all the difference for some people. Changing or adding signage or defining certain areas or fixtures by colour helped; adding a coloured toilet seat to a white toilet base.

•□At one mealtime one person was having difficulty in picking up a white china tea cup which sat on a white saucer. The member of staff offered to get a fresh cup of tea, which came in a red patterned tea-cup on a white saucer. This had been deliberately altered so the person could differentiate the cup from the saucer; they drank independently without difficulty.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

At the last inspection on 26 and 27 October 2017, we asked the provider to take action to improve the content of people's care plans and other relevant care records. This was so that care records reflected the support people required, the support they had received, and so staff were provided with updated guidance about people's care. During this inspection we found this action had been completed and the service met the legal requirements.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

- People's care records were detailed and up to date. They gave clear information and guidance to staff on how to meet people's needs. For example, detail about how to meet people's choking risks and what care is required to prevent skin damage and falls.
- Care plans included information gathered about people's life histories, family involvement and personal beliefs, resulting in very personalised and tailored care plans.
- The Alzheimer's Society document "This is me" provided additional information to support person-centred care, by giving detail about people's culture and family backgrounds, preferences and preferred routines and what was important to them. Families had been involved in completing these.
- The information we read about people's care reflected the care and support we observed being provided to people.
- These records had been reviewed and amended at regular intervals as well as when needs or circumstances altered. This kept information about people's care needs up to date so inappropriate and unsafe care was avoided.
- Electronic devices had been introduced for staff to record the care they had provided. One member of staff said, "So easy, you just record it straight after doing it, you don't have to make notes to refer to later." Care plans were also in the process of being transferred to the electronic system.
- People and their representatives were 'partners in care' and their involvement in planning and reviewing care was integral to the delivery of person-centred care. How this was achieved in practice varied according to people's abilities and relatives' desire to be involved. One relative said, "Yes I do get involved in updating her care plan" and another said, "Yes we always get involved in his care plan, they're revised every six weeks and we always have a say." Another relative told us they could be involved but the process would worry them. They said, "I have blind faith in the staff here."
- Relatives we spoke with, either way, were very aware of how their relatives care was delivered and were very involved in supporting people's wellbeing.
- The registered manager was aware of the Accessible Information Standards. Information about how people communicated and needed information given to them was recorded in their communication care plan. These flagged up needs related to culture, language, disability and sensory loss. One person's care plan gave detail about their hearing loss and how best to manage this, information about their dialect and their pattern of conversation had been included. It advised staff to use closed questions and to make

physical contact by holding the person's hands which gave the person reassurance.
•□Knowledge of people's life interests, their hobbies and social preferences helped staff to involve people in social activities. One member of staff said, "It's really important to get in there and find out what makes them tick; building on who they were helps."
•□The home had five staff who had dedicated time and skills to support social activities throughout the week and at weekends. One member of staff said, "It's about having fun. I scrape an activity if people are not enjoying it and together [people and member of staff], we find something that they do enjoy."
•□Many people benefited from one to one activities which we saw staff supporting them with throughout the inspection.
•□Organising time to support people with social activities was viewed as being as important as supporting people with their personal care needs. Activities were used to build self- confidence, retain skills, avoid loneliness and give quality of life.
•□We observed people being included in games and conversations which they clearly enjoyed and were fully engaged in. At times we observed healthy competitiveness.
•□People's engagement in the activities was evaluated. One member of staff explained, "They have to be meaningful to people."
•□The home's flexible way of working allowed other staff to support people's one to one activities which potentially required more supervision to keep people safe, such as going for a walk or visiting local parks or shops.

Improving care quality in response to complaints or concerns.
•□The registered manager explained they did not receive many complaints and the Provider Information Return (PIR) confirmed that one complaint had been received in the last year. Decisions were made following this complaint that staff would intervene, in decisions made about how to support a person's health, if in the person's best interests, it was necessary to do so.
•□The registered manager was approachable and visible to people. They kept communication channels open with their representatives, so any areas of dissatisfaction could be addressed immediately. Relatives felt able to talk with them about anything. One relative had expressed dissatisfaction about the return of incorrect laundry to their relative; they confirmed this was sorted out immediately. Another relative said, "If I had a problem I would speak with [name of registered manager]." Another relative said, "I have never needed to complain."

End of life care and support.
•□People's end of life wishes had been explored with them or with their relatives (where people and relatives had been willing to discuss these). Staff were aware of what these were so these could be met at the appropriate time.
•□There were good working relationships in place, with the right community health care professionals, to support a comfortable and dignified death. For example, GPs to review people's medical and medicine needs, pharmacist support to supply medicines when required and community nurses to support and advise staff.
•□The home had access to support people's diverse spiritual needs.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At the last inspection on 26 and 27 October 2017, we found improvements had been made to how the provider monitored the service. However, improvements needed to people's care records had not been identified. We asked the provider to continue making improvements to their quality monitoring systems to ensure these requirements were met. During this inspection we found this action had been completed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Since the last inspection there had been a change of home manager. The previous deputy manager had become the registered manager of the service in August 2017.
- They were fully aware of their responsibilities in maintaining compliance with necessary regulations, in ensuring statutory notifications were submitted to the Care Quality Commission (CQC) and displaying the service's rating awarded by the CQC.
- They were supported by the previous registered manager who had provided mentorship and who now played a key role in supporting other staff.
- One of the company's Directors (the Nominated Individual – NI) visited the home on a regular basis to complete their own monitoring checks and to provide support. They followed up on completed actions from audits and reviewed other service improvements. They provided business support and leadership to the registered manager; supporting but also monitoring, for example the use of agency staff and other expenditure.
- The registered manager had regular contact with the NI in-between these visits and kept them well informed of events and the services progress.
- The registered manager told us they felt well supported and they said, "There is no problem in accessing what is needed."
- All senior managers contributed to the quality monitoring of the service. We reviewed a selection of quality audits completed by the home managers. These were completed in line with the provider's quality monitoring program and identified areas for compliance and any required improvement. Since the last inspection an audit on all statutory notifications had been introduced to ensure the correct information was shared with the CQC.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- The provider understood and supported the adopted model of care, the 'Butterfly Approach'.
- An observational tool was used by the provider to assess and measure how embedded person-centred care was, by observing the quality of staffs' interactions with people. The aim was for all staff interactions

(with people) to be meaningful to the person, for it to add value to any given moment a member of staff is with a person and for it to promote a positive outcome. Staff were expected to be active participants in their relationships with people and to add to a person's wellbeing and quality of life.

•□The registered manager kept the day to day culture of the service under review ensuring staffs' values, attitudes and behaviour were in line with the requirements of the 'Butterfly Approach'.

•□Managers worked alongside staff and were seen by them [the staff] as very much part of the working team.

•□They provided support to the staff so they felt positive about their abilities and proud of their work. One member of staff said, "I feel privileged to be working here" and another said, "I feel really blessed doing this job and I will stay doing this until I can't do it anymore." Staff told us they felt valued by the managers.

•□Duty of Candour was understood and met. Managers promoted a culture of openness, transparency and honesty within the staff team. This also applied to discussions had with people or their representatives, about care and treatment, accidents and incidents or near misses which occurred and had an impact people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

•□Simple feedback, was sought from people who lived with dementia, on an informal basis during conversations with them. For example, "What did you think of lunch?" and "Did you enjoy that?" (following an activity).

•□Relatives felt able to provide feedback. One relative told us the registered manager was "Very approachable", they said, "Her door is always open, she has become a friend." Another relative said, "The manager is smashing… she is always there to talk to you, her door is never shut and the same with the staff, they're very good."

•□A relative forum, for discussing things and providing feedback had always existed but was now being held on a regular basis (every quarter). One relative said, "We couldn't get to the last meeting but we will go to the next one" and another set of relatives were aware of the forum and said, "They are going to have them more often now and we will be going to them."

•□Staff had regular staff meetings to discuss issues and receive information on, for example, quality matters and any proposed changes. They also met daily to handover information about people's care. These meetings were also opportunities for them to feedback to managers any concerns or ideas. Staff told us they felt included and informed about decisions made in the home, and in any problem solving which needed to take place. They told us they felt their input was appreciated by the registered manager.

Continuous learning and improving care.

•□Managers used reflective sessions to support continuous learning.

•□Feedback was acknowledged by the managers who acted on this to improve the service. This was seen in how actions had been devised following the last inspection to meet shortfalls identified at that time.

Working in partnership with others.

•□Managers worked closely with and shared relevant information with health and social care professionals to ensure people could access the support they required.

•□The registered manager worked well with hospital staff, social workers and people representatives to ensure pre-admission assessments were completed swiftly, so people could access the support they needed.

•□Staff worked with external agencies, other professionals and companies to source the support equipment needed by people.

•□Links had been made with local churches so that people's religious beliefs were supported. Attempt to

make links with a local school had not yet resulted in establishing a beneficial relationship but the registered manager was going to continue working on this.