N. Notaro Homes Limited

Stuart House

Inspection report

21-23 Clevedon Road
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Somerset
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Tel: 01934429086

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Stuart House on 9 January 2017.

Stuart House is situated in Weston-super-mare, Somerset and one of the 11 services provided by N. Notaro Homes Limited. Stuart House is located within walking distance of the town and seafront in a quiet residential area. The home is registered to provide residential care for twenty one older people living with dementia, however the provider uses the double bedrooms as singles for a maximum of 19 people. The home also cared for older people living with mental health issues such as Korsakoff's syndrome (alcohol related brain damage). At the time of the inspection 17 people were living at Stuart House with another person receiving temporary respite care. People were also able to book in for day care.

The last inspection was carried out in July 2014 and we found the service to be compliant with the standards we inspected and meeting all the legal requirements in relation to the regulations.

At this inspection we found the service was still meeting all regulatory requirements and did not identify any concerns with the care provided to people living at the home.

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

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. People were able to choose what they wanted to do and enjoyed spending time with the staff who were visible and attentive. People were encouraged and supported to maintain their independence.

There was a sense of purpose as people engaged with staff, watched what was going on, played games and pottered around the home or went out. The majority of people were living with dementia and were independently mobile. Staff engaged with them in ways which reflected people's individual needs and understanding.

People said the home was a safe place for them to live. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. People said they would speak with staff if they had any concerns and seemed happy to go over to staff and indicate if they needed any assistance.

Staff were vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia. People and relatives knew how to make a formal complaint if they needed to but felt that issues

would usually be resolved informally. One person said "I don't have any problems, the manager and all the staff are lovely. "

People were well cared for and were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to choose. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on. Staff were present with family when the care planning was discussed, for example some people living with dementia were able to say if they would like a key to their room or not and have input into activities they liked to do. For example, one person liked to go for a swim and told us about how they enjoyed doing that to alleviate their aches and pains.

There were regular reviews of people's health, and staff responded promptly to changes in need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Medicines were well managed and stored in line with national guidance. The home used a new computer medication administration system. Therefore, electronic records were completed with no gaps, with on screen alerts highlighting medication due to be given. There were regular audits of medication records and administration and to ensure the correct medication stock levels were in place.

Staff had good knowledge of people, including their needs and preferences. Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. Comments about staff included, "They are so nice. I had bad rheumatism once and went to lie down. They came and checked on me. They really care" and "The staff are nice. They help me go for a walk when I want."

People's privacy was respected. Staff ensured people kept in touch with family and friends. One relative told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private. For example, if a person did not want to go to their room a privacy screen was used in the communal area to maintain privacy but also reduce distress from moving. We saw how staff positively supported relatives, especially where the behaviour of the person living at the home could be challenging due to their dementia, reassuring the relatives and discussing positive aspects of the person's day.

People were provided with a variety of opportunities for activities and trips. These were individual as well as group organised activities, such as a trip to the shops, putting up Christmas decorations, arts and crafts or simple board games. People could choose to take part if they wished. Staff also used subtle ways to promote independence such as asking people to pick up their drink from the trolley to ensure some movement. Activities were not only organised events such as trips out and external entertainers but on-going day to day activities. For example, there was always something for people to do for stimulation such as chatting with staff, playing games, looking at books, household chores or just tidying or moving things. People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people walked around touching and moving things in a purposeful way. Staff were always visible to interact or sit with people. One care plan said, "[Person's name] likes one to one with staff so take time to sit with them every day." This person was playing dominoes with a care worker during the inspection.

The registered manager showed great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people in individualised ways. Some staff had returned from working elsewhere because they missed working at the home. Other staff had worked at the home for many years and all comments were positive. They included,

"It's lovely here, there is a lovely feel. We do a good job looking after people so I love my job" and "We get to know people well. It's nice to see them doing well. We work well as a team and [registered manager's name] is great. That's why we stay." Recent thank you cards from relatives stated, "Both my [parents] settled in quickly and it was a great joy to see [person's name]'s face would light up and tears of happiness filled their eyes when they spent time with the genuinely warm, compassionate and happy carers and staff of Stuart House. [Person's name]'s wit and playfulness could be engaged even at the end of their life. We are indebted and extremely grateful to you all."

There were effective quality assurance processes in place to monitor care and plan on-going improvements overseen by regular provider audits. There were systems in place to share information and seek people's views about the running of the home, including relatives and stakeholders. People's views were acted upon where possible and practical, and included those living with dementia. Their views were valued and they were able to have meaningful input into the running of the home which mattered to them. For example, some people said some of the chairs in the lounge needed replacing and these were ordered.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. We checked whether the service was working within the principles of the MCA. We found that the provider had followed the requirements in DoLS authorisations and related assessments and decisions had been appropriately taken.

Staff spoke positively about the training available. We saw all the staff had completed an induction programme and on-going training was provided to ensure skills and knowledge were up to date. Staff confirmed they received supervision with their line manager, which along with the completion of team meetings, meant they were supported in their roles. Care plans were individualised and comprehensive ensuring staff had up to date information in order to meet people's individual needs effectively.

Observations of meal times showed these to be a positive experience, with people being supported to eat a meal of their choice where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with who. The registered manager also encouraged staff to take their meals with people regularly. We saw nutritional assessments were in place and special dietary needs catered for.

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 were protected from the risk of harm or abuse.

People were supported with their medicines in a safe way by staff who had appropriate training and knowledge.

Risks were identified and actions taken to manage risk and maintain people's safety whilst also promoting people's independence.

Is the service effective?

Good

The service was effective.

People and/or their representatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

People benefitted from clean, well maintained and equipped accommodation.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

People and/or their representatives were confident their wishes related to end of life care would be followed.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which was responsive to their changing needs including their social and leisure needs.

People made choices about aspects of their day to day lives.

People and/or their representatives were involved in planning and reviewing their care.

People and/or their representatives shared their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Good

The service was well led.

People benefitted from effective quality assurance systems to make sure areas for improvement were identified and addressed in a timely way.

There was an honest and open culture within the staff team, and they felt well supported.

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

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Stuart House

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 was 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 9 January 2017. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by one adult social care inspector.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home.

At the last inspection carried out on 24 July 2014 we did not identify any concerns with the care provided to people who lived at the home.

At the time of this inspection 17 people were living at Stuart House with another person receiving temporary respite care. We spent time with 10 people using the service and one relative. As most people were unable to comment directly on their experience of the service due to living with dementia, we spent time observing care in the communal areas and took lunch with people. We also spoke with the registered manager, the administrator, the provider quality performance manager, senior care worker and four care workers and a domestic. We looked at a sample of records relating to the running of the home and to the care of individuals, such as medication records, three staff files, quality assurance documentation, audits and four individual care plans.

Good

Is the service safe?

Our findings

The service was safe. One person said, "Oh yes, it's lovely here. A real home." One relative said, "It's very homely. We all come and visit, there's no worry on our side." Most people at the home chose to spend their time in the communal areas, the lounge diner, conservatory and main dining/activity room with open access to the secure garden. These areas were clean, comfortable and well furnished with attractive décor in a homely way. There were areas of interest for people living with dementia to investigate, which helped to minimise frustrations associated with living with dementia such as sensory fabrics and pictures. Rooms were bright and airy, many having been repainted along with the corridor areas, in colours people chose to make them brighter. The ground floor corridor was painted in a garden mural with a washing line showing photos of the staff team for people to recognise. There was a garden bench, butterfly ornaments and birds. A small bookcase area was used by people who preferred a quiet area. The registered manager had ensured people, especially those living with dementia, had various areas to move around with seating at intervals. Accessed by stairs or a lift, the landing offered a circular walk which is good practice for people living with dementia, in order to avoid 'dead ends'. The home was having plain, new flooring throughout the stairways and landings, which is also good practice because patterned flooring could be confusing for people living with dementia.

There were five bedrooms on the ground floor for those who were less mobile, a toilet, toilet/shower room and an assisted bath. All the rooms were decorated in a pleasant way. People had fresh laundry and bedding, and well equipped rooms full of their personals items. We could see that people's rooms and possessions were valued and cared for. There was a newly refurbished laundry room. Areas used for storage had been organised and locked, keeping substances hazardous to health safe. People showed us around their rooms and were proud of the environment, saying they felt safe at home and happy. Other people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other.

The environment had been risk assessed and actions taken, for example radiator covers and window restrictors were in place, and there were no trip hazards. Legionella water checks were up to date. Staff had received regular fire safety instructions and fire drills from an external qualified instructor. All care plans contained individual person evacuation plans (PEEPS) which included details about people's communication needs and mobility. These plans would enable staff to keep people safe in an emergency. Copies were also kept in a 'grab bag' for use by the emergency services.

All accidents and incidents which occurred in the home were recorded and analysed, and action taken to learn from them. For example, where people had fallen risk assessments were reviewed and preventative measures taken, including continuing to promote movement to maintain mobility. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The registered manager and provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. Staff had received training in safeguarding adults. They had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action

would be taken to make sure people were safe. The registered manager had informed us of any safeguarding incidents and these had been dealt with appropriately involving the local safeguarding team. Relatives said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any; they felt they would be listened to and action would be taken to address any issues raised.

Staff encouraged and supported people to maintain their independence. Most people were able to move independently, or with prompting and staff support. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help. There were risk assessments which identified risks and the control measures to minimise risk. The balance between people's safety and their freedom and choice was well managed. For example, one care plan noted that one person was reluctant to mobilise, although they could. To maintain their independence and mobility staff used subtle ways to promote movement, such as offering drinks and medication from the trolleys rather than walking to the person. Where there was a history of alcohol abuse, the care plans were clear about rehabilitation/treatment plans devised with the person for their benefit in liason with external health professionals. Care plans were very detailed about risks relating to self-neglect showing how staff could encourage a person to accept personal care using methods that the person responded to such as running a bubble bath, prompting to fill the washing basket and distraction. Where people didn't want to accept personal care, usually due to their mental health needs, staff were patient and returned later. We saw this happening but staff did not always change the daily records to reflect this. The registered manager said they would raise this and ensure records showed the return visit to provide care. People looked well cared for.

Care staff ensured they prompted people to dress themselves and assisted with putting on clothes in the right order. People were wearing appropriate clothes for the weather. On the day of the inspection it was pouring with rain. Staff ensured people had their coats on and warm clothes and the home was warm and comfortable. Staff ensured people were happy with their choices to prevent behaviours which could be challenging for staff and distressing for people. For example, one person wanted to 'borrow' their best friend's coat and this was facilitated sensitively to avoid conflict.

Risk assessments and actions for staff to take were included to minimise risks related to pressure area skin damage, falls and nutrition. Where people required pressure relieving equipment to maintain their skin integrity, staff ensured the equipment, like cushions, went with them when they moved. One person wore a pressure relieving boot. No-one at the home had any pressure damage or was being nursed in bed. Care plans showed staff checked people's skin integrity regularly. Records contained risk assessments stating where people were unable to use their call bells and how staff were to manage this, for example with regular checks. Night care plans detailed when people required regular night checks and described how to encourage a regular sleep pattern. For example, one person would settle in bed if they were shown their room and given tea and supper in their room. Risk assessments showed clear decision making for door alarms which would indicate to staff if a person with limited mobility was mobilising around their room.

Where people were at risk of recurrent urine infections, which could affect their mobility, dementia and cognition, staff were vigilant in sending samples off for testing and ensuring the person had appropriate treatment to keep them safe.

Staff files showed that the relevant checks had taken place before a staff member commenced their employment. This included criminal record checks (DBS), gaps in employment and at least two references, including their previous employer. This was to make sure potential new staff were safe to work with vulnerable people.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. During our inspection there was the registered manager, administrator, senior care worker and two care workers supported by a domestic and laundry/housekeeper. Staffing numbers were determined by using a dependency tool, this was a tool that looked at staffing levels relating to people's needs, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell, to assist with outings or if a person was nearing the end of their life. Staff attendance was monitored using a new computer 'clock in' time and attendence system. We saw that people received care and support in a timely manner. All meals were delivered on a hot trolley ready for dishing up from the provider's home next door therefore there was no cook at Stuart House, although staff could use the kitchen and kitchenette to make drinks and snacks.

Staff were attentive to people's needs. For example, one person became anxious in the lounge and staff discreetly assisted them. They ensured they prompted people to the bathrooms regularly to manage people's continence effectively.

All staff who gave medicines were trained and had their competency assessed before they were able to do so. The home used a new computer system to manage medication administration. This ensured only staff with the password could administer medication. The system highlighted who was due medication and when, and alerted staff to medication changes, new medication and medication due. Medication prescribed 'as required' was monitored. For example, staff recorded if a medication given 'as required' had worked, such as paracetamol for pain. Medicines entering the home from the local dispensing pharmacy were recorded when received. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. The system also enabled staff to look up information about each drug, which was live and up to date. A medication handover form enabled staff to share information with other staff, such as if stocks were low or a person needed a medication review.

We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines and undisturbed during the medication rounds. Medication competency was included in staff supervisions, with the registered manager observing medication rounds. Staff explained to people what their medicines were for and ensured each person had taken them before signing the medication record. The care worker stayed with one person whilst they took their medication at their own pace. Medicines were thoroughly audited by the registered manager and there had been an external audit by the local pharmacy provider. Night staff also carried out random stock 'spot checks'. A medicine fridge was available for medicines which needed to be stored at a low temperature such as eye drops and insulin. Staff could monitor the use of medication 'patches' using individual rotational medication patch forms. There was secure storage available for medication legally required to be more 'controlled' and recorded. The home was not using medication of this type at the time of this inspection.

Good

Is the service effective?

Our findings

There was a stable staff team at the home who had a good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. Relatives spoke positively of the staff who worked in the home. Comments about staff included, "They are lovely ladies, thank you for making [person's name]'s life as good as possible" and, "A lovely care home with wonderful staff." One relative had written in a thank you card, "Special thanks to [staff members names] who formed a bond and visited them so often in hospital." Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes. For example, one person who could display aggression due to their condition, liked to help out with chores. Staff facilitated this safely, asking the person if they minded passing a cushion or helping with the drinks trolley, so they felt useful and occupied in the way they enjoyed. People and their relatives really appreciated the care they received at Stuart House.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. The provider offered a wide range of topics through their head office who emailed staff training courses to choose. The quality performance manager also highlighted a different topic for discussion in staff meetings. This month it was 'The importance of good record keeping'. A number of staff had attained a National Vocational Qualification (NVQ) and were encouraged to develop professionally. Two staff had applied to attend a nationally acclaimed dementia care course successfully. As a result of dementia care training the registered manager and staff had ensured each area of the home had items for conversation and stimulation, which is good practice when caring for people living with dementia. There was a training programme to make sure staff training was kept up to date and refreshed. Where there were gaps, training had been booked. Training desired by the provider included safeguarding, manual handling, fire, infection control, health and safety and food hygiene. The registered manager also sought additional resources and training which may be relevant to people's current needs. For example, staff had information about specific needs in relation to Korsakoff's syndrome, a mental health condition related to alcohol abuse and brain damage. They were able to tell us how they managed a particular person's alcohol use effectively with input from the community mental health team. For example, they had listened to the person's anxieties and were enabling the person to discuss their fears using a dream diary, so the person knew they could talk to staff at any time.

There were 24 staff employed at the service. Policies and procedures were accessible to staff who signed to say they had read them. New staff had a six month probation period. There was a clear induction programme for new staff in line with nationally recommended standards. The home used the Care Certificate documentation. These are nationally recognised resources which give guidance in how to achieve a good standard of care in a range of topics. A new induction programme included five days initially in the classroom, followed by a week working with more experienced staff for a period until each new staff member felt confident to work independently. This time varied with each individual, and was monitored using regular supervision. . Other training included end of life care, confidentiality and dementia care.

Staff said they liked working at the home and felt they could say if there was an area of training they were

interested in. Staff received regular one to one supervision sessions. This enabled staff to discuss career and training needs, any issues and for the registered manager or deputy to assess competency. One supervision record showed how an area for improvement had been highlighted and was being monitored to ensure the care given was effective and safe with appropriate disciplinary processes.

People had access to health care professionals to meet their specific needs. Records showed people attended appointments with GPs, dentists, chiropodists, district nurses and speech and language therapists. People said staff made sure they saw the relevant professional if they were unwell. These visits were recorded in people's care plans and clearly showed issues were identified, treatment and action taken and on-going health monitored. For example, one person had seen their GP for a possible eye infection in a timely way. Staff also initiated full medication reviews for people, especially those admitted with lots of medications. This showed staff were pro-active in ensuring people were only taking essential medication to maintain their wellbeing.

Most people who lived in the home were not able to choose what care or treatment they received. The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. We saw many records showing how the staff ensured best interest decisions were made in line with the MCA. For example, there was discussion with an independent mental capacity advocate (IMCA) about the needs of a person without any next of kin. This meant the home helped people to access independent people to support those who needed it. There was close liason with the community mental health team around restricting alcohol in a managed, sensitive way, or covertly enriching foods for some people at high risk of declining to eat. For these people there had been very positive outcomes. Staff spoke about how good it was to see these people progress and improve their quality of life, whilst being involved and happy with the decisions made. There were best interest decisions made and clearly recorded relating to people at high risk of self-neglect. For example, one method of locking the person's bedroom door when preparing a bath to coax them to the bathroom was working, with regular reviews and discussion with health professionals.

People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The majority of people required some restrictions to be in place to keep them safe. The registered manager had made appropriate applications to the local authority to deprive people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the MCA. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the people's advocates. Staff were aware of the implications for people's care and care plans showed details about how to minimise people's distress, for example if they wanted to leave but were confused due to their dementia. They knew what people liked to do and how to manage these situations with distractions. One person no longer displayed distress and had settled in well.

The provider and registered manager kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. For example, decisions about use of restrictions such as bed rails and door alarms had been made in people's best interests with their representative or health professionals.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Care plans included nationally recognised nutritional assessment tools to ensure staff knew who was at high risk and what action to take. For example, one person who needed prompting to drink had daily records in their care file stating, "Each time [person's name] woke up we encouraged them to have a few sips." Staff said each care worker was responsible for ensuring a person had their breakfast when they wanted, in bed or in the dining room. Some people had early breakfasts and then another one later on, for example. Staff told us, and care records showed, that appropriate health professionals had been contacted to make sure people received effective treatment. This showed staff knew who to contact if a person was finding eating difficult. People at the home during this inspection had normal or enriched diets, with one person being diabetic.

Stuart House had a kitchen and kitchenette for people and relatives to use but did not provide the catering in general, other than simple snacks available at any time. Meals were delivered using a hot trolley from one of the provider's homes next door. This included hot breakfasts. People's individual nutritional needs were shared with all staff and with the kitchen staff next door.

Everyone we spoke with was happy with the food and drinks provided in the home. Comments included, "I like the food, it's tasty" and "Yes, I like that, I don't cook it." Relatives said they were happy with the food and that they could be included too if they wanted to stay for a meal. We took lunch with nine people being served in the lounge/dining room. Some people chose to eat in the main dining area or in their rooms. On the menu was chicken sweet and sour and rice or mashed potatoes, or a veggie burger, with sponge pudding and custard or ice cream for dessert. Other people who were more reluctant to eat were able to snack during the day. Sand snacks and drinks were available on a snack table in the lounge for people to help themselves. People sat at tables which were nicely laid and each had condiments for people to use. People chose meals in advance and were offered a choice of two meals on the day. A picture of the food was displayed on the notice board to assist choice.

Throughout lunch people were treated with respect and dignity. All staff came together to serve the meal. There was friendly banter between people, and staff knew which people got on with others and who preferred quiet time.People were offered their choice of drinks. They were not rushed but food was served in a timely way. One person was always more anxious about meal times so staff sat with them. Another person's care plan stated the person would always say no when offered food as they had a negative history with eating. We saw staff give the person their meal with no comment and the person carried on and ate it all. This staff knowledge all helped to make lunchtime a pleasant, sociable event.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home, and people had individual walking aids, wheelchairs, assisted baths or adapted seating to support their mobility. The garden was well maintained, level and secure and had nice seating areas.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. For example, one person had very limited comprehension. We saw staff trying to engage with them using gentle touch as they had their head on the table. Staff interacted well with people, touching, reassuring and complimenting people as they passed. They knew people's 'little ways' and used information detailed in care files to facilitate conversation. The registered manager had further encouraged conversation between people and staff by adding a hairdressers chair and mirror to an area on the landing. Staff could use hair accessories and other hair equipment to ensure people had an enjoyable experience getting ready in the mornings. This was now a place for people to have a chat with staff whilst having their hair done. People we spoke with said they thought all the staff were caring saying, "I like them all" and, "They [the staff] make it a real home for me."

Throughout the day we saw staff interacting with people in a caring and professional way. There was a good rapport between people; they chatted happily between themselves and with staff. Some people liked to use the quieter dining room where people were more able to chat. Staff ensured they checked the television showed people's preferences correctly and asked people if they would like a drink or a snack. At tea time people enjoyed smoothies and homemade cake with staff.

When staff assisted people they explained what they were doing first and reassured people. One person said how attentive the staff were. They had gone for a lie down and staff had regularly popped in to check on them. Staff told us how they managed people with irregular sleep patterns. They followed individualised methods documented in their care files. For example, if people got up very early staff assisted them at any time getting dressed and offering them tea to avoid distress. Night care plans detailed how people settled to go to bed. For example, ensuring particular lights were on or the door left open as the person wished. Staff also promoted a sense of evening and night time to help orient people living with dementia. Staff did not wear uniforms but did have name badges and wore night clothes during the night shift.

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their continence. A clear plan in one person's care file ensured staff prompted the person to the bathroom during the night and the use of inappropriate areas as the bathroom had reduced. Continence aids were stored discreetly. Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. Staff spoke about people in a respectful way and were clearly fond of the people they cared for. They told us how the work was challenging at times but they felt rewarded when people's quality of life improved since they had moved to the home. The registered manager operated a 'Star for the Day' award for people living at the home ensuring each person, regardless of whether they had visitors, was made to feel special. People were assisted to choose a special treat or something they wanted to do. All staff were involved in making each person's day special.

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Most people were not able to tell us about their choices directly due to their dementia. Care plans contained people's preferences which gave staff a basis to work with. Staff said they could update care plans as they

learnt more about people. All staff had access and input to the care plans, which meant the information about people's support remained current. For example, one person's care plan said they took time to answer and respond. This meant staff ensured they waited for a response before opening their door. The care plan was also clear about ensuring the person had private space, liking to be dressed smartly and to have their hair done as they liked it. Each person's door was styled like the front door of their house with a knocker. There was an accompanying framed collage showing items and information that was personal to each individual, to enhance conversation. For example, one person was from another country so their picture included the flag from their country. This also helped people identify their rooms independently and make them comfortable in the homely environment. People could choose to have a key to their door if they wanted. Each person had a named keyworker to oversee aspects of their care. For example, one care file detailed how the keyworker had asked a relative to provide more socks and underwear. Care files included what choices people could make as well as those they had difficulty making.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. The registered manager had asked relatives/representatives about people's end of life preferences which were recorded on a 'What I want for the future' form. This was done sensitively and at a time to suit people. There was also information about people's bereavement experiences so that staff were aware if people living with dementia were asking for someone who had died, and how to manage the situation. We discussed a recent example of end of life care with the registered manager. There had been input from the GP who had prescribed a 'just in case' bag for emergency accessible medication. Equipment such as a specialist bed had been sourced and the care plan was simplified to focus on end of life care and comfort. For example, where pressure damage was not a high risk, staff did not disturb the person as regularly to move their position unnecessarily. Appropriate health care professionals and family representatives had been involved in these discussions. The registered manager said the GPs and district nurses had been very supportive and they gave nice feedback. They added, "We fight hard to try to enable people at the end of their lives to come back home from hospital."

Recent thank you cards from relatives stated, "Thank you for making [person's name]'s last 30 months as good as possible", "Thank you so much for looking after my dad so well. I really appreciate all the care you gave him. You do an amazing job and I really appreciate what you do" and "[Person's name] was so lucky spending their final years with you all." One person commented on a national care home review website, "Dad recently passed away at Stuart House and I am extremely grateful that his needs were so carefully considered and that Mum can now share her loss with those around her. I have been very touched by this and feel very fortunate that we found a home where such a breadth of support is available." Staff attended people's funerals where they could and relatives sometimes continued to visit the home having developed a bond, some recently attending the Christmas party.

Good

Is the service responsive?

Our findings

People looked happy and contented, interacting with staff and being occupied. People's social and leisure needs were met in individual ways appropriate for people living with dementia. Care plans contained detailed information about the things people had previously enjoyed. Each care file had a 'This is Me' document. This is a form used by the Alzheimer's Society to encourage people and their families to record personal information about people's backgrounds and experiences, likes and dislikes. This enables staff to provide a more person centred approach to care delivery as they are able to get to know people despite their dementia. Some families had completed the forms and in other cases staff had tried to find out and document people's preferences on an on-going basis. For example, one person had been a school teacher and enjoyed writing at the care worker desk, which they did. There was also a summary of people's needs used to ensure staff could easily access information to aid care delivery in a person centred way, for example if staff were temporary or during people's first few days. This meant staff were vigilant to ensure people were wearing glasses, had their dentures if they wished and were able to communicate as well as possible.

As most people spent much of the day in the communal areas, they were able to interact with staff and watch what was going on, so there was a low risk of isolation. All staff took part in offering activities and social events, individually and in groups. A third care worker was employed in the afternoons to facilitate more organised activities. The registered manager was also monitoring how activities were going, checking that people were enabled to receive appropriate stimulation and engagement that met their individual needs. Some activities were spontaneous such as going for a walk to the shop or playing a game when people wanted to. The beach, town and park were all nearby and people had been out regularly if they wished. The registered manager said the problem was usually that people were anxious about going out. They gave examples of how staff had slowly reassured people and encouraged them to take up outing opportunities. One person would now go out if shown their coat. People's care files had daily records which included activities and stimulation. However, it was difficult to monitor these records amongst other notes. The registered manager said they would devise a separate activity form to ensure this was easier to monitor for each individual.

Following dementia care training the registered manager and staff had resourced items to use to engage with people. For example, nationally published research had shown that the use of dolls and soft toys could be useful for people living with dementia and these were available as well as pens and paper, magazines and books. The registered manager said people had really engaged with the life-like baby doll and staff were kind and respectful when helping people, calling the 'baby' by its name. A relative had donated a beautiful old fashioned pram which people living with dementia enjoyed engaging with. We saw people's faces light up when talking about the 'baby'.

There were many areas in the home which offered stimulation and engagement. The activity room had items easily accessible for people to look at and pick up. For example, there were books laid open to encourage people. The registered manager said, "If things are left out people will engage with them. It's lovely to see. [Person's name] particularly likes this book so we leave it here for them." There were interesting wall murals, posters of older musical stars, a music area with instruments and a sensory area

with keys, switches and locks for people to touch. People also enjoyed trying on various scarfs and hats in the hall. A notice board was up to date showing people in pictures what the weather was like, and the day and month. For example, on the day of the inspection it correctly showed a frosty morning.

There were lots of photos around the home celebrating what people had been doing, and people's art work was on display. We saw staff sitting with people throughout the inspection, ensuring they had contact with them despite the limitations of living with dementia. Staff were playing dominoes with two people together, for example. Other people were doing a puzzle game, doing arts and craft with a care worker, playing scrabble or just observing and relaxing. People had enjoyed time in the garden, and the registered manager said several people had been gardening in the raised beds.

People had been out on various trips in the home's minibus to see the Christmas lights, shopping in town and local landmarks. People had been able to attend church with their loved ones or staff. Staff took two people to a Christmas eve service which was particularly special for one person whose spouse had been a Sunday school teacher. There were also external entertainers booked such as the 'music man' and a weekly reminiscence session. Where people's care files stated they liked music and singing they had been involved in this. People were also involved in daily chores such as making drinks, helping staff in the kitchen and being involved as part of maintaining a sense of value and belonging. One person liked to go for a swim and told us about how they enjoyed doing that to alleviate their aches and pains.

People received care and support that was responsive to their personal care needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone. People were involved in discussing their needs and wishes if they were able and people's relatives also contributed.

During the inspection we read four people's care records. Care plans were detailed, written using respectful language and all were personal to the individual, which meant staff had details about each person's specific needs and how they liked to be supported. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required. Information relating to how their personal care needs were met was followed by staff including social and leisure information. Staff updated the care plans regularly as they gained further information. Records contained detailed information about people's wellbeing, such as behaviour and mental health which could affect their wellbeing, and what they had done that day. For example, one person was being monitored because of their possible negative behaviour. There were clear details about how to minimise this. The registered manager said it was important to be able to report on progress with the community mental health team. Some daily records did not reflect identified issues such as risk of self-neglect. We could see the person's care was good and staff told us how they managed this but the daily records did not show if the person was accepting personal care or not. The registered manager said they would raise this with all staff.

Staff were very responsive to changes in need and referred people to appropriate health professional in a timely way. For example, one person had banged their arm in the night and staff were reassuring them and taking them to hospital for a check up. Staff recognised when a person who had just moved into the service from hospital required a thicker consistency for fluids to minimise the risk of choking. In the above case, the registered manager also discussed omissions in the discharge information about the person's fluids from the local hospital to ensure safer discharge communication in the future. This showed they were keen to get things right for people. When people from Stuart House needed to go to hospital the home sent a summary of their needs and the 'This is Me' document and transfer form to promote consistency of care during their

stay.

Most people were unable to be directly involved in their care planning but the registered manager met with each person and/or the person's representative if they wished to discuss the care plans. People and their representatives said they would not hesitate in speaking with staff if they had any concerns. The registered manager said their door was always open and they hoped to minimise the need for formal complaints through regular chats, coffee and meetings. For example, one relative had been worried about an issue and it had been dealt with immediately. We saw relatives having a cheerful chat with the registered manager during the inspection. People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Formal complaints had been dealt with appropriately. We saw an example of how a formal complaint had been addressed. There had been a thorough investigation, including staff statements, despite the complaint being anonymous. This showed the process had been used to promote learning. There had been one formal complaint for the last 12 months. Issues were taken seriously and responded to in line with the provider's policy.

Good

Is the service well-led?

Our findings

People and their relatives were extremely complimentary about the management team at the home and the positive culture they had developed that ensured people were at the heart of where they lived. The registered manager had worked hard to promote good practice within an open, compassionate culture that celebrated the benefits for the people in their care. There were positive signs that people, especially those living with dementia, enjoyed a good quality of life, and robust quality assurance systems ensured the staff made on-going improvements to maintain good standards. One relative commented on an independent care home review website, "Stuart House is a genuinely warm and caring home where people with differing experiences of dementia receive holistic care and support. We received excellent support from the manager from the first point of contact and this has been the case time and time again. From the beginning, the staff really took the time to get to know Mum and Dad, their needs and their quirks and the inevitable ups and downs of life with dementia are responded to with patience, humour, creativity and compassion."

There was a management structure in the home which provided clear lines of responsibility and accountability. The registered manager had been registered with CQC since 2012 and was supported by a deputy manager, senior care workers and a stable staff team. The provider management team at head office regularly monitored the service and ensured the registered manager was doing a good job. A regular overall quality performance review was carried out by them. This was very detailed and followed CQC standards and regulations, highlighting good practice and making suggestions. The review in November 2016 resulted in all 'good' outcomes, using the provider's rating system. For example, comments were made about whether people living at the home could be involved in future staff interviews and the registered manager was looking at how this could work. The registered manager felt well supported and the provider quality performance manager visited Stuart House during the inspection to further support the staff. There were also regular managers' meetings for support and to discuss and share information. When the registered manager made requests to the provider these were listened to, for example new flooring was being laid on the stairs and landing and in the lift.

Staff told us, and duty rotas seen confirmed, there was always a senior care worker or manager on each shift. Staff said there was always a more senior person available for advice and support. Staff and the registered manager showed enthusiasm in wanting to provide the best level of care possible. Staff had adopted the same ethos and enthusiasm and this showed in the way that they cared for people. One staff member said, "It's very supportive here. I came back after working in another home. You really notice the homeliness here. People care about each other and we treat people as people. If we have an issue we can go and talk to anyone." Another staff member commented, "We work well as a team. That's why we stay. The care plans are good, we all have input. We play to our strengths, [staff member name] is good at paperwork."

Staff were formally supported during one to one or group supervision sessions. These were completed regularly and detailed information with a regular agenda about staffing issues, training requirements and staff competency. Where issues had been identified such as practice issues or staff behaviour, these were discussed and actions taken and followed up. The registered manager ensured staff were happy in their job,

giving them opportunities to give feedback.

There were regular team meetings and training workshops. One workshop had included a 'Team greatness' exercise. Staff wrote about each other stating what people should continuing doing, what to stop doing and what to start doing. Comments about the registered manager were all positive including, "You're a lovely manager, always nice", "Do exactly what you are doing, you're a great manager" and "Supportive, helpful and kind to all." Most comments went on to ask the registered manager to not work so hard and to take breaks. Care staff meetings enabled staff to discuss any issues and changes at the home. For example meeting minutes showed staff had been informed. There was now a named district nurse link to promote good communication, there had been reminders about ensuring records showed if people had declined care, and there had been updates on people's health conditions and forward planning. Staff valued the registered manager's leadership and hard work and this resulted in enhancing the positive culture of the home for people in their care.

The manager had an open door policy and they were available to relatives, people using the service and health professionals. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. For example, ensuring people had regular medication reviews with their GP and resourcing information about individual medication conditions.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care including medication audits, care plans audits and falls. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen risk assessments were reviewed and preventative measures taken. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

There were systems in place to share information and seek people's views about the running of the home. An annual satisfaction survey took place. Recent results from September 2016 had resulted in good feedback and a large percentage of excellent comments. Comments included, "You do not need to improve, you are excellent", "Wonderful staff, who are very friendly" and "Comfortable room." Some relatives had asked for additional trips out so the registered manager had fed back to them that sometimes people did not want to go out when the time came. Care plans showed when people had been offered and declined with follow up and encouragement was given to people to be independent but this would be easier to see with individual activity records rather than within the daily records.

There were resident's meetings. Minutes from December 2016 showed there had been good attendance at the coffee morning, and staff and people living at the home had discussed how Christmas had gone. The service had attempted to offer relatives meetings but no-one had attended. The registered manager said they spoke to relatives on a regular basis and during individual care reviews and maybe they felt they already had the opportunity to feedback. They were going to arrange another meeting in the future. This enabled the home to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's wishes and needs.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.