Amore Elderly Care Limited

Abbey Court Care Home

Inspection report

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Date of inspection visit:
16 April 2018
17 April 2018

Date of publication:
19 July 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16 and 17 April 2018 and was unannounced.

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

Abbey Court Care Home accommodates 88 people in one purpose built building. The home is split into four units with a nursing unit (Jasmine)and a residential unit (Sunflower) down stairs and two secure dementia units (Bluebell and Forget Me Not) upstairs.

At the last inspection we found two breaches of our regulations. We found that the provider was not keeping people safe from the risk of abuse and that they had failed to submit notifications of events they were required to tell us about by law. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well led to at least good. At this inspection we found that the provider had made the improvements necessary to meet all the requirements of the regulations. The number of incidents where people were put at risk of harm from other people living at the home had reduced and the provider had ensured that notifications were submitted whenever required.

At the last inspection the home was rated as requires improvement, at this inspection we found that the provider had made the improvements necessary and was rated as good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were enough staff available to meet people's needs and staff had the training required to ensure that they delivered safe care to people. In particular, the provider had ensured that staff had received training in supporting distressed people living with dementia to reduce the number of incidents in the home. The registered manager used a tool which looked at the needs of people to calculate the staffing levels needed on each unit to keep people safe. There was concern about the continued use of agency staff and the registered manager was working to recruit more staff so there was less reliance on agency staff to cover shifts. The provider's recruitment processes ensured that staff were safe to work with people living at the home.

People's ability to eat safely was assessed and where necessary people were referred to healthcare professionals for advice and support. The provider had reviewed their assessment of people's ability to swallow following two incidents where people appeared to choke and had ensured that the assessment followed the latest best guidance practice. The incidents had been referred to the coroner. In the case which had been concluded the coroner found that there was no fault with the care provided. Other risks to people

were also identified and care was planned to keep them safe. Incidents were reviewed to see if any changes were needed in the way that care was delivered.

Medicines were safely managed and administered to people in a timely manner. Staff had received training in infection control and how to minimise the risk to people by using protective equipment. The environment had been updated and now supported people living with dementia.

People received an assessment before moving into the home and were also involved in developing their care plan to meet their needs. There were systems in place to ensure that any changes in legislation or best practice were identified and shared with staff to ensure they were able to reflect this in the care they provided.

There was a good relationship between people living at the home and staff. Staff promoted people's ability to make choices about the daily care they received and ensured that people's privacy and dignity were respected. There was a variety of activities available to promote people's well-being.

Information was available for people and their relatives on how to raise a complaint. However, the registered manager told us that they encouraged people to raise concerns before they became a complaint. People living at the home and their relatives told us they were happy to raise any concerns and that the registered manager was approachable and helpful.

The provider has systems in place to monitor the quality of care provided. These were effective in identifying concerns and action was taken to resolve the issues identified. The views of people living at the home and their relatives was gathered and used to drive improvements.

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 harm by staff who knew how to support them when they became distressed and how to raise concerns.

Risks to people were identified and care was planned to keep people safe.

There were enough staff to meet people's needs and recruitment processes ensured staff were safe to work with people living at the home.

Medicines were safely managed and available for people when required.

Staff had received training in infection control and used protective equipment to minimise the risk of cross infection.

Incidents were monitored and action taken to reduce the risk of incidents occurring.

Is the service effective?

Good

The service was effective.

People received an assessment to ensure the care provided would be able to meet their needs.

Staff received the training needed to ensure that they provided safe care.

People's ability to eat safely was monitored and advice was sought from healthcare professionals when needed.

Systems were in place to ensure staff knew what their responsibilities were each shift.

The environment supported the needs of people living with dementia.

People's rights under the Mental Capacity Act 2005 were respected.

Is the service caring?

Good

The service was caring.

Staff took the time to know people and their preferences.

People were offered choices about their everyday lives.

People's privacy and dignity was supported.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning their care.

People were able to access activities which supported their physical and mental well-being.

People were supported with dignity at the end of their life.

The provider had a complaints policy in place and the registered manager took action to resolve any concerns raised.

Is the service well-led?

Good

The service was well led.

People living at the home and their relatives felt the home was well led.

There were effective systems in place to monitor the quality of care provided.

People's views of the service were gathered and used to improve the quality of care provided.

The registered manager continually monitored the quality of the care provided and looked for ways to improve the care delivered.

Abbey Court Care Home

Detailed findings

Background to this inspection

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

We were aware that there had been two incidents of choking at the home which had been referred to the coroner. We therefore ensured that we explored this particular aspect of care provided to people and to see what action the provider had taken to prevent a reoccurrence of the issue.

This inspection took place on 16 and 17 April 2018 and was unannounced.

On the first day our team consisted of two inspectors, a specialist advisor who was a nurse 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. On the second day one inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home. This included the action plan completed by the provider following our last inspection. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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, three nurses, a senior care worker, three care workers, the dementia lead, the assistant manager, the peripatetic manager, the activities co-ordinator and the lead housekeeper. We also spoke with seven people living at the home and five visitors to the service.

We looked at a range of documents and written records including nine people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Good

Is the service safe?

Our findings

At our inspection on 10 and 11 May 2017 we found that the provider had not always taken action to ensure people were safeguarded from harm. This was a breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. This was because in the Forget Me Not unit there was an unacceptably high number of safeguarding concerns due to the challenging behaviour of the people living on the unit. Following our inspection the provider wrote to us and told us they would ensure that they would implement all the changes needed.

At this inspection on 16 and 17 April 2018 we found that the provider had taken action to improve the quality of care that people received. They had reviewed the quality of the environment for people, invested in the activities to support people, had reviewed the staffing levels in the unit and provided further dementia training for staff. All these changes helped the people who lived on the unit to be calmer and settled and we saw that the number of incidents on the unit had reduced to the number that we would expect to receive from a home this size. The provider was now meeting this regulation.

People living at the home told us that they felt safe. One person told us, "I think this is the best it can be, it's safe for me to be here. I had falls when I lived at home and now I haven't had any since being here as there's always someone around." Another person said, "Yes I feel safe here. They respond well to me when I need to press my buzzer and they are here in a flash even in the middle of the night." Relatives were also confident that people were safe. One relative told us, "Yes I know my family member is safe here. I come every day and see what goes on. They know her and her needs very well." Another relative said, "Yes I feel my family member is safe. There is a gate on the entrance to her room to stop others from wandering in."

Staff were aware of the signs of abuse and told us they would report any concerns to the nurse, or the manager. They said they would escalate it further if action wasn't taken, either by contacting head office or using the whistleblowing policy. A member of staff said, "The residents always come first." They were aware they could report to the local authority or the CQC.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Risks such as falls, pressure ulcers, choking and nutritional risk were identified and reviewed monthly care was planned to keep people safe.

Pressure relieving mattresses were in place when people were at high risk of developing pressure ulcers but they were not always set at the correct weight for the person. We raised this as an issue with the registered manager. They had already found the same concern and had identified a way to ensure all staff that entered the person's bedroom knew what the setting should be. They were in the process of implementing this change during our inspection. When people required re-positioning to prevent the development of pressure ulcers documentation indicated this was completed. Staff told us they had a routine for ensuring regular checks and re-positioning was completed.

Where people needed the support of equipment to move safely around the home we saw care plans

identified the equipment and number of staff needed. We saw some people being assisted to move around the home using equipment. Staff worked safely to good practice guidelines and kept the person informed of each move in an appropriate manner.

Care plans contained personal evacuation plans for people, these supported staff and the emergency services to know people's needs if an evacuation of the home was needed.

People told us that they were happy with the staffing levels but raised concerns over the number of agency staff the home was using. One relative told us, "The only thing is that they have a lot of agency staff and it's not their fault, but they don't always know the resident that well. It's a shame they have to use so many as they do." While another relative said, "[Name] is well looked after and the care staff are really good. I did have concerns about the number of agency staff and nurses used."

We raised this with the registered manager who was trying to reduce the need of agency staff within the home. There had been a recruitment drive for the home and the registered manager and provider were looking at initiatives to encourage registered nurses into the home. While they still had to use agency staff the registered manager told us how they would request the same agency staff so that it minimised disruption and maintained some continuity for people.

Staffing levels were identified for each unit. There was a staffing tool in place which took account of the needs of people living on each unit and identified the number of care staff needed to provide timely support. Records showed that as the number of people on each unit changed the staffing levels would be increased or decreased accordingly. In addition, more staff were provided in the dementia units as people living with dementia needed a higher level of care.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home. In addition checks were I place to ensure that any agency staff used had been checked by the agency and had all the relevant qualifications.

People were happy that their medicines were safely managed and available to them when needed. One person told us, "They give me my medication on time and it's never been a problem."

We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. We looked at the medicines on each of the units. We could see that medicines were stored safely and accurate records were kept about when medicines were received, administered and destroyed. There were systems in place to ensure stock levels were checked and medicines reordered in a timely fashion to ensure they were available to people when needed. Where people received their medicine in the form of a patch, recording sheets were in place to monitor when each patch was used and removed and where on the body it was placed.

Some medicine, such as medicines to help people manage their distress, had been prescribed to be taken 'as required'. Records showed when these medicines had been taken, what dose had been given and why. However, for some people there was no information in place to support staff to recognise when this medicine was should be administered. This was important for those people were unable to request medicine if needed. We raised this with the unit manager and they ensured that the paperwork was

completed and in place before the inspection finished. Where medicine doses may vary, such as those for blood thinning medicines, there was clear recording of the number of tablets to be taken each day to reduce the risk of errors.

People's preferences for taking medicines were noted and respected. For example, a nurse explained how one person liked to have a bit of chocolate when taking their medicines. Important information such as any allergies to medicines were recorded to help staff keep people safe. Homely remedies such as cough mixtures and pain killers were available for people when needed along with clear guidelines of when they should be administered and for how long.

We found that suitable measures were in place to prevent and control infection. People we spoke with were happy with the levels of cleanliness maintained in the home. One person told us, "My room is always clean and tidy and bedding always changed regularly." On the day of the inspection the environment was visibly clean. There was a cleaning schedule in place and systems were in place to reduce the risk of spreading infection. For example, different coloured mops and buckets were used. Each person had their room deep cleaned once a month. We did see on Jasmine, the nursing unit that the sluice area had not been kept as tidy as other areas. We raised this with the registered manager who took immediate action to rectify the situation.

There was a member of staff on each unit who was the lead for infection control. We spoke with one infection control lead and they were able to explain how they supported colleagues to work to minimise infection. They were able to talk us through the precautions they took when there was an outbreak of infection such as diarrhoea or vomiting in the home. They said put a sign on the door about precautions needed, they used a different colour apron and kept them outside the room. They removed their apron and gloves immediately before leaving the room and washed their hands. They cared for the person in their room to prevent the spread to other people.

We found that the registered persons had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager and the staff at the provider's head office carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. Staff told us they were encouraged to report incidents and completed an incident form.

Good

Is the service effective?

Our findings

There had been two incidents at the home where people had choked. They had both been referred to the coroner for an inquest. The coroner had reviewed one case and identified that there was no concerns about the care given but that the person's ability to swallow and digest their food had deteriorated as their dementia progressed. Staff had identified concerns about the person's ability to eat safely had referred them to a healthcare professional for advice and support and had requested a soft diet for the person to help them eat safely. The other case was still waiting to be reviewed. The provider had reviewed the incidents and had identified areas where improvements could be made. All staff at the home had received further training in nutrition and swallowing difficulties. The assessment of people's ability to swallow had been reviewed and a consistent process put in place to ensure information about people's dietary needs was exchanged when staff come on shift.

People we spoke with were happy with the food provided. Relatives were also satisfied that people received the support they needed around mealtimes. One relative told us, "I think my relative is safe here yes. They are very good with her. She needs a lot of one to one at times especially when eating and they supervise her well." We saw a person, who was in bed, being assisted to have their lunch by a staff member. The staff member sat alongside the person and encouraged them to eat their meal, describing each spoonful to them. The interaction was good and the staff member was courteous and polite.

We saw that the dining experience was tailored around people's needs. For example, on Sunflower, the residential unit, the lunchtime dining experience was very relaxed and organised. People sat together in friendship groups and tables were set attractively with tablecloths, table mats and cutlery.

There was a four week rolling menu in place which had been developed by the chef. This changed seasonally or if people did not like a particular item on the menu. Each day two options are given for the main meal but staff told us that the chef, "Will cook anything else people ask for." The chef received feedback on the food by attending relatives meetings and staff meetings. Kitchen staff had all the information needed on people who required a soft diet and those who required a diabetic diet. The dementia lead told us they had liaised with the catering staff to improve choices for people living with dementia and to increase the amount of food served to them. They said they had introduced snacks such as cheese and crackers and smoothies when people were at risk of losing weight.

We observed lunch in one of the dementia dining rooms and saw that people were offered a choice of food. Where people were struggling to make a choice both options were plated up and shown to them. People's independence with eating was supported and encouraged. One of the options given to people was able to be eaten with fingers for those people who found cutlery too difficult to manage. One person was not interested in any of the food offered to them and chose not to eat anything. The staff noticed this and prompted the person. When they continued not to eat the member of staff asked if they would like a ham sandwich. The person agreed to this and the kitchen was requested to make a sandwich for the person.

People's ability to eat safely had been assessed and where needed people had been appropriately referred

to healthcare professions to for further assessment and advice. The risk assessment had guidance in place on the action staff need to take at each level of risk. We saw that for one person on the nursing unit staff had been concerned about their ability to eat and drink, especially as they had been sleepy. They had arranged for the person to be given a soft diet. However, this information was not available in their care plan. While there was no impact on the person as they had received appropriate food we raised this as a concern with the registered manager who arranged for the file to be updated immediately.

People's weight was monitored to ensure they were able to maintain a healthy weight. People were weighed monthly where possible and the records we reviewed showed people were maintaining their weight. When people were at risk through not drinking adequate amounts fluid target were set to ensure they maintained an adequate intake.

We found that arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. When people moved into the home they had their needs assessed and any risks to their care were identified. The provider had developed risk assessment forms for each risk identified and ensured that the forms reflected the latest clinical guidance. The provider had also ensured that each unit had a copy of the provider's policies which detailed the care which should be provided to people.

The provider had also worked with a university to develop training for staff around dementia. This training was called 'Creative Minds'. Creative Minds has the aim of supporting people with dementia to live their lives to the fullest capacity. The training covered, understanding the impact of dementia on the person and family, enabling communication and positive experiences, understanding stress & distress reactions, promoting dignity and respect and providing meaningful activity for people living with dementia. Following our last inspection the provider arranged for all staff at the home to complete this training. We saw that this had impacted on the care people received especially for those in the Forget Me Not dementia unit. A relative told us that they thought staff were managing people better so that there were less distressed reactions on the unit. They told us, "I feel the dementia training is getting better."

At our previous inspection we had found that this was a chaotic environment with a high level of incidents due to challenging behaviour. At this inspection we saw that the quality of care provided had improved and the environment was calmer. The provider employed a member of staff as the dementia lead. They told us they were there to provide support in caring for people living with dementia. They said they wanted to offer the best possible care and said the home was the last step in the person's life and they wanted to ensure they were given the best care. They told had they had made changes to the way people were cared for, by promoting choice.

Relatives said they were happy with the care provided by the care staff and they thought the staff were competent and trained. Records showed that new care staff had received introductory training before they provided people with care. The induction consisted of a minimum of three days shadowing but more shadowing was available if the new member of staff lacked confidence. Observations were completed to check competencies in each task, and new staff were required to complete the care certificate. The care certificate is a set of national standards that will provide staff with the basic skills needed to provide safe care. In addition, staff had also received on-going refresher training to keep their knowledge and skills up to date. At the time of the inspection 93% of training in the home had been completed. There were systems in place to monitor that staff completed their training as required and if staff had not kept up to date they would be sent a letter reminding them of their duty to complete all required training.

Staff told us they completed mandatory training and were encouraged and supported to gain nationally recognised qualifications in care. They told us that if they identified a training need they would speak to the

training lead who would arrange something for them. One member of staff commented that the quality of the training was good. For example, they said the training lead did practical moving and handling training with them. A nurse told us they were able to access continuing professional development and the provider had provided training for their re-validation. The provider was starting to produce competency assessments for the nurses; at the time of the inspection they had covered some areas around medicines and pressure ulcer management.

Care staff received ongoing support from the nurse on their unit. While regular supervisions were not completed, supervisions were undertaken in response to incidents or issues being raised. Staff said they had an annual appraisal to discuss their training requirements and career development.

Systems were in place to ensure that all the staff in the home knew what their duties were on each shift. Staff were allocated to a particular unit and they told us how told us how their tasks for the shift were identified for them by the nurse or senior carer on the unit. There was a handover process when the shifts changed to ensure that all staff had the information to care for people safely. There was also a communication book on each unit to and a basic day-to-day summary is documented regarding people's needs and any changes required.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. People had an emergency grab sheet in the care files which included important information about them. This could be taken to hospital with them so that important information about the person was shared.

Staff at the home worked with healthcare professionals and families to support people to access healthcare whenever needed. One person living at the home said, "I have had the GP a couple of times, but it's no problem to them." Relatives told us that the manager and staff had contacted the doctors and social worker for support and advice when needed. Records showed that the staff had identified when people were unwell and had arranged for them to see their doctor.

We found that the accommodation was designed, adapted and decorated to meet people's needs and expectations. At our last inspection we found that the environment was not supportive of the needs of people living with dementia. At this inspection we found that had been a lot of work undertaken to the environment so that it supported people's needs. For example, on the Forget Me Not unit we saw that the communal lounge area had been refurbished and made more homely. There was fireplace with a welcoming glow and there were a range of areas where people could sit. Lots of small activities had been placed around the room for people. An example of this was some picture cards with different breeds of dogs which relatives used to interact and start conversations. A relative said "They have spent a lot of money lately on redecorating and replacing a lot of the furnishings which is good to see. Everywhere looks nice and is in very good condition." Another relative told us, "They have decorated and everything looks better."

There was good use of signage in the home to help people living with dementia find their way around the home independently. The signs had words and pictures to help people understand their meaning. On the dementia unit further action had been taken to support people's independence. For example, toilet doors had been painted yellow as this helps people living with dementia to identify the toilet doors easier. People living on the dementia unit also had memory boxes outside their rooms. Memory boxes are glass boxes that people can put objects in to help them identify their bedroom. These were not always in use as some people had indicated that they wished to maintain their privacy.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where there was any concern that people may not be able to consent to living at the home the staff had requested that the person be assessed under the DoLS. The registered manager had clear processes in place to monitor the DoLS and when they expired and would need reauthorisation. No one living at the home had any conditions on their DoLS. Conditions can be added to the DoLS to reduce the restrictions on people.

Staff had received training in the Mental Capacity Act. They understood it was about supporting people's abilities to make decisions for themselves. They explained how they supported people to make choices by responding to each individual's abilities. For example, by giving them small pieces of information. When people were not able to make some decisions for themselves, mental capacity assessments and best interest decisions were recorded. Where people had made legal arrangements for others to make decisions on their behalf, this was recorded in their care plan.

We found for one person a Mental Capacity Assessment had not been completed to show that they could be given their medicines covertly. Covert medicine is where medicine is hidden in food so that the person does not know that it is being taken. This is only done when the medicine is important to keep the person well and the person is not able to understand the impact if they refuse the medicine. We raised this as a concern with the registered manager who told us they would see that the relevant paperwork was completed immediately. Other people living at the home taking covert medicines had completed mental capacity assessments in place.

Good

Is the service caring?

Our findings

We saw that the staff ensured that people were treated with kindness and that they were given emotional support when needed. We saw staff interacting well with the people they cared for. Staff chatted with people and spoke softly to them when they were discussing personal care. They were knowledgeable about people's interests and talked with them about things the person was interested in. All the residents appeared well presented; some ladies with make-up, jewellery and styled hair, and co-ordinated clothing. One relative told us, "They really care about her, for example, I had put her favourite perfume in her room and the care staff put the perfume on my wife when we were visiting the other day, which was a really nice touch."

Staff monitored people moods and took action whenever possible to make life better for people. An example of this was a person living at the home had made good friends with another person in the home and missed them following their death. The staff were aware of the impact this bereavement had on the person and encouraged them to spend time in a different unit for a change of scene.

People's preferences had been taken into account. An example of this was some people who had needed residential care when they moved into the home but whose needs had deteriorated and so they now needed nursing care. However they were happy and settled in their rooms and so the nurse visited the residential unit to provide the care and support they needed.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. One person told us, "They help me to bed and get me up when I want. I have a nice room and they look after me well. I don't really do anything much. But I have the choice. I have a shower when I want one." Another person told us, "I prefer the shower, but I can have a bath if I want to."

The reception area was a pleasant and relaxing area for people to spend time in. There was information available in the reception to keep people and their relatives informed about events at the home they may choose to get involved with. For example, there was lots of information available about activities in the home and the results of the latest resident's and relatives' surveys were displayed so that people could see what areas had been identified for improvement.

People told us privacy, dignity and independence were respected and promoted. A relative told us, "She is always well presented and tidy and I have no issues regarding her personal care and cleanliness." During the day we saw staff appeared polite and courteous to the people and we saw that staff knocked on bedroom doors before entering.

Staff used 'Personal care in progress' signs on bedroom doors when they were providing personal care. Staff told us they closed doors and curtains when providing personal care and put signs on the door to discourage interruptions. They tried to gather everything together prior to providing care and kept people covered as much as possible. They said the trainer was the dignity champion for their unit and made sure

everyone adhered to the appropriate procedures.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Information on how to access advocate services was available to people. Advocates are independent people who can speak for a person when they are no longer able to communicate their needs.

Good

Is the service responsive?

Our findings

People and relatives they had identified as wanting to be included had been involved in planning their care. One person told us, "I had a care plan review yesterday, my brother came and we all discussed things together." Another person said, "They write everything down in the blue folder that's up there on the shelf in my room and it's there for the professionals to see as well as my family if they want to. I have a care plan which I know about too."

Care plans were in place for people's care and support needs and they contained sufficient information about the person's care and their personal preferences. Care staff we spoke with were knowledgeable about people's needs and were able to describe the care as recorded in the care plan. Care plans were reviewed regularly and when people's needs changed. Care plans also contained a profile of the person and life story information. This is particularly important for people living with dementia as people's history would give care staff information about their current behaviours. For example one person living at the home always got up very early in the morning. This was because they had got up early to go to work when they were younger and so were maintaining a routine that was important to them.

Staff were trained in NAPPI (Non-abusive psychological and physical intervention). This is training in the management of challenging behaviour using positive support approaches. We reviewed the care of a person who was living with dementia and showed distressed behaviours which presented a risk to themselves and others. Their care plans and risk assessments provided details of this and the action staff should take when the person became agitated. The person often refused personal care and staff identified that whilst they should initially try to gain the person's consent over a period of time, there were occasions when personal care was essential and they were unable to gain the person's consent. The person's care plan provided a clear escalation plan to enable staff to use the least restrictive option to provide the person's care. A member of staff who was NAPPI trained was always present when the person was resistive of care. Staff we spoke with about this person's care were clear about the process and said they always tried to gain the person's cooperation and gave the minimum level of care required to maintain the person's safety when the person was uncooperative. They were clear about the escalation process and the requirement for a person with the appropriate level of training to be present. Relatives told us they were happy with the care provided to help people stay calm and happy. One relative told us, "They manage my dad well as he is a lot calmer now than when he first came in. He is happier."

People's communication needs were recorded in the assessment process and any aids to communication such as glasses and hearing aids were recorded in people's care plans. The provider understood that some people living with dementia may struggle to understand and communicate information. Therefore, they had invested in communication aids such as pictorial aids to help people communicate their needs.

People showed us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One relative told us, "The activities girl is very good, my wife loves dancing and she really engages with her when music comes on. I took her this morning into the garden which she really loved it. It was a positive experience for her as the gardens are so

nice here." A person living at the home said, "I have started knitting again which is good for my hands and brain. We have done cake decorating, Easter bonnets, and there is lots going on if you want to be involved. The hairdresser is here on a Monday, it's nice to get your hair done. I like to go in the garden, we went yesterday afternoon."

There were two activity co-ordinators working at the home and they provided activities seven days a week. We saw that activities were tailored to people's needs. For example, in the dementia unit activities were short to keep people's attention while in the residential unit more complex activities, such as baking, took place. In the communal areas activities were left available for people to amuse themselves. In one of the lounges we saw there were large format dominoes, magazines, plastic bricks, a basketball hoop and soft ball, colouring books, soft toys, a laundry basket with laundry, and fiddle boards. Staff chatted with people and people were offered the opportunity to go into the garden.

As well as daily activities events were planned to bring a greater variety of activities to the home. They also helped people orientate to the time of year and improve their physical and mental well-being. We saw that the activities folder showed that recent activities included Easter decorations, the Grand national and tai chi and going out for lunch. We spoke with a relative who had accompanied people out for lunch and they expressed their pleasure that their family member had been included as they needed a lot of support to access the community. The registered manager had also encouraged groups such as alocal choir, a local group call Knit and Natter and the WI to come into the home and socialise with people.

Care plans showed that people and their relatives had been involved in discussing their wishes at the end of their lives. For example, if they wanted to go to hospital or preferred to stay in the home. Their wishes around resuscitation had also been discussed and the paperwork put in place if they did not wish this to be attempted. Staff had received training in supporting people at the end of their lives and they worked with other healthcare professionals to support people to have a dignified pain free death. Staff spoke to us about the care provided when people were at the end of their life. They showed sensitivity and told us they went out of their way to ensure the person was comfortable. They said experienced staff would attend to them to ensure they handled the person appropriately and provided them with extra comfort. If they were reluctant to eat they would offer things which were easily digested and milkshakes.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Information on how to raise a complaint was listed in the brochure people received when they moved into the home and was also on display in the home. People told us that they were happy to raise any concerns they had. A relative said, "They keep me well informed and if there are any issues, I address them when they arise with the manager." The provider had received one verbal complaint since our last inspection. Records showed that this had been dealt with in line with the provider's complaints policy. The registered manager told us that they hope people would feel able to raise any concerns immediately so that they could be resolved before they developed into a complaint. To encourage this early raising of issues the registered manager had an open door policy and there was also a comments box in reception.

Good

Is the service well-led?

Our findings

At our inspection on 10 and 11 May 2017 we found that the provider had not notified us of all the incidents that the provider was required to tell us about by law. This was a breach of Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2009. Following the inspection the provider wrote to us and told us they would ensure that all notifications were submitted in a timely manner. At this inspection we found that the provider had reviewed how notifications were processed and following some initial delays we were now receiving notifications in a timely manner and they contained the information we needed to make judgements about the care provided. The provider was no longer in breach of this regulation.

We found the provider had taken action to meet their other legal requirements by ensuring that the manager had registered with the CQC and by displaying their rating in the home and on their website.

People told us that they considered the home to be well run. One person told us, "I have seen improvements this past year. I think the dementia training has improved." Relatives told us they knew who the registered manager was and that they were actively involved in the day to day management of the home. A relative told us, "I am happy with the care my wife receives definitely. They keep me very well informed and I have no concerns. She likes drawing and colouring and they encourage that. She is always dressed nicely and they put her jewellery on. I know she is safe here and I have peace of mind. I know about the care plan, it's like a book." Another relative told us, "I think it is better now here and well led. This home has had so many managers and so much disruption over the years. It's a shame because the staff are kind and they do really care for my relative. I have faith in them and they have listened to my requests and acted."

Staff universally praised the manager. One person said, "She is absolutely brilliant. She is all over the home and is in touch with everything that's happening. If you need to speak to her, she will try and fit you in or ask you to come back later in the day." Another member of staff said, "She has a great style, very calm but a warm personality and down to earth." Other comments included, "You can speak to her in confidence. She genuinely listens and cares about you," and "She always makes time for you no matter what." Staff said the manager and other senior staff were fair and treated people equally. This open and inclusive approach by the registered manager had increased staff engagement with the home with staff wanting to provide the best care possible to people. A member of staff said, "It's a good place to work. Each unit is like a small family and you develop bonds with the residents. We all help each other out, it isn't just me, and staff will stay behind at the end of their shift to ensure they have done everything they can before they leave."

The deputy manager discussed the changes that had taken place within the home since our last inspection. They told us that they felt well supported by the registered manager in helping staff ensure that the changes were properly implemented. Staff were also happy with the level of support they received and told us that it was a good team working environment and they want to continue to improve the standard of care they give to people. We saw that the registered manager proactively identified areas where staff may need support and ensured that it was provided for them. For example, on one unit on the day of inspection there was a nurse who was returning to work following an absence. The registered manager had arranged for them to have support available during their first shifts so that if they had any problems someone was on hand to

help them.

The provider and registered manager had audits and reports in place to help them monitor the quality of care provided. Where concerns were identified action was taken to help staff ensure that there was no repeat of the concern. For example, there had been some medicines errors in the home and the registered manager had identified this and taken action to keep people safe. They had audited the medicines and developed and action plan which included, reviewing the competency of all staff administering medicines and providing extra training to all staff. The provider received all the incidents for the home and all their other homes and so was able to analyse the data and look to see if they were any trends which would indicate areas for review.

The provider had recognised that with such a large home the registered manager had needed some support to drive the identified improvements forwards and ensure that they were embedded in the care that people received. They had provided a peripatetic manager to work alongside the registered manager for a period of time. We saw that the two managers were working well together and progress was being made on identifying concerns and driving change. The provider also had key people which engaged with the home to ensure that best practice was identified and used to provide care. For example in dementia care and in driving quality care. There were key systems in place which were used to monitor the quality of care provided. These included monthly governance and compliance meetings with the provider's staff so that the provider kept up to date with the care in the home.

The registered manager had engaged people living at the home and their relatives to input into the development of the home. They had recently surveyed people to identify what they did well and any areas where improvements could be made. We saw that they had analysed the results and displayed them in the entrance area for people to view along with the plan on what action they would take to improve some areas. In addition other information to keep people informed of what they should expect from their care and how to raise a concern within the home or with external agencies was also on display. This showed that the registered manager was happy to be open about the standard of care that people should receive and encouraged people to raise concerns if they had any worry that care was not meeting this standard.

In addition the registered manager had provided education to people living at the home and their relatives about their conditions and how the home supported people. The registered manager had recently held a modified diet day. Modified diets are when food if mashed or pureed to make it easier for people to eat. People living at the home and their relatives were invited and were able to sample different types of modified food. This helped relatives to understand their care that was provided for people. On relative told us, "My wife needs one to one supervision when eating, which they do. Recently I participated in a demonstration all about non choking foods and swallowing, learning about foods which melt in the mouth. It was for people like me (relatives) and staff. It was brilliant and very informative." Residents' and relatives meetings were held on each unit to allow the registered manager to update people and their relative on any changes in the home and to facilitate conversations about what changes people would like to see.

We found that the registered manager and provider had made a number of arrangements that were designed to enable the service to learn and innovate. The registered manager told us that they were pleased with the progress they had made since the last inspection. They said that they had engaged people living at the home and their relatives and they felt that the home was now working better as a community with relatives supporting each other. They kept up to date with any changes to best practice or clinical guidelines and ensured that they were reflected in the care provided. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles. The registered manager was aware that more work was needed to maintain the

standard of care that they wanted to provide. Therefore they continually reviewed the processes in the home to identify changes that were needed. For example, the deputy manager was going to introducing clinical discussions to support nursing staff with revalidation. Revalidation is where nurses have to show that they have continued to access training and support to ensure that their clinical skills remained up to date. In addition the registered manager was looking at making changes to the induction programme and to develop the lead roles on each unit in areas such as dementia and pressure area care.

We found that the service worked in partnership with other agencies to enable people to receive 'joined-up' care. They ensured that they shared information with other agencies to support people's joined up care when people moved between services. In addition they had linked in with local organisations to share learning an example of this was an activities co-ordinator who had joined the dementia group in the local community.