Sanctuary Care Limited

Garside House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Garside House Nursing Home on 13 and 14 June 2016, the inspection was unannounced. Our last inspection took place on 7 August 2014 and we found that the provider was meeting all of the regulations that we checked.

Garside House Nursing Home provides accommodation and respite care for up to 40 people on three separate floors, caring respectively for people with general nursing needs, dementia and palliative care. The home is situated in the town of Pimlico and close to community facilities. At the time of our inspection there were 30 people living at the home.

The service had 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.

People were supported to have a choice of enough suitable food and fluids to meet their needs. There were arrangements in place to identify and support people who had specific dietary requirements.

Staff provided compassionate care and were committed to ensuring people felt valued. Staff interacted with people in a caring manner and respected their privacy, dignity and independence. The service was accredited for providing end of life care to ensure better experiences for people.

People and their relatives had positive relationships with staff. People were given information on how to make a complaint and said they felt comfortable raising any concerns or giving feedback to staff.

Staff did not receive regular supervision to ensure they received adequate support to carry out their roles effectively.

People had individual risk assessments detailing the risks to their health and safety, based on assessments of their needs. Staff were familiar with risks relating to people's wellbeing and what measures were put in place to keep them safe.

Staff received training that was reflective of the needs of the people who used the service. Thorough recruitment checks were completed to assess the suitability of the staff employed.

Staff had an understanding of Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty and followed correct procedures to protect people's rights.

Specialist healthcare professionals were available to meet the wide range of health care needs of the people in the home. Prompt action was taken in response to illness or changes in people's health.

People participated in different activities and their involvement was central to their health and well -being. The registered manager was nominated for the provider's kindness awards by a member of the team. Staff felt valued and respected by the registered manager.

We have made a recommendation about the safe storage of medicines and we found one breach of regulations relating to staffing. You can see what action we asked the provider to take at the back of the full version of this report.

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 told us they felt safe and supported in the home.

Thorough assessments had been developed to minimise and monitor risk when they occurred to ensure people were provided with safe care.

Safe staff recruitment practices were followed by the provider and there were enough staff to meet people's needs.

People were supported with their medicines at the right time and their medicines were regularly reviewed. However, we found that medicines were not always stored at the right temperature.

Is the service effective?

Requires Improvement

Parts of the service were not always effective.

Staff did not receive ongoing supervision to ensure they were adequately supported in their roles. People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

Consent to care and treatment was sought in line with relevant legislation and guidance on best practice.

People had their nutritional needs met. There were arrangements in place to identify and support people with their specific dietary requirements.

The provider worked with a number of different specialist healthcare professionals to help them to meet the wide range of needs of the people who used the service.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring, and people were involved in making decisions about their care.

Visitors were welcomed and people's privacy and dignity was respected.

People were encouraged to maintain their independence. Staff provided compassionate care and were committed to ensuring people felt valued.

Is the service responsive?

Good

The service was responsive.

People were actively encouraged to participate in different activities and their involvement was central to their well-being.

People's comments about the service were listened to and where necessary changes were made to improve the service.

People's concerns and complaints were investigated and responded to within satisfactory timescales.

Is the service well-led?

Good

The service was well led.

The registered manager was nominated for the provider's kindness awards. Staff told us they felt valued and respected by the registered manager.

The home worked actively in partnership with other stakeholders to improve the quality of care for people.

People were asked for their views and these were included in the development of the service. The quality of care was regularly monitored to ensure good standards were being maintained.

Garside House Nursing 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.

This inspection took place on 13 and 14 June 2016. The first day was unannounced. The inspection team consisted of one inspector, a specialist professional advisor who is a GP and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, previous inspection reports and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider. We also contacted the local authority and looked at the information they sent us about the service.

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 eight people who used the service, six relatives, two visitors, the GP and three nurses. We spent time observing the care people received including the activities they attended. We also observed the staff handover and toured the building.

Additionally we spoke with four care workers, the deputy manager, the occupational therapist, two activity coordinators, the chef, housekeeper, two clinical leads, the maintenance worker, the regional manager and the registered manager. We looked at the records in relation to eight people's care including their medicines records. We also looked at six staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the provider's policies and procedures.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe. One person told us, "Yes I do feel safe, some of the carers are very good," and another said, "Oh yes I feel perfectly safe in my surroundings." Another person commented, "Yes I feel comfortable here in my room, it is a little silent sometimes because there is nobody living on the ground floor but I feel safe up here." We also spoke to relatives who confirmed this and one explained, "Oh yes safety is not an issue here from what I can tell."

There was a safeguarding lead whom staff could report to in the event that they had concerns about a person's safety and potential abuse. The provider had procedures in place, which included a clear flow chart for staff to follow when reporting concerns. We spoke to staff about their responsibilities to keep people safe from harm or abuse and they had a good understanding of how to recognise different types of abuse and confirmed they had received training in safeguarding adults. We saw where concerns had been reported protection plans had been put in place to minimise further harm to people. The registered manager explained how staff learned from a safeguarding concern that had arisen for a person. Following this, a comprehensive protection plan was implemented and the provider had put systems in place to ensure that when people first arrived in the home they would be subject to closer observation during admission.

Information received by the Care Quality Commission (CQC) demonstrated that the registered manager was committed to working in partnership with the local authorities' safeguarding teams and the clinical commission groups (CCGs) to help ensure that people were kept safe. The CCGs are clinically led NHS organisations responsible for the planning and purchasing of health care services for their local area.

Staff were familiar with the whistleblowing policy that gave clear guidance and advice about who staff could report to in the event of any concerns they wished to raise in the workplace. The contact information included the provider, the CQC and other external organisations such as Public Concern At Work, which is a charity that aims to protect society by encouraging workplace whistleblowing.

People told us they would feel comfortable about raising concerns if they felt unsafe. One person said, "I certainly think so, I won't have any of it," and a relative commented, "I believe my [family member] is looked after well, I mean I'm here every day." An assessment of people's needs was carried out prior to the service providing care. This included risks to the person receiving care and any potential environmental risks. Risk reviews for people were completed on a planned basis and when any new information was received regarding people's needs. Robust assessments had been developed to minimise and monitor risk when they occurred, to ensure people were provided with safe care. For example, we saw that falls incidents calendars were placed on office notice boards, which were colour coded. This showed that where people had fall-free days this was highlighted in green and days on which falls occurred were highlighted in red. There were very few red squares on the calendar. We found where a person had a fall they had been examined by two nurses .The person and was frequently observed, additionally the nurse had contacted the falls helpline and an incident form had been completed.

Staff recorded when people had refused care or intervention so that this could be monitored and followed

up to reduce any risks of avoidable harm. Staff supported people with 'safe and comfort' checks at regular intervals to observe their well-being. Sensory aids were in place for people who had visual or hearing impairments. Telephone and call bells were placed in each room and we saw that call bells were within easy reach.

We asked people if there were enough staff to support them in the in the home, and people commented, "I suppose they cope, but they come and go in a flash. I guess they could do with more staff to take the pressure off" and another person said, "They could definitely do with more staff especially in the evenings and nights. I have my buzzer but they don't come straight away, in seconds, I would say minutes, which is ok considering they have to run around looking after everyone. I do get it you know." One person commented, "I think there is, they manage alright if I call my bell someone comes perhaps in a couple of minutes." Another person told us at the time they needed staff to be attentive to their needs due to their health needs, that the staff were always available.

In August 2015, there was a change of providers from the NHS to Sanctuary Care Limited. During the transitional period, there was a high level of staff vacancies, and other staff were transferred over to the new provider, which had an impact on staffing levels. The provider focused on recruitment as a priority and worked closely with the CCG to ensure no new admissions were referred to the home until staff levels were increased. Additionally to ensure people were kept safe, people on the ground floor were transferred to the first floor. During the time of our inspection, the ground floor was not in use and was in the process of being refurbished. There were plans to start using the eight beds in the near future.

We spoke to staff including the clinical lead on the second floor, who had been in post for nine years and explained that the transition from NHS to the current provider had taken place so smoothly that most members of staff had not even noticed. The clinical lead explained that the staff numbers were adequate, and there were enough care workers, but that the home required more qualified nurses. Other staff we spoke to told us the staffing levels were sufficient and spoke positively about the changes.
The registered manager confirmed that there was a concern regarding the issue of qualified nurses and this was being addressed by the provider, as the last two permanent posts had recently been filled. One nurse was due to start on the day following our visit and we saw the nurse being inducted into the home on the second day of our inspection. The second nurse was awaiting her background checks to be verified. The home used agency staff nurses who had worked in the home consistently, some for a number of years and were knowledgeable about the people's care needs and the provider's procedures. The registered manager told us all the additional posts had been filled and there was a phased process of people being admitted into the home. Additionally there was a health professional from the CCG who planned the safe admission and discharge of people for the service. We found in the minutes of staff meetings that the registered manager had kept people informed regarding the changes and had worked proactively to ensure staffing levels were sufficient, such as advising staff that breaks are to be staggered to ensure there were enough staff to support people in the home.

We looked at the rotas and staff allocation sheets and found the home had sufficient staff to meet people's needs. The home operated with one nurse and nine carer workers during the day and one nurse and four care workers during the night for each floor. The clinical lead stepped in to support the nurse when there was a need to do so and we saw that the clinical lead took over the medicine round, as the nurse had to assist the GP. The registered manager was a qualified nurse and explained she was able to assist in the event of planned leave for staff.

The registered manager told us there was a new induction in place for new employees and we saw in the staff files that the provider had followed its own policy and procedure for the recruitment of new staff. The

appropriate background checks had been sought before staff began work. Staff files included written references, identification checks and interview questionnaires. Criminal records checks were carried out on all the staff and the provider had systems in place to verify if staff were suitable to work with the people who lived in the home. Verification checks on nurses had been obtained through the Nursing and Midwifery Council (NMC). The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK.

There were arrangements in place to deal with foreseeable emergencies. People had specific written plans on how they should be supported when leaving the home in the event of a fire. There was clear signposting to the fire exits and rescue mats on the walls of the stairwells. We saw that a recent fire drill had not been undertaken in home. After the inspection, the registered manager sent us information to confirm that fire practice drills were carried out twice a year and the next one was due in July 2016. In light of this the registered manager conducted a fire practice drill and sent us details of the participants who had attended and any actions that needed to be taken.

To ensure the home was kept safe for people routine servicing was carried out on fire, gas, water and electrical equipment and installations. The provider had a designated maintenance worker who was employed to carry out repairs and complete regular health and safety checks on the building. There were two lifts in home and one relative told us one lift was consistently breaking down, and was discussed in the residents' meetings. During our inspection, we noted one of the lifts was not working. We looked at maintenance records and found the faults had been reported consistently over the last four months. We spoke to an engineer who was repairing the lift during the second day of our visit and they explained they were waiting on various parts to be ordered. The registered manager told us as the home had been utilising the other lift therefore this problem had not affected the service operating efficiently, however the registered manager confirmed they would continue to liaise with the engineer regarding the repairs.

The home was clean and free from malodours. We saw there was good infection prevention and control measures to ensure that people who used the service received safe care. For example, we observed staff washing their hands when appropriate and noted a sufficient number of hand sanitisers along the walls. Personal protective equipment (PPE) such as plastic aprons and suitable gloves were available and worn by staff. Water temperature checks and weekly flushing of the taps in vacant rooms were undertaken. We spoke to a staff member and relative who told us the clinical waste disposal bags were too thin and had split and the staff were advised to use double bags to dispose of clinical waste. We spoke to the operations manager who explained they had liaised with the provider regarding the bags and were seeking to resolve the issue.

People told us the staff gave them their medicines at the right time and their medicines were regularly reviewed by the GP. Two people explained, "They come and I take them myself, I don't need any help and I haven't found any problems with it. I was allergic to an antibiotic once so the doctor reviewed it and put me on something else" and another said, "The nurse brings them daily and I take them with water without any problems." Another person explained, "Medication is timely, the nurses come on their rounds and drop it by. If there's ever a problem with it the doctor will see me, the doctor here is excellent."

We observed the nurse completing the medicines rounds during lunchtime. Medicines were stored in locked cupboards in people's rooms and in the nurses' office and there was a current edition of the British National Formulary (BNF) book on the nurse's trolley. The BNF is used so that nurses can remain up to date with the latest prescribing information. We found good practice when nurses accessed medicines. The nurse responsible for the medicines round held the keys to all the medicines cupboards, and the cupboard that contained the Controlled Drugs (CDs) required two keys. Two signatures were seen in the medicines administration records (MAR) for the administration of CDs. We checked the MARs and stock levels and

found these to be in order.

Repeat prescriptions for people provided a four-week cycle which minimised the risk of giving out-of-date medicines. Two nurses checked the medicine supplies and we saw that an internal medicines audit was carried out monthly. Some people had medicines prescribed to be used 'as required' when they had a specific health condition. In these cases the nurse was patient and asked the person, for example, whether they had any pain and if they declined this was logged in the MAR. One relative said of the nurses who worked in the home, "They offer marvellous, first-class care. My [family member] is much happier here than at home. The nursing staff are fantastic and always friendly."

We found that the fridge temperatures were correct and that this temperature was checked and signed daily. However, the room temperature on the first floor was above the recommended maximum for the storage of medicines and was 27 degrees Celsius. This was pointed out to the clinical lead who was advised that steps should be taken to ensure that the temperature in that room should never exceed 25 degrees Celsius. This was also discussed with the registered manager who assured us this would be addressed as a matter of urgency.

We recommend that the provider review their current practice for monitoring and ensuring that medicines are stored safely at an appropriate temperature.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who were adequately supported in their roles. Not all staff received regular supervisions. We asked staff how often they had supervision meetings. One member of staff stated, "At the moment, every six months." Another member of staff could not remember when they had their last supervision. We looked at the records relating to the planning of supervisions of care staff that were in permanent employment and found there were significant gaps in the frequency of supervisions. For example, at least four staff had not had a supervision meeting since January and February 2016. Staff should receive appropriate ongoing supervision to ensure their competence to undertake their role to support people effectively is monitored and maintained. The above evidence shows that staff did not always receive appropriate supervision necessary to enable them to carry out their duties. The registered manager acknowledged this and agreed to prioritise with immediate effect.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were suitably qualified staff working in the home. Staff training records showed they had completed training in medicines management, infection prevention, clinical record keeping, fire safety, resuscitation, equality and diversity, dementia, nutrition and falls prevention. However, we found the majority of the training only comprised of e-learning and staff felt this was not always effective. We spoke to the activity coordinator who told us they attended the staff council meetings to speak on behalf of the staff team. The coordinator had suggested more face-to-face learning that was more productive for the staff team. The registered manager agreed with this and explained that a health care professional was to facilitate training on tissue viability, and staff were to receive additional training in wound management and end of life care. All the staff that worked in the home had completed a recognised national vocational qualification in Health and Social Care.

People and their relatives told us they received care from staff based on good practice. One relative said, "I couldn't fault them on their ability to support people in the way that they need as individuals and I have never doubted their expertise. I'm sure they do go on courses and such like to keep themselves up to date," and another commented, "As I said, they seem competent in their role so I don't really question it unless I see something that looks concerning." A relative was supportive of the way staff cared for their family member and said, "They do know how to support my [family member], they do it well. I don't know about the training side of things, I'd like to think they have the relevant training for their job."

Yearly appraisals of work performance were held with care staff and the registered manager to review their personal development and competence. There was new guidance in place for staff to follow to ensure they met the requirements of the service that focused on people's health care and well-being, and staff informed us they were being trained on this.

We listened to a handover between staff and where there was a change to people's needs this was discussed. Staff told us there were detailed handovers for all staff each day so they were aware of the most

up-to-date information about people's needs. One staff member said, "I really enjoy the work I do here." The operations manager discussed a new approach to team meetings that involved not only clinical staff but also the maintenance worker, chef and the cleaners. This was to ensure that there was consistency in the care staff provided for people. For example, records of the meeting showed that the chef was informed of new admissions into the home, care plans were being completed, new staff were welcomed and staff were focused on key priorities of the day.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We saw records to show that where people had been deprived of their liberty four applications had been made to the local authority and best interests meetings had taken place in line with the MCA framework. The registered manager explained she would inform the Care Quality Commission (CQC) of the outcome of the applications if the local authority agreed the applications. Staff had completed MCA and DoLS training and during discussions with care workers, we found that they fully understood the principles of the MCA.

We saw that staff obtained people's consent before carrying out any aspect of care and relatives had had been involved in any decision making on behalf of their family member where appropriate. One person said, "I know how to make my own decisions thank you very much, but if I need a hand I'll ask for it. The ladies do ask me before I need something done, I do have my dignity." A relative made further comments, "The staff do involve me in what they think is in my [family member's] best interests should there be something to do with his/her needs, I'm always well informed of what's going on." One relative reported, "I do make decisions for my [family member] in his/her best interests and I have had discussions and meetings over the years about my [family member's] changing needs."

Consent forms had been signed by people to show they had agreed to the care and support they received. We also saw consent forms for people who self-administered their medicines and to have their photograph taken and one person said regarding their medicines, "They are very careful with all of that, it's very important." We found capacity assessments in care files for people that included discussions about their wishes and the care they preferred. For one person we saw an Independent Mental Capacity Advocate (IMCA) had been sought for a person who required support with a particular decision. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

The home had a protected mealtime policy. This meant that mealtimes focused on avoiding unnecessary interruptions, providing an environment conducive to eating, assisting staff to provide people with support and assistance with meals, whilst placing food as an important aspect of people's well being. We observed mealtimes using the Short Observation Framework Inspection (SOFI) and found staff interactions with people at mealtimes were positive. Because of the high number of people with limited mobility, most meals were consumed in people's rooms, and the staff appeared to cope well with this. We found that each food tray had a dietary requirement sheet for each person which took into account their preference of food, where they would be eating, positioning while eating, whether they required any assistance with food and

anything to look out for.

The portion sizes were generous, food was attractively presented on the plates and people were offered second helpings. One person had been assessed as being underweight with a low appetite and was dependent on staff to help them with eating and drinking. We observed staff supporting them at lunchtime, offering the person small amounts of food in a patient and calm manner. We saw staff and people smiling and having playful and friendly exchanges of conversation with each other.

People told us the food was good and a variety of choices were readily available. Comments about the meals were mainly positive and included, "There is a choice and I am happy with what they have to offer. I don't really eat outside of mealtimes but I can get a drink when I want it if I ask them," and another person said, "It's good and they do have a choice every day. There is something different on the menu and if you don't like it they can adjust it for you. You can have a snack if you get a bit peckish and drinks are always available." Another person reported, "I don't always have a meal in the home, my [relative] took me to a restaurant yesterday as I really felt like some proper chicken. So that was nice to go out for a bit, change of scenery." One person expressed their preferences on how they like to be served their meals and said, "I enjoy the food here, they bring me my food first and then my pudding so it doesn't get too cold. I like a lot of custard but not if it's cold. I like my cups of coffee too, I like them a lot" and another person said, "Sometimes the food is not up to standard."

There was a nutrition and hydration procedure in place and we saw that this was followed. Where required, people had been assessed by a speech and language therapist or dietitian and, where needed, their diets had been adapted. For example, a soft diet was available for people who had difficulty with eating and swallowing. We saw food and fluid charts were documented and included people's food preferences, individual dietary requirements, and food allergies were written in care files and were written on the chef's whiteboard in the kitchen. Menus were reviewed weekly and included healthy food choices such as fruit and vegetables including bananas, grapes and salads. People told us there were snacks and drinks available for them throughout the day. A relative told us, "There appears to be a good assortment of food available and drinks are always offered even when I come to visit."

The chef explained that people's dietary needs were assessed when people moved into the home and that meals were provided for people to meet their cultural needs such as vegan, vegetarian and Halal meals. One person commented, "I like Caribbean food. I came to this country very young and it's nice to be reminded of my home food even if it's not exactly the same" and another explained, "I don't particularly like the quality of food here but I suppose they do have a selection of different food. But it is whatever is on the menu that goes and I have an English taste like my [family member] did and the food isn't the best, not like what you would eat in a restaurant."

One family member told us cheerfully, "I like to call it the Pimlico Ritz. The chefs here are so good, including this [chef] here. The quality of food is fantastic, the consistency and they have soft puréed food for those who need it. The solid food is to die for. I'm vegetarian, they have barbeques here, and they make such tasty vegetarian food, it's so hard to find decent vegetarian options when you go to eat outside, I only know too well. But this place is excellent, it's [persons] birthday and so [the chef] will bake a marvellous cake for the occasion as they do for all the residents, and those that are allowed an alcoholic beverage will have one to celebrate. It really is lovely here, they make the residents feel like they have a quality of life."

People and their relatives told us they had access to health care and health professionals were always available to assist them with their healthcare needs. One person told us, "The doctor here is extremely good. I tell him/her when I feel like there's something wrong with me but first and foremost I do tell God," and

another reported, "Yes the doctor here is excellent I saw an optician once as well. I know I can get appropriate help should I need it." A relative further explained, "Yes my [family member] does, that's never a problem at all. The doctor comes every week which is so handy."

We spoke to the GP who visited the home twice a week, during which time the GP visited every person who received end of life care. In addition to this, the GP was available on an 'as required' basis and liaised with the pharmacist and the specialist at the local hospice. The GP explained that every person was seen once every two weeks and was very complimentary about the care provided by the home. The GP had been involved with the home as the dedicated doctor since 2009.

Care files we viewed showed that people had been appropriately referred to health care professionals as needed such as occupational therapists, dietitians, dentists, physiotherapists and the palliative team, and contained a recorded input from health professionals. We saw that where people had pressure ulcers we found they had been seen by the tissue viability nurse and staff used specialist equipment such as cushions, mattresses and hoists. We found that people were turned at the appropriate times and we noted where a person had a pressure ulcer on admission from hospital that a wound management plan was in place and we saw the pressure ulcer was healing. Pressure ulcer groups were held in the home for staff to discuss best practice. One person told us, "I was in pain all the time when I came in, but not anymore." We evidenced good practice of staff using colour dots as indicators on the front of people's care files to predict the likely course of a medical condition.

Where people had been diagnosed with diabetes there was a diabetic support plan in place and this was followed. People's risk of malnourishment had been assessed using a tool designed for this purpose, the Malnutrition Universal Screening Tool (MUST) and we found people's weight was regularly monitored. We spoke to the occupational therapist who observed how people were moved and positioned safely and spoke positively regarding the care provided by the staff. One person explained, "I usually listen to what the nurse and doctor have to say and do things accordingly. They recommended physio once and that really helped. Once I have a wheelchair I will be able to move about more and leave my room from time to time. I like my own space so I enjoy being in my room."

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the staff that supported them in the home. People told us, "They are kind people and I feel like they know me as a person, they call me by name which is more personal and friendly" and another explained, "They are nice, they do try their best given the circumstances and I do appreciate that, it's not easy looking after those who are not very independent. I'm quite lucky I have come a long way."

Relatives we spoke with told us the staff were attentive and kind, "They are very attentive and very approachable. They know my [family member] as he/she has been in here a while now so they know his/her needs although my [family member] can't speak my [family member] is alert," and another relative commented, "They are friendly and kind, we have a laugh with them as well." A third relative said, "The staff are attentive in terms of caring for my [family member], but they need to improve their management."

We observed staff interactions with people and observed that staff had in-depth knowledge of the people they worked with and showed true empathy and kindness when supporting people in the home. People were spoken with in a kind manner and staff were seen to be attentive and caring when supporting people. For example, we observed a care worker guiding a person back to their room, and asking the person reassuringly to walk "gently".

A relative told us, "They always talk to me on the phone if they feel I should know something. My [family member] had a little [health] scare so their [health need] was reviewed. Every day my [family member] is alive is a bonus for us. I'm grateful to the staff here for keeping a close eye on her/him."

People were supported to express their views and make informed decisions about their care, treatment and support and relatives were involved in discussions about their care. Care records showed discussions had taken place before people were transferred and discharged into the home and offered advocacy support when needed. People explained that staff asked about what they would like to the wear, the type of food they preferred, and if they would like their bed made, but one person disagreed and said, "Once they didn't let me wear my favourite red and white striped socks because they said I had them on for too long." A relative told us, "Yes staff do facilitate people to make decisions where they can, they really do try to encourage people's independence here. The activities that they run really help too."

The registered manager told us people were given the option to personalise their rooms before coming to the home, and we saw people's rooms were furnished with their personal items, such as ornaments, books, music and photographs. A relative told us, "The staff here always treat my [family member] with great care, dignity and respect." The provider's privacy and dignity policy guidelines read 'staff must knock and wait, address service users by title or preferred name, encourage independence, and to treat people in a dignified way,' and we observed that staff adhered to these guidelines. The registered manager showed us bright day labels they had designed for people's doors that said 'please knock and introduce yourself' and told us she planned to give them to people if they wished to use them. The home had celebrated Dignity Action day. The day aims to ensure people who use care services are treated as individuals and are given choice, control

and a sense of purpose in their daily lives.

People told us staff respected their privacy and said they were able to receive visitors, one person said, "My room is the most private place, but I suppose I could go into the lounge if no one else was there. They all knock before coming in. I wouldn't have it any other way, everyone has a right to their own personal space. I have visitors around whenever they are able to make it in, my family have busy schedules and they all vary" and another told us, "They do knock before they enter which is nice because it gives me privacy. I'm sure visitors can come round at certain times of the day." A relative informed us, "My [family member's] privacy is always respected as is her/his dignity, they make sure they close the door when they are attending to [my family member's] needs which is what I would expect."

The home had achieved the Gold Standard Framework (GSF) and were awarded and accredited for the 'commend' status in April 2016. The GSF offers training to all staff providing end of life care to ensure better experiences for people. Advanced care wishes were written in people's care plans on how people wished to be supported with their end of life needs and evidence of discussions, observations and planning were documented. We saw recorded that a person had asked to be taken on a scenic riverboat trip to view beautiful and natural scenery and this wish had been granted. This demonstrated that people's wishes and preferences were recognised, valued and celebrated.

The home worked in partnership with other multidisciplinary teams such as the palliative care team and the hospice. Do not attempt resuscitate (DNAR) forms were in place for individuals where appropriate and we saw evidence of discussions with health professionals and people's relatives to ensure that people's needs were met. During our inspection, a relative visited after their family member had passed away in the home, to see the staff and people who lived there. We observed staff members welcomed the relative warmly. The registered manager explained they worked closely with the hospice and as part of people's individual bereavement counselling, visits to the home could be therapeutic for relatives.

Compliments and cards were written by people and their relatives regarding the care they received when using the service. One relative gave praise to the staff for restoring their family member's confidence after a serious health condition. The relative concluded that staff had supported their family member to regain confidence and become stronger and more independent because they were able to make their own tea and porridge in the morning. The registered manager told us, "We recognise that the home provides palliative care for some people in the home, but we encourage people to be independent, aim for people to get better and be able and live in the community." Other written compliments included, "Thank you for the security" and "For receiving a better level of care," and "For giving up your Christmas."

Good

Is the service responsive?

Our findings

We asked people and their relatives if the service was responsive to their needs and one person said, "They ask me how I like things to be done. When my [relative] came yesterday to pick me up for lunch I asked for my bed to be made earlier and they did this for me." A relative commented, "I do think they are very responsive here, I mean look at the progress [my family member] has made since she/he first moved here, from being unable to move in bed to being able to walk again." Another relative explained, "Yes they are, my [family member] can't get involved in activities and such because she/he is bed bound but my [family member] does have the television which is good. Whenever my [family member's] health needs change they are on the phone to me straight away which I'm very satisfied with."

We spoke with the activities coordinators and saw they were enthusiastic about their work and we observed a good rapport between them and people during their one-to-one interactions. A person had written a compliment regarding the activity that read, 'I enjoyed the words of comfort by the activity coordinator'. Activities that people had participated in included silver Sunday tea dances, arts and crafts, baking, balls games, fancy dress parties, pampering sessions and children came to volunteer from a local school to visit people in the home and perform music. The activities staff told us that people benefited from interacting with young people as this relieved boredom and improved their well being. We spoke to the hairdresser who had worked in the home for 10 years. She told us she thoroughly enjoyed her work and was seen taking people to have their hair done to help enhance their self-esteem and take pride in their appearance. There were rummage boxes in place to help people living with dementia reminisce to share meaningful conversations. One person told us once their mobility improved they would attend the activities in the lounge, and the activities coordinator held one to one activities in their room. They said, "I don't really mind, once I am able to get into the wheelchair. I wouldn't mind going into the lounge for activities, they massage my hands and do manicures sometimes. I don't get bored easily, I keep myself occupied by reading."

Celebrations for people's birthdays were held and we saw the chef had won the provider's Christmas cake competition. The cake was designed as a Christmas tree and laced intricately with iced branches and colourful Christmas parcels. The cake was displayed on the front of the provider's newsletter and sent to all the people who lived in the home. This showed that the catering team took a genuine pride in providing special experiences for people.

Residents and relatives meetings were held to discuss any issues of concern and inform people of any changes about the service. Records showed that pet therapy was due to take place and another barbeque was planned. A relative commented, "It most definitely puts the needs of people first. I attend meetings and I do feel like our voices as friends and relatives are listened to and respected" and another relative commented, "I think it is centred around management. I do attend meetings regularly every month but no, I don't feel particularly consulted, I hardly see the regional manager much to be quite honest." There was a suggestion box near the entrance door so people could give their views and ideas regarding how the service delivery could be improved.

We observed an activity session held at the home called 'Namaste'. The Namaste Care Programme

integrates compassionate nursing care with individualised, meaningful activities for people with advanced dementia at the end of their lives. Namaste Care seeks to engage people with advanced dementia through sensory input, especially touch, and to enrich their quality of life.
The atmosphere seemed calm; the lights were dimmed, the room was filled with lovely aromas and therapeutic music played in the background. The people that were involved appeared very comfortable and at ease. We looked at activity records, which showed the provider had held a conference, and the founder of the programme was one of the speakers. We saw that the founder had also attended the home and observed a Namaste session. One relative commented, "Great care and activities that really benefit physical and mental wellbeing, I don't know what possibly they could improve here."

We saw that the activities coordinators were fully engaged, and patient with people during the activities for example, we observed the ball games where three people who participated had limited mobility. The people appeared alert and responsive to the games that were played which included throwing the ball to the activity co-ordinator, hitting skittles, throwing darts, and throwing a bean bag onto a target hoop. All the activities involved coordination and physical movement of their hands and arms. The activities co-ordinator persevered with people to support them to engage and gently encouraged them during the activity. We noted the staff member interacted well with people on a personal level, addressing each person by their first name and talking with each of them while conducting the activity. The co-coordinator then made people cups of tea and coffee and finished the activity in time for lunch preparation. On relative told us, "I mean you can see [my family member] loves to take part in the physical activities, my [family member] loved sports, and went on tour with [a celebrity] so they talk to [my family member] about that because he/she likes that. They know what [my family member's] physical needs are they are very much on top of it all."

Information about some people's life history and photographs were not included in their files. We saw that the care plans were under review, and the regional manager showed us new care records they would soon be implementing, such as a new simplified plan, in particular in respect of end-of-life care. During our inspection, we saw staff completing training in the new approach to person centred care planning. The care plans showed that prior to the person coming to live at the service, there was a detailed assessment of needs carried out and the registered manager determined at that point if they could meet the person's needs. Care plans monitored positive outcomes for people and included a new resident settling in checklist, daily records, activities logs, communication from relatives and representatives, acute and core care plans and we saw these had been reviewed when people's care needs changed.

The provider had recently held an event called 'building a dementia friendly society', to hold a celebration of the provider's three homes. This aimed to ensure people with dementia received the understanding and support they needed to lead enjoyable and fulfilled lives.

Records showed that the provider took into account people's cultural needs, we saw religious and spiritual advisors were available and interpreters were made available to people when requested. One person told us, "I like to watch television that's enough for me, and I have my mobile phone to call up my loved ones so that keeps me busy. I don't really have any cultural needs so to speak." and "I'll tell you now God is my best friend, I'm not bored if I have Him." In addition, one person described they liked watching the television and listening to the radio about their religious beliefs.

People said they would know how to make a complaint and were confident their concerns would be listened to. There was a complaints procedure displayed on the noticeboard for people and staff said they would support people if they wanted to make a complaint. The procedure gave information about external organisations that people could take their complaint to if they were not satisfied with provider's response. We viewed the welcome packs given to people when they arrived in the home and noted it was recorded

that people could speak directly to the Care Quality Commission (CQC) if they had a concern or complaint. We spoke with the registered manager and explained that this was incorrect as it was not within CQC's powers to investigate individual complaints. CQC however, does respond to information of concern about providers and therefore is interested in receiving information about care services. The complaints investigated showed that the appropriate action was taken within the timescales outlined in the provider's policy. One person said, "I've not had to complain about anything before but I'm sure they would listen if I had any concerns and take the appropriate action" and another person told us they would speak to the registered manager when they had any concerns and said, "The manageress, I have always spoken up if I have any concerns."

Good

Is the service well-led?

Our findings

People and their relatives gave positive views about the management of the home and told us they knew who the registered manager was. One person said, "I do see them they come round and give me a hug and say hello" and another person commented, "She stops by to ask how I'm doing." The majority of relatives we spoke with echoed this. One relative told us, "I couldn't really fault it, the care is of a high standard. The staff are brilliant, every single one of them," and another said, "It's good, I wouldn't say it's the best but it's not bad I've heard horror stories about other places but this one is decent" and the third relative reported, "I don't know much about it but I would like to say the home appears to be well managed."

We saw there was a high level of commitment from the management team, from the regional manager to the registered manager and the clinical leads. Members of staff that we spoke with were complimentary about the support they received from management, in particular from the registered manager. The clinical lead described the registered manager as "very supportive". One care worker told us, "It's the 'way' she speaks to me and asks me to do something, very respectfully" and further explained when the care worker had a concern that the registered manager acted on this and resolved the concern immediately.

One staff member had nominated the registered manager for the provider's 2016 'kindness awards' and had written, 'The manager is professional and makes you feel you matter. I aspire to be like her, we have a full strength team.' The kindness awards were held annually by the provider to give recognition to members of staff that go over and above to keep kindness at the heart of care.

The registered manager was a qualified nurse and had worked in the home for a number of years before advancing to the role of registered manager. During our inspection, we found her to be professional, patient, empathetic and she displayed a positive attitude throughout the inspection. Her qualifications included a higher national vocational qualification in health and she was due to soon complete the provider's management programme. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.

People told us their overall opinion of the home and their comments included, "I'm quite content", "I have got used to it here now" and "I suppose it's not bad is it." One person told us that if they were scoring, "I would give it a seven out of 10." People's relatives reported, "Fantastic, no faults as far as I'm concerned" and, "I'm happy with it overall, I know my [family member] is in good hands, considering her/his condition," and another said "It's good."

Good systems were in place to monitor and improve the quality of care people received. The registered manager attended monthly GSF meetings. The service was awarded the Quality Hallmark Award in March 2013 for the period 2013-2016 and in March 2016 for the period 2016-2019 by the GSF team. This demonstrated that a high quality of care was provided by the home.

We reviewed the audit conducted by the GSF team and the inspection was comprehensive in its scope,

covering aspects from staffing, infection control, hospital admissions and medicines management. The home received a final score of 47 out of a possible 50 and was given eight 'excellent' ratings. We saw at the most recent audit the home had been awarded a score of 62/68 in respect of the medicines audit.

People were protected from risk as the registered manager ensured lessons were learnt from any incidents and accidents to protect them from further harm. They used this information to identify any trends around accidents and incidents. For example, recent analysis showed where more participation was needed from multi-disciplinary teams, such as bereavement support. Additionally we saw records to show that call bell audits were completed to check the response times. The local authority carried out monitoring visits and any shortfalls found were acted on and clear improvements made. The CCG worked in partnership with to monitor positive outcomes for people using the service. The registered manager operated a range of audits within the home. Where audits or observations identified concerns, clear actions were implemented. For example, ensuring the all the staff received training on person centred care, and ensuring people's care plans were regularly reviewed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure the staff receive appropriate supervision to enable them to carry out the duties they are employed to perform Regulation 18 (1) (2) (a)