Elmbridge Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 January 2018 and was unannounced. It was carried out by one inspector.

Elmbridge Residential Home Limited 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. The home can accommodate 16 people in one adapted building. During this inspection 15 people lived there. The home specialised in the care of older people who lived with dementia or who had mental health needs.

The home provided people with accommodation which comprised of 14 single bedrooms and one shared bedroom. People had the use of communal toilets, a bathroom and a shower room, as well as a lounge, conservatory and dining room. A garden to the back of the home provided people with a safe space outside to enjoy. Limited car parking was provided but car parking was possible in the surrounding area. There was disabled access into the home. Inside a stair-lift supported access to the second floor.

A registered manager was in place. 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.

At the last inspection on 2 and 6 February 2017 we rated the service Requires Improvement and asked the provider to take action to make improvements. These were to ensure people received their medicines as prescribed, that systems were in place to assess, monitor and improve the quality and safety of the service and to ensure accurate records were held with regard to people's care and treatment. The provider was required to submit a monthly written report (to CQC) with the results of their quality monitoring and the improvements they had made to the service. We found the above necessary improvements had been made. Improvements to the key questions, is the service safe, effective, responsive and well-led? had also been made in order for the rating of these, as well as the service's overall rating, to improve to Good. The rating for the key question, is the service caring? was previously rated a Good and has remained Good.

During this inspection we made two recommendations to further improve the provider's good practice in relation to the managing of environmental risk and gaining additional professional support. There were arrangements to keep people safe. Risks were identified and action taken to reduce these. People were protected against potential abuse and staff worked with other agencies to safeguard people. There was zero tolerance of any form of discrimination. Staff were recruited safely and there were enough staff on duty to meet people's physical and emotional needs. People received their medicines as prescribed and safely. The home was kept clean and arrangements were in place to prevent the spread of potential infections. The kitchen had been refitted and the home had been recently awarded the highest rating possible by the Food Standards Agency.

People's needs were assessed and staff worked closely with other professionals to ensure people received the care they required. Staff had received training and people's diverse needs were met safely and skilfully. Staff understood and adhered to the principles of the Mental Capacity Act 2005. 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. People had a choice in what they ate and their nutritional wellbeing was monitored. Some adaptations had been made to the home to support people's independence and to help them receive safe care.

People's care was planned with their involvement and the involvement of their relatives. Care was personalised around people's likes, dislikes, preferences and wishes. Daily and social activities brought a quality to people's lives and helped them retain skills. A complaints process was in place but open and transparent communication with relatives and others meant complaints were rarely received. People at the end of their life were supported to have a comfortable and dignified death. Relatives were provided with support at this point.

The registered manager provided strong leadership. They were fully aware of what was going on in the service and they communicated effectively with their staff. They were fully committed to ensuring the service provided a high quality of care. The arrangements by which the service was monitored had improved. A new electronic quality monitoring assessment tool had been chosen. This was to be started soon to help the registered manager assess the service's on-going level of compliance with necessary regulations. Feedback had been sought in a proactive way from relatives and the management and staff were open to suggestions and ideas. The staff did not belong to, or attend, professional forums which supported best practice. These could provide the service with support and new ideas. The registered manager told us they were open to exploring some of these.

People were supported to use the local community and there were longstanding links with a local church. The registered manager was open to exploring further ideas and suggestions with regard to links with local community groups.

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's medicines were administered safely and they received these as prescribed.

People were protected from abuse and avoidable harm. Risks were identified and actions taken to reduce these.

There were sufficient staff to support people and safe recruitment practices ensured people were protected from those who may not be suitable.

People lived in a clean home where infection control measures protected them from avoidable infections.

Is the service effective?

Good

The service was effective.

People's needs were assessed and met. People had access to health care professionals, which also helped to assess and support people's needs.

Staff received training which enabled them to look after people's diverse needs. Staff understood people's right to be treated equally.

People were supported to make decisions and when unable to do this the principles of the Mental Capacity Act 2005 were adhered to and practiced.

People were supported to eat and drink and maintain their nutritional wellbeing.

Adaptions had been made to the environment to help people physically and to orientate themselves.

Is the service caring?

Good

The service was caring.

Staff were highly motivated and committed to ensuring people were provided with the utmost kindness, compassion and respect.

Staff were extremely skilled in forming meaningful relationships with people which enabled them to maintain people's wellbeing.

Staff got to know people well in order to personalise the care they delivered and to be able to support people to live well.

Without exception, all staff were committed to ensuring people's dignity was upheld.

Relatives were communicated with and their contribution and involvement in their relatives' care valued and supported

Is the service responsive?

Good

The service was responsive.

People's care was planned in order to meet their needs and took into consideration their, likes, dislikes, preferences and wishes.

Staff involved people in day to day and social activities which improved people's quality of life.

There were arrangements in place for people to be able to make a complaint or raise areas of dissatisfaction and have these addressed.

People were supported to have a comfortable and dignified end of life. Relatives were provided with all the support they needed.

Is the service well-led?

Good

The service was well-led.

The service was led by a strong leader whose visions and values were shared by their staff.

A mixture of informal and formal arrangements allowed the management of the service to monitor the services provided and to make improvements where these were needed.

Arrangements for getting feedback from relatives had improved and staff and management were open to receiving ideas and suggestions which went towards improving the service.

Elmbridge Residential Home Limited

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 10 and 11 January 2018 and was unannounced. It was carried out by one inspector.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We contacted the commissioners of the service to obtain their views about the care provided to people. This included one health care professional.

During the inspection we spoke with one person who used the service and 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 a relative, a visiting professional, the registered manager and two members of staff. We reviewed the comments of two other relatives which had been specifically written and shared with the service since the last inspection. We requested the views of one other health care professional following the inspection visit.

We reviewed the care records of three people and the records pertaining to the Mental Capacity Act 2005 for three people. We reviewed several people's medication administration records. We reviewed one infection control audit and five monthly medicine audits. We reviewed records pertaining to the monitoring of health and safety and cleaning processes. We reviewed four completed relative questionnaires and one newsletter.

We reviewed all accident and falls records since the last inspection. We reviewed two staff recruitment files and five staffs' training certificates. We reviewed four of the provider's policies.

Good

Is the service safe?

Our findings

At the last inspection on 2 and 6 February 2017 the provider had not ensured people received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. During this inspection we found there were arrangements in place to ensure people were supported to receive their medicines safely and as prescribed.

Medicines were administered by staff who had completed relevant training. This included the administration of insulin. We observed staff following best practice when administering medicines. Medicines were stored securely and correctly. People's medicine administration records (MARs) were well maintained and showed when people had taken their medicines. Since the last inspection a new fridge for storing medicines at low temperatures had been purchased. The temperature of where medicines were stored, including the fridge, was monitored to ensure they were stored according to the manufactures guidance. This ensured optimum effectiveness of the medicine.

There were arrangements in place to reduce the risk of infection and staff had received relevant training. Actions were taken to reduce the risk of legionella infection in the water system. Water samples were taken annually and sent to a specialist laboratory for testing. At the last testing in June 2017 no legionella bacteria was present. Appropriate precautions were taken to reduce the risks of exposure to legionella. However, the provider did not have a risk assessment in place that detailed the steps taken to prevent or control risks relating to the water system so that a record would be available for staff to refer to in the registered manager's absence.

We recommend that the service seek advice and guidance, from a reputable source, about the need for a risk assessment in association with the management of risks related to legionella.

Staff took actions to prevent the introduction and spread of infection. For example, they wore protective gloves and aprons when delivering people's personal care and when serving food. Arrangements were in place for the segregation and safe handling of soiled laundry and for the safe removal of waste. The registered manager was aware of when to report the presence of infection to Public Health England.

People lived in a clean home. One relative said, "[Name's] room always smells clean whatever time I visit." The care staff carried out the cleaning. Cleaning schedules were in place and staff recorded the cleaning they completed. Care staff also did the cooking and cleaned the kitchen. All staff had competed food hygiene training and separate cleaning schedules were in place for the kitchen. Since the last inspection, a new kitchen had been installed and the home awarded a rating of '5' by the Food Standards Agency. This is the highest rating an establishment can achieve.

People were protected from potential abuse and discrimination. One person said, "They [staff] all treat you fairly here." A relative told us they felt reassured enough to be able to leave their relative and not worry about how they were being treated. They told us they visited regularly and had never witnessed any form of inappropriate behaviour towards people by the staff. Relevant information was shared with appropriate

agencies and professionals to ensure people were protected. The provider's policies and procedures supported this approach. Training certificates showed that staff had received training on how to recognise potential abuse and report concerns. Staff had also received training on the Equality Act and issues around potential discrimination. The registered manager told us people were treated equally, irrespective of their gender, disability, sexuality, spiritual and religious and cultural beliefs.

Staff had received training in safe ways of working. Risks were identified and action taken to reduce these. We reviewed the support given to two people who had experienced falls. Both people lived with dementia and enjoyed walking freely around the home. Staff were keen that this freedom continued. Actions taken to reduce the risk of injury had included altering the layout of furniture and the lighting in one person's bedroom. Both people had been referred to the GP for a medical review and review of their medicines.

Another person who lived with dementia could not move without the support of the staff. Staff were keen this person did not become isolated because of this. Staff had sought advice and asked for assessments to be carried out by physiotherapists and occupational therapists to find the best way of moving this person. The person's care plan gave specific guidance on how this was to be done. The person no longer remained in bed, which had been the case before they moved to the home.

Care records demonstrated staff monitored the condition of people's skin. Where staff were concerned that a person may be at risk of developing pressure ulcers, they referred the person to the community nurses. They formally assessed the person and where a risk was identified, organised pressure reducing equipment to be delivered to the home. Staff ensured this was used and the community nurses continued to review the person's level of risk.

Potential risks arising from people's behaviours were identified and managed. The registered manager told us staff had been trained to recognise the early signs of behaviour which could be perceived as challenging. Guidance on how to manage people's individual behaviour was woven throughout people's care plans. Staff were aware of what may trigger distress in a person so they tailored their care to avoid these triggers. If needed staff sought advice from specialist health care professionals. One such professional said, "They [staff] seem to know their residents very well" and "They [staff] take up suggestions and they think outside of the box." The provider's Behavioural Management Policy Framework defined safe and transparent ways of working. It stated what acceptable practice at the home was, for example, the home supported "restraint free care".

Potential risks in the environment were monitored and actions taken to keep people safe. Daily visual checks of the environment were carried out by all staff. Monthly checks of specific areas of health and safety were completed and recorded. Staff checked people's bedrooms for example, for any broken electric sockets, plugs and window restrictors were checked. All fire exits were visually checked on a daily basis to ensure they remained clear. Staff recorded anything that needed to be addressed, by the maintenance person, in the maintenance communication book. For example, a radiator safety cover had been pulled off. These helped to reduce the risk of surface scalds from hot radiators. As this posed a risk to people, this was mended immediately. The same was seen for requests for light bulb replacements and adjusting two door closures which had not been closing properly.

Good

Is the service effective?

Our findings

The care people received was based on an assessment of their needs and resulted in good outcomes for people. One person told us they felt well looked after. A relative said, "I think the care is fantastic – it's always excellent. We have had other experiences…I can put the care here into perspective." This relative went on to explain that in a previous care home their relative had "rapidly gone downhill". They said, "They proactively care for [name] here….. we are lucky we found this place." Another relative commented in a letter, shown to us during the inspection, that in their view, their relative had arrived at the home, from another care home, "physically and mentally shot to pieces". It went on to say staff were "alert and diligent" when it came to their relative's needs. The letter said it was through the "dedication" of the registered manager and her team that their relative's quality of life improved so much. A professional said about one person's needs following their admission, "I feel they [staff] went above and beyond to try and settle [name] and meet their needs." Care records showed they had been successful in doing this. About another person they said, "I have no concerns about [name's] care." They went onto to tell us what the staff did to support this person and the fact that this had not been happening in the person's previous care home.

An assessment of need was carried out before admission to the home. This gathered necessary information about people's care needs. Staff could then determine if they could meet these. We spoke with one relative who had been involved in this process. They told us the registered manager had been on holiday at the time they had been looking for care for their relative. Despite this, the registered manager had made themselves available to answer any questions they may have and to reassure them. The registered manager explained that assessments were sometimes carried out in people's homes, other times in other care homes where staff found they could not meet the person's needs. Professionals involved in a person's care, at the time of the assessment, were consulted.

We reviewed staffs' training certificates which confirmed they had completed training relevant to people needs. This had included dementia care and the dementia pathway, challenging behaviours and person centred care, nutrition and diet as well as safe moving and handling. One member of staff said positively, "We are always having training to complete." Another member of staff said, "[Name of registered manager] is very hot on training and is always making suggestions." Feedback provided by a relative since the last inspection stated, "I never had any doubt that staff were adequately trained to take appropriate action when needed."

The registered manager showed us how they organised the staffs' training. All staff completed induction training when they were first recruited. Staff new to care completed the care certificate. This training aimed to support staff to be able to deliver basic care, to a recognised standard, once completed. Through individual meetings with their staff the registered manager knew what their on-going training needs were and monitored staff's compliance with the provider's policies. For example, staff were waiting for spaces on the county council's dementia leadership and dementia link worker (DLW) course. We spoke with one member of staff who had completed the DLW course. They spoke about one person's dementia in a knowledgeable way. They told us they were able to support other staff with dementia care. One member of staff wanted to complete additional training in end of life care so the registered manager was looking for an

appropriate course for them.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf, must be in their best interests and be as least restrictive as possible. We found people were supported to make independent decisions and care was delivered in the least restrictive way possible. The registered manager told us how two people who had required surgical interventions had been supported to make their own decisions regarding this. Where people were not able to make decisions independently, the decisions made on their behalf, about their care and treatment, were recorded in their care plans.

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 found three people had authorised DoLS in place and these had no conditions added. The service had been slow in making applications for some people following their admission, however, the registered manager was working through all necessary applications. Two completed applications were awaiting assessment by the supervisory body.

Decisions regarding resuscitation had been discussed by a GP, with people or their relatives. The decision was clearly recorded so that visiting emergency health care professionals were aware of what these were. People had access to appropriate health care professionals. A GP provided an 'enhanced' service, which meant they visited every other week to review people's medical needs. GPs also visited in-between when people were taken ill. Community nurses visited some people on a regular basis. The registered manager told us they had a close working relationship with mental health professionals. They were able to speak with a specialist mental health practitioner and Consultant Psychiatrist when needed about people's mental wellbeing. One person's behaviour had altered significantly, so the registered manager had referred this to one of these professionals. During the inspection this person was reviewed by the Consultant Psychiatrist. People were supported to access NHS optical (eye) and dental care. People had access to chiropody (foot care).

All people required some form of support to eat and drink. People needed to be reminded that it was time to eat or drink. Staff encouraged them to move into the dining room to eat, not because there was no choice in this, but because it was an opportunity to get people walking. They were then also seated around prompts which were associated with eating and drinking. For example, at a table which was laid in readiness for a meal, near to the kitchen hatch where familiar meal preparation noises and smells came from and with others who were eating.

People who were at risk of losing weight were provided with additional calories by having butter, cream or powdered milk added to their food and drinks. People's weight was monitored and staff referred to the GP if they had concerns. One person had slowly continued to lose weight over a period of time. The GP was aware of this and medical tests had been completed. This person was monitored at mealtimes and supported to have snacks in-between, which we observed them eating as they also walked around. Another person had been sleeping for a couple of hours during one afternoon. They were gently woken up and provided with several glasses of squash to ensure they caught up with their fluid intake. They were also offered and accepted fruit to eat.

Staff helped people to make choices about what they ate. We observed staff talking with a group of people about their evening meal. A collective decision was made and a full English breakfast style tea was decided on, so this was cooked and enjoyed. A relative had told staff that their relative enjoyed Chinese food, so this had been added to the menus. People's independence at mealtimes was supported. One person who lived with dementia required support to maintain their weight. If, at times they chose to eat with their fingers, and this meant they carried on eating but without using cutlery, staff supported this. Bed-time drinks and sandwiches were available but specifically encouraged with one person to help promote a better night's sleep.

Technology was used to support independence and safety. The registered manager explained that alarmed sensor mats were sometimes used when people first moved in. This was so staff could monitor people's risks while they got to know the person. For example, a person known to be at risk of falling maybe distressed by unfamiliar faces [staff] checking on them at night. A sensor mat alerted staff to movement, which they could then check on and provide support if needed.

Some adaptations had been made to the environment to support people. For example, a stair lift helped people access the second floor and a bath hoist helped people get into the bath safely. Some chairs in the dining room had wheels which could drop down from the main frame. This made it easier for staff to help push a person towards or away from the table. Pictorial as well as written signs helped people locate a bathroom or a toilet. Outside, a path took people from the conservatory into the garden. Ornamental railing provided a boundary between the car park and the garden. The gate to this was secured so that access to the road at the front, without staff support, was prevented. A few bedrooms also had patio doors leading into the secure garden. This garden acted as the outside 'safe zone' in the event that people who lived with dementia needed to be evacuated from the building.

Good

Is the service caring?

Our findings

Staff delivered highly personalised care which maintained people's wellbeing. Both staff and the management were fully committed to ensuring people who lived with dementia and who had mental health problems, had a voice. One relative said, "…..the staff are really quite loving you know. They look after people as you would want a family member looked after." A relative's comments in a letter to the registered manager pointed out the "special bond" staff had with their relative. The letter also contained the comment, "Your whole team is a credit to you." The registered manager told us that, "In their [the registered manager's] heart of hearts the people would always come first." They were passionate about ensuring people had quality of life and their staff were also fully committed to this.

We observed staff showing affection towards people and people responding positively to this. For example, we saw all staff, at some point during the inspection, give someone a hug or just simply hold their hands. Staff were afforded time to sit with people and to talk and engage with them. We observed that the majority of staffs' time was spent engaging with people or just being around them. Staff had a genuine interest in people and this came over in the way they interacted with them. Care and compassion also came over in the way people's care was planned and what was considered at this point. One person's care record for example, stated that the person was a very caring and sensitive person who could easily become distressed by the distress of others around them. It went on to state how this person would be protected and supported from this.

Some people had complex communication needs and many required support to express themselves. Staff knew the people they looked after extremely well. They had taken the time to have open and transparent conversations with people and their relatives, so they learnt about what was and had been important to them. The registered manager said, "You learn about people as you go."

Staff used innovative and creative ways to build up effective and trusting relationships with people, which subsequently had a profound impact on their quality of life. These special connections with people meant, people with complex needs, received the physical and emotional support they required. Some people were unaware of their needs and were totally dependent on the staff to understand what it was they needed. This was done with one person through the use of humour and banter. The registered manager explained that, through this kind of communication, they could "sew a seed" in the person regarding the need for personal care. Staff explained that communicating this message, in this way, over a few days, usually resulted in the person being receptive to staff supporting them without them getting distressed.

A member of staff spoke with us about another person who could get easily distressed. This person was highly vulnerable both physically and mentally. They were unable to express themselves verbally. The member of staff explained it had taken the staff team many months to build up a trusting relationship with them. The staff member demonstrated, on us, how the staff approached this person, which was in an extremely caring and non-threatening way. This had enabled staff to deliver care to this person without causing undue distress. It had improved this person's quality of life because, over time, they had allowed staff to get close enough to them to be able to move them. The result of this was that the person spent time

out of their bed and on most days, sat with others in the communal rooms. The registered manager explained that they had been asked to accept this person because staff at the person's previous care home had not been able to manage the person's "challenging behaviour."

We observed another special friendship which had built up between one member of staff and another person. We observed this person put their arms around a member of staff and look in their pocket for a sweet. This interaction had become a "little habit" which the member of staff had banter with the person over. This interaction was friendly but remained professional and enabled the member of staff to attend to the person's personal care needs. The member of staff had used a moment of wellbeing and connection with a person to help maintain their dignity. The registered manager explained that when this person first arrived at Elmbridge Residential Home they expressed a lot of physical behaviour which had been extremely challenging to support. A professional who had reviewed this person's care told us, "Staff here are very kind in their approach."

We observed all staff, without exception, to be skilful at making caring and thoughtful connections with people. One relative told us about the time they had visited and found their relative in a state of wellbeing; brushing a staff member's hair. This had resonated with this relative as a "lovely thing" to see. It was something that their relative had probably done when younger with a family member. The relative said, "It's like a family here."

Staff had in-depth knowledge of people's likes, dislikes, preferences and their life story. The registered manager valued the input relatives gave and took the view that through joint working, staff and family members, could help people live well. Therefore a great effort was made to learn the detail about a person. The registered manager explained how important it was for staff to know who it was that mattered to people, both present and past and what their relationship/s had been like. They explained when people reminisced, mentioned a name or behaved in a certain way, staff were far more able to provide a meaningful and compassionate response if they were aware of the context.

The staff culture was one of caring for each other. One member of staff told us they had received exceptional support from the registered manager. This had been when they were unable to work. The registered manager spoke of some members of the team having worked in the home for many years. They said, "You get to care for each other."

Relatives were made to feel welcomed and part of the family. The registered manager explained that relatives were often in need of "love and compassion" as well. They described the support they gave to one relative who found visiting difficult at times. Information about how to access advocacy services was available. The need for independent advocacy for people was considered and organised when needed.

The last review carried out by commissioners of the service in August 2017 also highlighted the fact that it was "the little things that matter" and "going that extra mile to fulfil residents' wishes." They described Elmbridge Residential Care Home Limited as a "home from home" and commented, "…..the residents along with the staff, are at the heart of the home."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care records showed relatives were involved and consulted with about people's care. One relative said, "I'm consulted about [name's] care. I can ring up and speak to [name of registered manager] anytime." Relatives had opportunities to speak on their relatives' behalf.

Care was planned around people's preferences and wishes. Care planning took into account people's diverse needs. Care plans recorded people's wishes to remain independent and recognised and promoted retained skills. For example, one person's care plan recorded that the person enjoyed finger foods. It also recorded that the person could use cutlery, when reminded to do so, but this made them tired. Another person's care plans made it clear what the person could do for themselves and what they required support with. In the case of one person who lived with dementia the impact of a physical condition had also been recognised. The person's activities care plan recorded what activities the person enjoyed taking part. It also made reference to the frustration the person experienced with regard to their physical condition. Despite this, in the summer, this person had enjoyed helping staff in the garden.

People's choice and control was supported. Just prior to a set tea-time we observed two people sitting at a dining room table. The registered manager explained that when people sat at a dining room table it was usually an indication they were hungry. At this point staff served these people with their evening meal, which they both enjoyed. The registered manager told us that both these people were prone to getting up and walking away from their meals. They told us it was therefore important to offer them food when they were indicating they wanted it. They said, "We fit in with them. If they return later with the others they can have more to eat if they want it."

Social activities and day to day activities were supported by the care staff. We observed several lovely interactions between staff and people which took place around an activity or just through talking. One talking activity was started by a member of staff who introduced four people to a toy dog. People engaged with the toy and a host of topics were discussed for the next 45 minutes. This included some reminiscence; for one person this had been about their days in one of the armed forces. Table games were played and we observed staff suggest a game to two people. Staff told us without this prompt these people would not socially engage or move from their armchairs. We observed these people to be thoroughly engaged in the activity. One person in particular, smiling and becoming quite competitive. At the same time, the member of staff was engaging them in conversation and laughter.

One person enjoyed sport of any sort and they confirmed this in conversation with us. They enjoyed watching this on the television so we observed them doing this at times throughout the inspection. Another person was supported to visit local areas with animals, which they loved. One person had enjoyed going out and shopping, but staff had noticed a change in this person's desire to do this. They now supported them to go for a more local walk if they wanted to.

Arrangements were in place for people to raise a complaint. We saw the provider's complaints procedure on

a noticeboard which could be seen by visitors. The registered manager discussed a complaint which had been raised through the local authority, but had not been raised directly with them. This had been made by a visiting professional, who had left the home with incorrect facts regarding the staffing of the home. The registered manager told us, if the professional had directed their concerns to them first, they could have responded and reassured them. The registered manager had not received any complaints from people or their relatives since the last inspection. They told us they spoke on a regular basis to most relatives and if needed relatives could contact them at any time. They told us they would rather deal with any areas of dissatisfaction proactively, so that these could be resolved, rather than people or their relatives feel they had no other option but to make a complaint.

People were supported at the end of their life to have a dignified and comfortable death. Staff had received training in how to care for people at the end of their lives. They were experienced in providing this support. They had also received training on how to support relatives and friends at this time. At the time of the inspection, no one was nearing the end of their life but feedback provided by a relative since the last inspection described the support their relative had been given. The relative had commented, "When [name] became close to the end of her life, gentle sincere care was given to her until she passed away peacefully in her sleep. [Name] passed away comfortable, cared for and with a member of staff with her. This gave her family great solace." They also made reference to staff attending their relative's funeral, commenting, it "reflects their dedication." The registered manager told us staff did this out of respect, to represent the people the person had lived with at the home and to get closure for themselves after caring for a person so closely.

People's end of life wishes were usually explored with the person's relative, but with the person if they were able to talk about this. Care records recorded what information had been gathered but in places this was limited. The registered manager told us they had tried to engage relatives in the process of advanced end of life care planning. This aimed to have these types of conversations whilst the person was still able to contribute and to avoid information gathering at a time when the person was actively dying. They told us this had not been very successful. They confirmed however that these conversations were usually achieved in time for staff to be able to meet people's end of life wishes. We saw in the home's newsletter (December 2017), the registered manager had broached this topic again and invited relatives to speak to them about this. Staff worked alongside health care professionals and other representatives from the community to ensure people remained comfortable and that their spiritual preferences were met at the end of their life.

Good

Is the service well-led?

Our findings

At the last inspection on 2 and 6 February 2017, the provider had not sufficiently demonstrated there were measures in place to effectively monitor the service, obtain feedback from relatives and act on these to drive improvements and ensure accurate records were kept about people's care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. During this inspection we found arrangements were in place to ensure regulations were met. Improvements had been made to how feedback was sought and how necessary improvements were identified and planned. Care records accurately recorded the care people received.

The registered manager sought feedback, predominantly from relatives. In 2017 a new questionnaire had been circulated to relatives. This requested feedback on 13 questions. These questions were in line with some of the areas we looked at when inspecting the service. A rating had been requested for each question and an invite to make comments. In December 2017 a reminder to complete these and send them back had been made in the home's Newsletter. This in itself had been reinstated after a period of absence and provided another more formal method of communication. The newsletter was a way for the registered manager to update relatives on important information, up and coming events and plans for future improvements.

For the majority of people who lived in the home, retaining the information in the newsletter would be a challenge. They had therefore been involved in, for example, choosing colours for the new lounge decoration, which the newsletter informed relatives about. They were also to be involved in conversations about the plans for improving the garden. Relatives had also been asked to feedback with suggestions, ideas and advice on this.

Relatives had been made aware of a new easy way to provide feedback. This involved a box in the reception area for submitting complaints, compliments and suggestions. The newsletter had also reminded relatives of the registered manager's email address if they needed to contact them.

We reviewed the four questionnaires which had been received back. The majority of the ratings indicated that relatives were very happy with the services provided. There were a few suggestions for improvement. One of these was to have more opportunity to formally review a relative's care with the registered manager. The registered manager had already been thinking of ways to do this, in person or over the telephone. The inspector was able to describe some of the successful arrangements they had seen in other services.

Quality monitoring arrangements were in place. These ensured the service was safe and meeting with best practice and necessary regulations. In 2017 the registered manager purchased an electronic quality monitoring system. Updated policies and procedures had come with this. We reviewed the following policies: safeguarding, equality and diversity, behavioural management framework and infection control. The electronic system provided the registered manager with a tool for self-assessment. They could enter into the system what they already had in place and the tool would cross reference this with all current best practice guidance, legislation and regulations. Where improvements were needed to demonstrate

compliance with these the system produced actions to be completed. The registered manager could then enter what action they had taken, review its effectiveness and impact and provide an audit trail of improvement.

The self-assessment tool had not been started at the time of the inspection because the registered manager had been waiting for an update to the system. This update would bring the monitoring tools in line with changes (introduced in November 2017) in the Care Quality Commission's Key Lines of Enquiry (KLOES). KLOES are areas looked at during an inspection by which a rating is then determined. The registered manager planned to start using this soon. They had already begun to review and update some existing policies and procedures which were more specific to the home.

Since the last inspection an infection control audit had been completed. After completion the home had found it was meeting with necessary guidance and regulations. We reviewed this and found it covered all necessary areas of compliance. This was a lengthy and in depth audit and the registered manager planned to use it annually. In-between they monitored relevant practice through observation, staff competency checks and training sessions. A similar arrangement was being considered for health and safety. This would complement the daily visual checks and monthly monitoring checks already in place.

Since the last inspection, medicine audits had been completed consistently on a monthly basis by the registered manager. These audited the whole medicine system, including medicine records. Between June, July and August 2017 the audit showed six staff had their competencies reviewed in medicine administration. Audits with actions to be completed showed the actions dated and signed as completed. The registered manager told us they liked to address any necessary actions from these audits immediately.

Care plans were audited by the registered manager informally. This was because they were the only member of staff who wrote these and they revisited them on a regular basis. The registered manager was aware they needed to empower and up-skill other staff to complete these. During our discussion about this we commented that the Care Home Support Team (CHST - team of NHS professionals who support best practice in care homes) could provide support with this. Both the registered manager and CHST subsequently let us know that a meeting had taken place and that improvements and learning in this area were planned for 2018.

The management and staff worked closely together. This was a small staff group who saw each other most days and effective communication was maintained. The registered manager communicated their visions and values effectively. The staff we spoke with and observed were clearly committed to these. Staff had meetings, often on an ad hoc and informal basis, because the registered manager was present in the home most days. They explained they and the staff talked over many issues during these conversations. Topics included changes and updates in care, employment issues, staffing and training. The home had a deputy manager who was also in contact with the registered manger on a daily basis. This meant they could seek advice or discuss concerns as soon as they needed to. It was clear, through a mixture of informal and formal arrangements, that the registered manager knew exactly what was going on in their service. They were aware of the staff culture and any issues which may compromise people's wellbeing and they addressed these.

The registered manager was aware of their responsibilities in making sure notifications were made to the Care Quality Commission. The legal responsibility to ensure the rating awarded to the home by the Care Quality Commission was understood by the registered provider. We reviewed the training certificates of the registered manager. These showed they kept themselves up to date with both mandatory care training as well as management related skills.

At the time of the inspection there was limited connection with local professional forums. We discussed this with the registered manager, in terms of making sure they were able to remain in touch with best practice and new ideas in adult social care. The registered manager could see the benefits of, for example, Gloucestershire Meaningful Activity and Wellbeing Forum. This is a multi-agency collaboration between health and social care agencies supporting best practice in meaningful activity and the wellbeing of people. The registered manager told us they would look into this.