St Valery Ltd

St Valery Care Home

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was unannounced and took place on 17 & 18 November 2016. St Valery is a family run residential service for up to 16 older people living with dementia; the service was full at the time of inspection. Some bedrooms are located on the first floor and can be reached using a stair lift. The majority of bedrooms are for single occupancy, some shared rooms are also mostly used in this capacity. St Valery is a large detached and extended former family home with ample parking.

This service was last inspected in September 2015 when we found the provider was not meeting all the regulations inspected at that time in regard to staff recruitment and training, staffs understanding of safeguarding people from abuse, medicines management needed improvement and the quality monitoring and assessment of service quality was not effective. We asked the provider to send us an action plan of what they intended to do to address these shortfalls which they did. This inspection found that the provider had implemented all the improvements they had told us about.

There was a registered manager in post but for personal reasons they had delegated day to day operational management of the service to an interim manager who had worked at the service for 25 years, and had the appropriate knowledge and qualifications to take on this role. An application to register the interim manager was currently being processed by the Care Quality Commission. A registered manager is a person who is 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 provided with a safe, clean environment that was maintained to a high standard, with all safety checks and tests routinely completed. There were enough skilled staff to support people and provide continuity. Recruitment processes ensured only suitable staff were employed. New staff were inducted appropriately into their role, they received training to give them the knowledge and skills they needed to meet people's needs. Staff felt listened to and supported and were given opportunities to meet regularly with senior staff on an individual basis or within staff meetings.

Staff understood how to keep people safe and protect them from harm, they understood how to respond to emergencies that required them to evacuate the building quickly and safely. It was recognised that for people with behaviour that could be challenging some restrictive practices were necessary to maintain people's safety for example, the use of bed rails; although there was a clear culture of least restrictive practice embedded in the service. Risks were appropriately assessed to ensure measures implemented kept people safe. Medicines were managed appropriately.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been authorised for some people and others were waiting to be processed by the local authority to ensure the people concerned were not deprived of their

liberty unnecessarily. People were encouraged by staff to make everyday decisions for themselves, but staff understood and were working to the principles of the Mental Capacity Act 2005 (MCA) where people could not do so. The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for themselves.

People's privacy and dignity was respected. Staff spoke to people in a dignified way and we observed them discreetly intervening if they thought people needed help or support without drawing undue attention to them, this approach ensured the person's dignity was maintained.

Staff demonstrated kindness and patience in their contacts and engagement with people. They took time to listen and interact with people so that they received the support they needed. We saw many positive interactions between people and staff.

People's health needs were monitored and referrals to health professionals made where needed. People were provided with a varied nutritious diet that took account of any specialist requirements they may have. People referred to the service had their needs assessed prior to admission to ensure these could be met. Care plans were detailed and personalised to guide and inform staff about individual needs and how these were to be supported.

Staff were enabled to spend time with people and facilitate activities to provide stimulation; external entertainers provided variety to the activities offered. Relatives felt confident of raising concerns and that these would be acted upon, they felt consulted and informed about their relative's wellbeing. Their views were sought about service quality to inform improvements and service development. A range of audits provided assurance to the provider and interim manager that service quality was being maintained.

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

There were enough staff available to support people.

Recruitment procedures for new staff ensured they were suitable to undertake their role. People were protected from harm. Staff understood how to identify and respond to abuse. Medicines were managed appropriately.

The premises were well maintained and routine checks and tests of fire detection equipment and gas and electrical installations were undertaken. Staff understood the action to take in an emergency to protect people from harm and evacuate them safely.

People were supported to take risks and comprehensive assessments ensured this was undertaken safely to reduce the risk of harm. Accidents and incidents were monitored and actions taken to minimise the risk of recurrence.

Is the service effective?

Good

The service was effective.

Staff received an induction into their role and they received essential and specialist training to give them the right skills and they were given opportunities to meet with the interim manager on a regular basis.

People were supported in line with the principles of the Mental Capacity Act 2005; people's consent was sought by staff in respect of their care and treatment.

People ate a healthy and varied diet, and their health and wellbeing was monitored by staff.

Is the service caring?

Outstanding

There was a strong, visible person-centred culture. People were given opportunities to meet children and students from visiting schools and to participate in activities provided by them.

Feedback from relatives and people was positive and relationships between people and staff were affectionate, caring and supportive.

People's privacy and dignity was respected, staff were responsive and enthusiastic about people's care. Staff respected and valued people; they were attentive but discreet. They supported and guided people to make decisions about their care and support where possible.

Staff supported people to maintain links with their families and friends. Relatives were always made to feel welcome and felt well informed and consulted about their relatives care.

Is the service responsive?

Good

The service was responsive.

People were assessed before coming to live in the service to ensure their needs could be met. People and their relatives were involved and consulted about their care and treatment which was kept under review. Detailed care and support plans guided staff in ensuring care was delivered that was consistent with these.

Staff facilitated activities for people supplemented with external entertainers to provide singing and informative talks.

A complaints procedure was available. Staff knew people well and gave them time to try and understand issues that affected their mood or made them unhappy. Relatives felt confident of approaching staff with any concerns.

Is the service well-led?

Good

The service was well led.

There was a registered manager, who had delegated the operational management of the service to an interim manager. Staff, people and relatives found the interim manager approachable and supportive.

Staff said they felt listened to, and able to express their views at staff meetings. Audits and systems were in place that checked service quality. Staff practice was informed by the provider's ethos supported by policies and procedures that were kept updated.

Relatives were asked to give their views about the service and

their responses were analysed and informed service development.

St Valery Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 the 17 and 18 November 2016. The inspection team consisted of one inspector because this was a relatively small service and people were given the opportunity to share their views with the inspector over two days.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the other information we held about the service, including previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with approximately six people but most of them were unable to speak with us directly about their views of the service, so we used a number of different methods to help us understand their experiences including 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 five relatives at inspection, the interim manager, the deputy manager, four care staff, the cook, and the housekeeper. We also spoke with six health professionals who have regular contact with the service, three of whom we met during the inspection.

We looked at four people's care plans, health records, individual risk assessments, and evidence of activities and stimulation. We also looked at medicine records, menus, and operational records for the service including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance audits.

We last inspected this service in September 2015 when breaches of regulations were found.

Good

Is the service safe?

Our findings

People were relaxed and comfortable in the presence of staff who knew their needs well. One person told us that they had been involved in creating a wall display for bonfire night which they had enjoyed helping with and they thought it was very colourful.

Relatives told us they were more than happy with the service their particular family members received. A health professional commented, "The home is clean and odour free. Nicely decorated and accessorized with people's personal belongings adding a familiar touch. Seating in the lounge areas is arranged so people can watch TV or have quiet time away from it but still be part of the company."

The premises, décor and furnishings were maintained to a good standard and provided a clean, tidy, comfortable home. Repairs were reported and dealt with in a timely way. We did discuss with the interim manager the need to ensure the laundry area was finished off decoratively and this was also highlighted by the fire risk assessor during their inspection as needing some further work and is an area that the provider is aware needs improvement. There was a dining area which could seat everyone and a large lounge that was separated into two areas with the activities and main seating in one end of the lounge and a quieter area at the other end, there was also a small seating area outside of the lounge where people could also sit with a relative quietly if they wished. Although there were shared facilities in two rooms which could be used for couples, these were currently used individually so that people all had their own rooms. There was a secure accessible courtyard with seating and umbrellas where people could sit in good weather.

Equipment checks and servicing were regularly carried out to ensure this was safe and in good working order, we noted that the record maintained of hot water temperature outlets showed a number of areas in the service both in bedrooms and in communal bathrooms where the hot water temperature exceeded 43 degrees, we noted that this had been reported to the provider and action had been taken to replace faulty temperature control valves and also to provide a new thermometer. The interim manager was monitoring two bedrooms and a wet room where temperatures were still above 43 degrees, she was seeking further advice and guidance to rectify the problem and had taken steps to alert people that the water in these outlets could be hot and to assess what further action needed to be taken to maintain people's safety

Internal checks and tests of fire safety systems and equipment were made regularly and recorded. Fire alarm systems were regularly maintained. Staff understood how to keep people safe in the event of an emergency and practiced how to evacuate people safely from the building if necessary; they told us that they participated in walk through fire drills and spot knowledge checks not only with the interim manager but also with a senior staff member who was a fire marshal.

Personal evacuation plans took account of people's individual needs to ensure a safe evacuation. The provider took the safety of people seriously and the fire risk assessment was reviewed annually by the interim manager. A new fire risk assessment was completed every five years by an external fire risk assessor who was on site during our inspection they highlighted some improvements that were needed that the provider should complete in the next three to six months but were not an immediate priority. The provider

had agreed to address these as part of their update to the premises.

Out of hours on call support was available from the interim or deputy manager in the evenings and at weekends to offer support, guidance and advice to staff if there were issues they thought unable to handle, training had been provided to staff on distinguishing what an emergency was and what were events in house that they were able to manage themselves as part of their role, this was to reduce the number of inappropriate calls to the on call staff.

Staff rotas showed there were sufficient staff on shift at all times during the day to meet the needs of people. Staff told us that there were always enough staff and rotas were followed and our observations showed that there were always staff on hand to help provide care and support or to engage with people around activities. At times of staff shortage through sickness or annual leave, only staff that were familiar with the needs of people and their routines were used to provide cover; this helped to ensure continuity in the care and support people received. Agency staff were never used for this reason.

We had previously expressed concerns that full employment histories had not been obtained as part of recruitment shortfalls. The provider had taken action to rectify those issues and to ensure that the recruitment process was more robust. Recruitment records viewed showed that the provider operated safe recruitment procedures. Staff recruitment records were clearly set out. Staff did not start work until the required checks had been carried out. These included a proof of identity check, satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check, a declaration of health fitness and a full history of employment. These processes helped the provider make safer recruitment decisions and prevent unsuitable staff from working with people.

We had previously expressed concerns that staff were unclear about who and how to report concerns. Since then all staff had received refresher training to remind them of their responsibilities. Staff received regular training in protecting people from abuse so their knowledge of how to keep people safe was up to date. Staff understood what to look for as signs of abuse and who they would report their concerns to, including those agencies outside of the organisation, such as the local authority safeguarding team. Staff were confident of raising any concerns they might have to the interim manager including concerns about other staff practice through the whistleblowing process.

We had previously expressed concerns about medicine management but since then the interim manager had implemented improvements to address these shortfalls. Only medicines trained staff were able to administer medicines. There were appropriate arrangements in place for the ordering and booking in of medicines. People were unable to administer their own medicines and this was made clear in their care records. We observed medicines being administered and saw the staff member speaking discreetly with people and explaining what the medicines were for and asking about pain relief if needed. A refusal of medicines was handled well and the medicines were stored safely to be reoffered at a later time. Only one person received covert medicines (this is the administration of any medicines in a disguised form); records showed this was in agreement with the GP and other relevant people in the person's best interest. Medicines including those requiring safer storage were stored appropriately and temperatures recorded. Medicine Administration Records (MAR) charts were completed properly. A returns book was used to return unwanted medicines to the pharmacy. A monthly medicines audit was conducted to ensure medicines were being managed safely.

Risk assessments were completed for each person; these were individualised and took account of each person's specific needs and their personal awareness and understanding of danger and risk. Measures were implemented to reduce the level of risk so that people were protected from harm, from risks within their

environment, or from or to other people. For example, people who were at risk from poor skin integrity were provided with pressure relieving mattresses. Risk assessments of the environment were reviewed and guidance made available to inform staff of what changes had been made. Individual risk assessments were kept updated and reviewed regularly or when changes occurred. Observations of staff practice regarding for example, moving and handling people, showed them to be following guidance correctly.

There were a low level of accidents and incidents mostly linked to slips, trips and falls or incidents of behaviour that could be challenging to others; staff were relaxed and confident in working with people who could at times become agitated. Incidents were recorded clearly. The interim manager monitored incidents and accidents and discussed with staff if any changes were needed to the support people received to prevent similar events in future.

Good

Is the service effective?

Our findings

Individual relatives told us that they were very happy with the support their own family member received from staff to maintain their health and wellbeing and that they were kept well informed by staff of any issues around this. Comments included, "St Valery was the only place we wanted mum to go, they have done so well getting her walking it's fantastic, the use of the stand aid for her has been inspirational, she is eating and sleeping and staff are well informed about her needs". Another relative commented "Since becoming a resident my husband has thrived and put on weight. He is happy and smiles much of the time."

Health professionals spoke positively about the service commenting that the service called them occasionally for advice but that they were rarely called for things like pressure ulcers as the service always had the right equipment and knew what to do, they told us that they had no concerns about the care delivered by staff who always referred people appropriately and had already put in many of the measures they would suggest. They said that people's health needs were managed well, and staff were always prepared when they received professionals and provided them with updated information about the people they were there to visit. Comments included, "This is a really good service, there is a nice atmosphere, and it's like a home". "The manager has sought help in the past when she needed to plan around the choices and wishes of one of her residents and was finding it a challenge with regard to best interest and DNARCPR (A DNACPR decision is a clinical one based on the patient's best interests on whether to provide cardiopulmonary resuscitation in the event that the person stops breathing the patient and/or relatives are consulted about the decision made); she worked collaboratively with me, the mental health liaison nurse and the consultant Geriatrician to resolve this difficult matter."

People were supported by staff to maintain their health and wellbeing. Routine health checks, for example with doctors, dentist and opticians were arranged; and where necessary referrals were made to other health professionals, for example the diabetic nursing service, community nursing service, and mental health professionals. A record was kept of all health appointments and contacts; each person had a hospital passport that provided medical staff with up to date information about their current health needs and how these were being supported. During the inspection a person had collapsed and staff dealt with this discreetly and efficiently to obtain the medical intervention the person needed.

People were offered things they liked to eat for lunch and alternatives were available. Meals were unrushed, and for people who were not interested in eating at the time, meals were set aside to be reheated and offered again a short time later. People had their main meal at lunchtime; this consisted of a hot cooked meal and a dessert. Discussion with staff informed us that menus were developed from knowledge gathered about people's food preferences from people themselves and their relatives. There was a four week menu cycle containing a varied and balanced diet for people. Food and fluid monitoring was put in place as an interim measure only if people were not eating and drinking as per their usual routine. A few people were monitored on a regular basis regarding their food or fluid intake. If there was a risk of someone not eating or drinking enough, food supplements would be offered when prescribed by the doctor. People were weighed monthly although where concerns existed about recurrent weight loss for one person this was being undertaken weekly.

We had previously expressed concern that the provider was not updating staffs 'mandatory training. Since the last inspection the interim manager and her deputy had made a concerted effort to ensure all care staff were completing the online refresher training to update their mandatory training in respect of fire, infection control, safeguarding, food hygiene, first aid, and safe moving and handling of people. Training in relevant specialist areas was also provided for example, the PIR informed us that 21 out of 25 staff had received and completed dementia training through distance learning and through care certificate induction standards. The care certificate is an identified set of standards that care staff can work towards. A training room had been developed and provided not only opportunities for staff meetings but also for informal training to take place delivered by the interim manager who was a trained trainer for subjects including moving and handling. The provider valued the need to embed good practice and ensured staff received support to acquire the right skills and knowledge; much of this was through informal training provided by the interim manager in house.

Observations of staff practice conducted by the interim manager and deputy manager enabled them to recognise good staff practice but also areas where this could be improved upon. The Provider Information Return (PIR) told us that 22 out of 25 staff had completed training to National Vocational Qualification (NVQ) level 2 or had a diploma in Health and Social Care which replaced the NVQ.

Newly appointed staff, in addition to initially working shadow shifts as an extra on the rota, were required to complete an induction programme that included completion over a three month probationary period of the 15 standards that make up the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care, an agency supported by the government. These are an identified set of 15 standards that social care workers can complete and adhere to in their daily working life. The interim manager expected staff to complete five standards during each month of their probation; we noted that action was taken in regard to staff who were not meeting this timescale including extending probationary periods or if not complied with more serious disciplinary action.

Improvements had been made to the frequency and recording of formal one to one supervision sessions. Staff said because the service was small there were always opportunities in addition to their formal supervisions to ask questions, seek advice or have a private conversation if necessary. Staff found senior staff approachable at any time. The interim manager and the deputy manager were very hands on, working alternate shifts at weekends. The interim manager and the deputy manager were always available throughout the week. In this way they were able to remain in touch with people's individual care and also monitor how this was delivered by staff on a daily basis. Staff felt that the handovers they received each day between shifts were comprehensive and these provided them with the information they needed about how people were and who needed closer monitoring during their shift because they may be unwell.

The interim manager promoted an ethos of providing care and support to people that they would want for their own relatives and their care and attention to people showed in the relaxed happy atmosphere that prevailed in spite of some people having behaviour that could be challenging for staff and others at times. Strategies were in place to manage any escalation in behaviour, and appropriate advice and support was sought from relevant health professionals around this. Staff put into practice the distraction strategies recorded in some people's files, for example one person was very anxious, and crying so a staff member asked the person to sit down at the table and brought them a jug of warm water with some cutlery in it, a tea towel and a cutlery tray and they then explained to the person that this was something the person liked to do and showed them what to do., The person responded and stopped crying and started to wash and dry the cutlery. . The number of incidents of behaviour were small and the infrequency of such events gave the interim manager and staff confidence that the support they provided to people at times of high anxiety was effective in reducing incidents of aggression.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. One person had been referred to DoLS because of the need for equipment that could be restrictive. Some people did not have the capacity to leave the premises unaccompanied and the interim manager was aware of their responsibilities to apply for a DoLS if one was needed. Staff supported people when making everyday decisions about what they wore, where they ate, what they ate, what they wanted to do. Where people lacked the capacity to make some more important decisions for themselves around their care and treatment staff were guided by the principles of the Mental Capacity Act 2005, to ensure any decisions were made in the person's best interests, and by people who knew them well. For example some people needed to use bed rails, records showed the relatives of one person had been fully consulted along with the GP and a best interest decision made on their behalf around this, similarly a record viewed showed evidence that a best interest meeting for a person in relation to an advanced decision regarding diet and fluid intake had been undertaken in which health professionals and family members had been involved.

Outstanding ☆

Is the service caring?

Our findings

Health professionals told us, "On my visits I have usually found the home to be 'buzzing' with an air of well-being; it is homely, with each individual being attended to in a kind and respectful manner."

The service was highly regarded by health professionals, they praised the standard of care received at the home; several had chosen this as a service to place their own relative.

Relatives were extremely complimentary about the staff providing care and their experiences of the service. Relatives could not praise the service enough saying that they were always made to feel welcome irrespective of when they visited, one relative told us she visited three or four times per week. Staff had enabled a couple to eat lunch together each week and had set aside a special table away from other people where they could be private when eating their lunch.

Several relatives express the view that staff went the extra mile when providing care and support. Two relatives told us that they felt confident when leaving their relative when they visited; that they thought they were looked after well as were other people it was always busy and felt like home, staff were lovely and they felt they were kept well informed. Another relative said they were 'very happy' with the care provided, their relative always looked well presented and "The girls are lovely I have observed them to be very affectionate." Another said, "Mum's face lights up when staff greet her."

Staff demonstrated enthusiasm and motivation to proactively encourage people to take part in activities, people were enabled to choose what they wanted to do and this motivated and empowered them.

The interim manager explained that they had developed good links with the local primary and secondary school and college providing work placement for secondary school and college students; this had proved very successful and participating students had responded well to this practical experience expressing their appreciation for this opportunity. People enjoyed having the primary school children in to sing for them for special events such as Harvest Festival or Christmas Carols, they were very receptive to joining in and clapping along with the singing, the interim manager said that people always liked having children in the home and recently a staff member had brought in their new baby and people had been excited by this. Older students spent one to one time with people giving them hand massages or undertaking craft activities with them, people enjoyed this and on one day they had set up a 3 hour craft event on two tables in the dining area and this had been well attended and occupied people's attention even for those people whose attention spans were usually much shorter.

All the staff had an excellent knowledge of people and were able to tell us about people and their life history. Staff could tell us people's likes, dislikes and preferences, and understood people's individual styles of communicating their emotions either verbally or through body language to provide the appropriate responses that calmed people or elicited a laugh or a joke. People were provided with information in a suitable format to tell them what the service offered them, these 'service user guides' were made available in the entrance hall and given to each person prior to admission.

Some relatives told us they felt equally as supported by the staff themselves as the relative they visited. Such was the relationship of relatives with the interim manager and staff that requests for support from the service to help relatives participate in and attend important family events was facilitated where possible by staff. This enabled families to enjoy the event with their relative in attendance without the worry of overseeing their wellbeing or checking on their whereabouts.

People were given opportunities to express their own views through service user meetings which were held on occasion and through surveys. Many of the service users enjoyed sitting out in the garden in good weather listening to music, socialising with others, the provider has allocated an area in the garden as a beach hut with a mural painted on the wall. The outside buildings had all been painted with different colours, with camouflage netting hung up for shade. The interim manager and deputy manager recognised that for some people organised activities did not meet their specific emotional needs. In the case of one person who was highly anxious, they had, with their relatives involvement, introduced visits to a friend's home for tea and cake and to meet their dog, this enabled the person to walk with staff support to the person's home crossing a road and using the crossing button to enhance the experience. They responded well to these visits, better than they would if taken out as one of a group of people.

The interim manager was actively supportive of people visiting their family and friends where this could be managed. They described how they had supported one person, who was unable to get into their wife's vehicle. They had dropped off and picked up the person using their own car so that the person could spend time at home with their wife each week.

The interim manager was very excited about Christmas and what was happening for people, she explained how she liked to make this special for people for example, putting up the Christmas tree and turning on the lights was a special event. To mark this she had purchased everyone a special gift to open at this time, this was in addition to the gift everyone usually received on Christmas day.

Sometimes people needed to move on to other care settings for example, if their needs increased. The interim manager explained that when this happened she liked to visit them in the first few weeks of the new placement often driving to other counties to assure her that they were well and settled. These visits continued for as long as the person wanted them to and in one case the interim manager was still doing so every two weeks since the person had moved away.

People were comfortable with each other and some friendships had developed between those who liked to sit with or near each other, with several people sometimes helping to complete a jig saw. Other people were contented sitting and watching others. The atmosphere was relaxed but perpetually busy with staff actively helping people or visitors and relatives coming into the service. Staff were attentive, respectful and most of all kind in their dealings with people. We observed many examples of gentle patient and supportive interactions from staff to the people they supported offering quiet persuasion, prompting and encouragement for example, "Do you want to drink some of your tea up", "X have you finished your coffee?" "Do you want another or do you want to finish this one off." "Would you like to come along with me?" Staff respected people's right to refuse support with medicines, food, drinks or personal care, and reoffered these later.

Privacy and dignity was promoted and maintained by staff. Staff were discreet in protecting people's confidentiality and privacy in the way they carried out personal care support, encouraging people to walk with them to their rooms if they thought they needed to use the bathroom or if they wanted to change clothing, other people were prompted quietly that they might like to use the bathroom. This was undertaken by staff so efficiently that it was barely noticeable that it was happening.

Staff were observed to knock on doors ensure curtains were closed and doors shut when undertaking any personal care support in people's bedrooms or bathrooms. Provision was made to ensure the service met people's cultural needs including access to a service from the local church on a regular basis Staff respected people's choices and understood that the nature of people's dementia may mean their choice could change several times and staff responded positively to this.

Relative's told us that communication with the interim manager, deputy manager and other staff was good and they were always contacted about matters relating to the health and wellbeing of their family member, and any changes in care and treatment before these were implemented.

They said they were included in regular reviews and were asked to contribute their thoughts and felt listened to. They said and records showed that they had helped with information for staff to build a profile of their relative's likes and dislikes and personal history. People were supported to maintain the relationships that had been important to them and a record of communication with relatives showed this was particularly well documented showing visits from relatives and telephone communication from and to relatives.

People were able to choose where they spent their time, for example, in their bedroom or the communal areas. Bedrooms had been personalised with peoples own possessions, family photos, pictures or other items of importance to people that reflected their previous interests.

The PIR informed us that nine people in the service had DNARCPR forms in place (this is a form that records a decision not to administer cardio pulmonary resuscitation) those viewed showed that consultation had been undertaken with family members at the time of a doctor's visit in most cases, in one case we were able to track where subsequent discussion with family had taken place and they were in agreement with the decision made.

Although on occasions people with deteriorating health had been placed on an end of life care pathway and were supported by medical staff coming into the service, the interim manager recognised that there was a need for staff training in this area. They had sought guidance from health professionals as to the most appropriate care plan to document people's end of life care needs. Plans to address these shortfalls were in hand through the support and guidance of a clinical nurse lead for older person's services from the local clinical commissioning group.

Good

Is the service responsive?

Our findings

Relatives told us they had been asked to comment on their relative's care and had no concerns, but if they had any they felt confident of complaining, but had never had cause to do so.

A relative commented "It feels like one big family, they are always doing things like bingo, games puzzles and lots of singing, I have completed a survey, we are kept well informed, if we notice anything we say for example, we did say previously that people needed more to do and they have acted on this and improved the amount of activities, (our family member) has been moved from her original room because it is safer for her, but this was in agreement with our relative and us".

Health professionals commented: "I have looked at care plans and have found them to be person centred". About the interim manager one commented "It was very clear that she knows her resident extremely well, advocating for them for the best outcome."

A mental health professional told us that they were very happy with the way the service had improved, developed and grown and had no concerns that people did not receive the very best care.

During the inspection we observed that people were content and in good moods. Staff deployment was good, which meant that there were always several staff in the main communal area facilitating activities and providing encouragement for people to participate. Some staff were singing to music, which most people enjoyed; some staff were dancing to the music and people showed this amused them or that they enjoyed watching this. Staff were prompting and encouraging throughout this time. For example staff said, "Come on X are you not going to draw anything?" "Come on X what about the bubble song? You like that", and "X what songs do you know? What would you like to sing?" Staff were supporting a group of other people to make Christmas decorations and were prompting and encouraging people to get involved. Other people were completing puzzles or participating in a board game. Staff were proactive in finding other activities to distract and engage with people; they were alert to when people may have finished something and provided them with something else to do.

There was no formal activity planner, but every week a professional entertainer came in each providing a different experience for people. For example, one might provide a solely singing entertainment; others provided informative talks with interactive participation from people that may also include some music and singing. On one day of the inspection people attended an informative talk about the 1960's the speaker played excerpts of popular music of the time coupled with picture prompts and questions about the sixties. Some people called out answers or responded by singing along to songs, this was a very interactive session that people clearly enjoyed.

The interim manager had purchased activity products specifically designed for people living with dementia including empathy dolls and activities requiring dexterity and memory. She had also developed good links with local primary and secondary schools and as a result people from York House and St Valery had been invited to a Christmas dinner at the secondary school cooked by catering students; staff supported some

people to attend this. The provider had recently purchased a 12 seater minibus with the intention of taking people out and trips to a local garden centre for cream tea had already taken place, with further outings planned.

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. An assessment of needs was usually undertaken at a pace to suit the person. For most people this meant either a visit to the service where they could be observed with other people and where information could be gathered from their relatives or representatives, or they were visited at home or in hospital. Further reports were requested from other professionals who may be involved in the person's care to inform the decision as to whether their needs could be met. Several relatives spoke of their experience of the admission for their relative and that they had visited other services before this, but felt they had made the right choice for their relative. Staff were proud that the reputation of the service amongst people in the community and professionals was very good and there was always a waiting list for people wishing to come into the service. For some people on the waiting list the offer of day care had enabled them to become familiar with the service and for staff to develop a good understanding of their needs before they were admitted permanently.

Following initial assessment people's everyday care and support was designed around their specific individual assessed needs. This included an understanding of their background history, interests, and preferences around daily routines which relatives helped to compile. Information about their style of communication, personal care needs, social and leisure interests and level of interaction and the support they may require at night and with any continence management during the day or night. The care plan also reflected any issues their might be regarding the person's emotional state and whether this could at times be challenging, where needed strategies guided staff in managing and de-escalating incidents of behaviour. All of this information provided staff with a clear picture of the person as a whole and guided them in delivering support consistent with what the person needed and wanted. There was also recognition of what people could do for themselves and people were encouraged to maintain independence however small.

There was a complaints procedure in place. The Provider Information Return informed us that no complaints had been received and when we checked the complaints log this was still the case. Relatives felt very confident of raising issues with the interim manager or deputy manager if they needed to and found all the staff approachable. Relatives said they had not needed to complain and any minor issues brought to staff's attention were dealt with immediately. The interim manager had also implemented a comments box with forms relatives or visitors could complete if they wished to.

Good

Is the service well-led?

Our findings

Relatives said they found the interim manager and the deputy manager easy to talk to and approachable at any time.

Health professionals commented they had never had any concerns about the service and found staff very proactive. Comments included "I feel that since the interim manager has taken over the whole atmosphere in the service has changed, there are more activities, and more enabling of people to do normal things like going out, going home with staff with relevant approval. They always refer people appropriately to us and implement the advice and guidance we have provided, feeding back to us how effective this has been, we have no concerns".

Another health professional said of the interim manager, "She is an active participant in the care home forum and has been involved with a recent workshop about 'behaviours that challenge'. Other health professionals made similar comments about how they found the interim manager to be responsive and open to advice and suggestions.
A student on a secondary school work placement from the local school had commented about their time at the service "tremendous thank you for all my time here. It was a wonderful experience; I have gained new communication skills and now have a further understanding of service users."

There was a registered manager still in post, but as noted at the previous inspection, owing to personal reasons, the registered manager had not managed this family run service for some time. They had delegated this task to an interim manager who was another family member who had worked at the service for 25 years. They were appropriately qualified, skilled and knowledgeable to undertake this role. There had been a delay in the application to change the present registered manager arrangements, but at the time of the inspection this was now being processed by the Care Quality Commission to formalise the present management arrangements and for the interim manager to become registered.

The interim manager demonstrated commitment to providing a small personalised and homelike service to people living with dementia, people said? the service had gone from strength to strength. The interim manager and her staff had developed an expertise in working with people living with dementia. The reputation of the service had grown steadily amongst professionals and the general public through word of mouth and there was always a substantial waiting list for places. The interim manager had begun to develop the service and take on the mantle of manager, professionals felt that the service had become more person centred and delivered good individualised quality care and support.

There was a clear management structure with team leaders in charge of each shift. Staff said the interim manager was a good manager, they said both the interim manager and deputy manager had an open door policy and were available for staff to talk to at any time. They said they felt listened to and that their views and opinions were valued. Staff meetings were held with groups of staff for example, night carers. The interim manager promoted an open culture by making themselves accessible to people, visitors, and staff, and listening to their views. Communication was good between the service and others and between staff.

The directors of this family run service were accessible, visible and hands on; from undertaking maintenance and repairs, housekeeping services to keeping an informal oversight of how care was being delivered.

The interim manager delivered training to staff in addition to the on line training courses they were required to do, this interactive training with the interim manager re-enforced knowledge and understanding of aspects of people's care and support needs, for example, how diabetes impacted on their wellbeing and staff responsibilities around this, or how staff were to work with a specific person whose behaviour could be challenging. The interim manager undertook with the deputy manager unannounced pop-ins where they checked that staff were completing night or day time tasks, and people were being supported appropriately.

The interim manager gave direct supervision to the deputy manager. The interim manager had responded to previous inspection comments and had implemented an increased and more structured range of audits to provide better assurance that all aspects of the service were working well. Among some of the audits undertaken were checks of window and door security, that servicing of equipment and installations were being met, first aid box contents were checked, health and safety checks undertaken, and staff made aware of any safety alerts. Internal medicine audits were supplemented by pharmacy audits every six months, audits of administrative documentation including people's fee accounts, complaints recording, daily communications, staff meeting records, and petty cash audits were also in place. People's care plans and risk assessments were checked monthly for updates and audited to ensure this was happening; checks of bed rail safety and pressure mattress settings were also undertaken.

The interim manager reviewed the audits undertaken to highlight those areas where improvement was needed and the actions to be taken. A service development plan was in place to show where service improvements had been identified and were scheduled to be addressed. The PIR told us about actions taken by the provider to improve the service and further planned improvements and these were included in the service development plan, for example, planned improvements to increase the lounge size.

The system was already in place whereby people's relatives were routinely asked in a variety of ways for their views about the service; this could be through phone contact, informal meetings and events where family and friends were invited, and through surveys. Analysis of survey feedback provided a positive picture from relatives comments included: "The staff and management have always been more than just carers for my relative and family, they have been there even when it was difficult for them due to being busy." "St Valery has always gone that extra mile and this has aided my mother". "She has and still is being cared for better than I could have ever expected." "Since becoming a resident my husband has thrived and put on weight. He is happy and smiles much of the time."

There were a range of policies and procedures governing how the service needed to be run. The provider subscribed to an on line service that ensured these were kept updated of changes to good practice guidance or legislation that impacted on their service. Staff were made aware of important changes to operational policies or to the support of individuals through handovers; any emerging concerns or issues discussed at handovers were relayed to the interim manager or deputy manager who also worked alongside staff on some shifts.

This family run registered company had membership of organisations that promote good practice in delivery of services to older people. This included the local Clinical Commissioning Group forums and meetings held by the Kent Integrated Care Association (KICA) that provides support to care home providers in Kent. The provider was also a member of Skills for Care and had implemented the new Care Certificate to ensure a consistency in the induction of care workers to ensure standardised skills, knowledge and behaviours and attitudes development of care staff to help provide compassionate safe and high quality

care and support. The interim manager had established good links with the local secondary school and offered ongoing placements for students studying health and social care who helped with activities and social interaction with people.

The provider notified the Care Quality Commission appropriately of any notifiable events.