The Order of St. Augustine of the Mercy of Jesus

St Clare's Care Home

Inspection report

St Georges Park, Ditchling Road
Burgess Hill RH15 0GU
Tel: 01444 873730
Website: www.anh.org.uk

Date of inspection visit: 30/06/2015
Date of publication: 24/08/2015

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

Overall summary

The inspection was carried out on 30 June 2015 and was unannounced. St Clare's Care Home is a nursing home that provides accommodation for people who require nursing or personal care for up to 60 adults over 65 years of age, some of who are living with dementia. At the time of our inspection the home was full.

Accommodation was provided in a purpose built, two story building and was set in large grounds in a rural area of East Sussex. The home had communal lounges, cinema, library, activities and therapy room, a large dining area and an attractive and fully accessible garden.

There was a registered manager in post. 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.

There was guidance for staff on actions to take to minimise risks to people and provide appropriate and individualised care to people. Care plans and risk assessments included people's assessed level of care needs, action for staff to follow and outcomes to be achieved. People's medicines were stored safely and in line with regulations. People received their medicines on time and safely.

Summary of findings

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made. People were happy and relaxed with staff. We heard different views about whether there were sufficient staff to care for them. Overall, there were sufficient numbers of suitable staff to keep people safe. One person told us, “Do you know, I have a great feeling of safety here. I couldn’t be in better hands”.

People felt well looked after and cared for and were encouraged to be as independent as possible. We observed friendly and genuine relationships had developed between people and staff. One person told us, “They treat you well here; it’s a home from home.” A visitor told us, “Fantastic, we know [our relative] is safe and happy.”

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work with people who required care. Staff were knowledgeable and trained in safeguarding and what action they should take if they suspected abuse was taking place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person’s best interests.

Accidents and incidents were recorded appropriately and steps taken by the home to minimise the risk of similar events happening in the future. Emergency procedures were in place in the event of fire.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, such as dementia and end of life care. Staff had received both one to one supervision meetings with the registered manager and annual appraisals were in place.

People were encouraged and supported to eat and drink well. One person said, “The food is home-made and good. I went off my food before I came here but I’ve picked up now and I’ve had two sweets today so I feel much better”. There was a daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Special dietary requirements were met. People’s weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were encouraged to express their views and completed surveys, and feedback received showed people were satisfied with the care they received. People and their relatives said staff were friendly and helpful. People also said they felt listened to and any concerns or issues they raised were addressed. One person said, “If there is anything wrong, they sort it out quickly”.

Staff were asked for their opinions on the home and whether they were happy in their work. They felt supported within their roles and described an ‘open door’ approach from the registered manager. The management were always available to discuss suggestions and address problems or concerns.

Summary of findings

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

St Clare's Care Home was safe.

Risk assessments were devised and reviewed monthly.

There were enough staff to meet people's needs. People's individual needs were met.

Medicines were stored safely and people received their medicines when they needed them.

People told us they were happy living in the home and they felt safe. Staff had received training on safeguarding people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Good

St Clare's Care Home was effective.

Meal times were observed to be social occasions. People were given choice about what they wanted to eat and drink and were supported to stay healthy.

Mental Capacity Assessments were completed in line with best practice guidelines. Staff understood Deprivation of Liberty Safeguards (DoLS) and what that meant for individuals.

As well as nurses on duty in the home, health and social care professionals from a range of disciplines visited the home on a regular basis.

Staff received ongoing professional development through regular supervisions, and training.

Is the service caring?

Good

St Clare's Care Home was caring.

People, their relatives and professionals spoke highly of the care delivered in the home.

Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect.

People were supported to dress in accordance with their personalities and lifestyle choice. Care staff were observed speaking about the personal care needs of people sensitively and discretely.

People's dignity was considered and protected by staff so that people were valued.

Is the service responsive?

Good

St Clare's Care Home was responsive.

Care plans showed the most up-to-date information on people's needs, preferences and risks to their care.

People told us that they were able to make everyday choices. There were meaningful activities for people to participate in as groups or individually to meet their social, emotional and spiritual needs.

A complaints policy was in place. People felt their complaint or concern would be resolved and investigated.

Summary of findings

Is the service well-led?

Good

St Clare's Care Home was well led.

People, their relatives and health care professionals made positive comments about the management of the home and staff spoke highly of the registered manager. They were open and responsive.

Incidents and accidents were documented and analysed. Processes were in place to monitor and review quality.

Staff were clear on the visions and values of the service. They expressed a commitment to delivering person centred care.

St Clare's 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. The 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 home and to provide a rating for the home under the Care Act 2014.

The inspection was carried out on 30 June 2015 and was unannounced. It was carried out by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist adviser brought skills and experience in nursing and caring for those living with dementia. Their knowledge complemented the inspection team and meant they could concentrate on specialist aspects of care provided by St Clare's.

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 they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about. We contacted selected stakeholders including three health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. They were happy for us to quote them in our report.

During the inspection we spent time with people who lived at the home. We focused on gaining the views of people who lived in the home, and spoke with eight people who lived at St Clare's. We spoke with staff and observed how people were cared for. We spoke with five relatives of people. We spoke with the provider, the registered manager, three nursing and care staff, the staff training and development officer and chef.

We observed the care people received. We spent time in the lounges, dining area and garden and we took time to observe how people and staff interacted. Because some people were living with dementia that restricted their spoken language we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at five sets of personal records. They included individual care plans, risk assessments and health records. We examined other records including three staff files, quality monitoring, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 5 March 2014 and no concerns were identified.

Good

Is the service safe?

Our findings

People, their relatives and visiting professionals told us they felt people were safe. They were confident the staff did everything possible to protect them from harm. People told us they could speak with the registered manager and staff if they were worried about anything and they were confident their concerns would be taken seriously and acted upon. For example, people told us, “I am safe and have no worries at all,” and “The staff can’t do enough for you, I feel very safe.” A relative said, “Its five star and very safe.”

The staff we spoke with demonstrated a clear understanding of the types of abuse that could occur, the signs they would look for and what they would do if they thought someone was at risk of abuse. They gave us examples of poor or abusive care to look out for and were able to talk about the steps they would take to respond to it. One member of staff said, “I would tell the manager but first I would try to stop the abuse if I could take steps to do so straight away. I I know we have the option of reporting it social services or CQC if we are not happy." Staff training records confirmed that all staff had completed training on safeguarding adults from abuse. The contact details for people to report concerns externally were made available in the home. These included the up to date contact details of the local authority safeguarding team. Details were also recorded within each person’s service user guide, a copy of which was given to each person when they moved to the home. The registered manager told us there were opportunities for safeguarding concerns to be discussed at meetings. Policies and procedures on safeguarding were available in the home for staff to refer to if needed.

Peoples’ risk assessments reflected people’s needs. They had information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mental capacity, mobility, continence care, falls, nutrition, including the risk of choking and a person’s overall dependency. Assessments also included identified risks around areas such as maintaining skin integrity for people who required assistance in aspects of daily personal care and meeting challenges caused by living with dementia. They looked at the identified risk and included a plan of action to promote people’s safe care, health, safety and wellbeing. Files contained risk assessments that included information for staff on how to care for people appropriately and keep them safe. We saw various risk assessments, including the care needed to move and handle people safely and the support people required when accessing the community. Where risks were identified there were measures in place to reduce these wherever possible. For example, risks associated with use of pressure relieving equipment were assessed. Pressure relieving mattresses were set according to people’s individual weight to ensure the mattress provided the correct therapeutic support. All risk assessments had been reviewed monthly or more often if changes were noted.

The management and staff had a positive attitude towards managing risk. For example, on the day of our inspection the weather was hot and we saw that details regarding heat wave planning were in place at the home. People who made the choice to were supported to sit outside and enjoy the sunshine safely. Staff ensured people were appropriately dressed, cover was provided, sun cream was offered and applied and cool drinks were readily available. However, people were able to take risks and the staff ensured the possible implications of taking them were discussed with them. For example, one person described themselves as a sun worshipper and spent more time outside than many other people. Even then, we observed sensitive and friendly enquiries of the person from staff about their comfort and steps were taken to ensure they remained safe, protected but happy.

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. The home was divided into four corridors of 15 beds over two floors. Staff teams covered 24 hour care for 60 people who maybe living with dementia, nursing needs and some with behaviours that challenged. During the day one nurse worked on each floor with an additional, ‘floating’ nurse on duty. Twelve care staff worked across the home and were supported by activities, kitchen, housekeeping and laundry staff. The registered manager was supernumerary to the staffing levels. Two nurses and four care staff provided support at night. Staffing levels remained constant on a day to day basis and staff were deployed in a way that was consistent with personalised care. For example some people required two staff to assist them with personal hygiene needs or with mobilising. We were told the provider used a formal staffing tool to assess required staffing levels for the dependency levels of the people they were providing care for. One relative told us “There is always plenty of staff. There is a low turnover.”

Good

Is the service safe?

A person said, “I think there is always enough staff here. If I press the button the staff come quite quick.” Our own observations were that calls bells were not rung too frequently but when they were activated they were responded to promptly. Another person told us, “Staff can be busy sometimes but I am quite independent so I’m alright.” Staff told us there were enough on duty. They said that if there was a shortage, for example due to staff sickness, the registered manager arranged for cover staff and that staff who knew people’s needs already were offered the additional shift first before it went to an agency to cover.

We saw the registered manager remained committed to providing care and support to people. When we arrived for the inspection he greeted us wearing an apron from assisting in the dining room. He explained that remaining involved on the ‘floor’ by providing care and retaining an overview enabled them to ensure safe practices were maintained.

We looked at the management of medicines. Systems for ordering, checking orders received, disposal and administration were in place to manage people’s prescribed medicines. Trained nurses administered medicine to people. Staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines. This ensured the system for medication administration worked effectively and any issues could be identified and addressed. We saw nursing staff administering medicines sensitively and appropriately.

The administration of medicines was checked at each step of the process. Staff always checked that they wanted to receive the medicines and asked if they had any pain or discomfort.

Medicines were stored appropriately and securely and in line with legal requirements. People had their medicines stored in a locked metal medicine trolley that staff dispensed the medicine from. Staff recorded the temperature within the medicine storage area daily to ensure that medications were kept within the correct temperature range. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

Policies and procedures on all health and safety related topics were held in a file in the office and were easily accessible to staff. Records showed that all appropriate equipment had been regularly serviced, checked and maintained. Fire safety equipment, water safety and electrical equipment were included within a routine schedule of checks.

People were protected, as far as possible, by a safe recruitment system. Appropriate recruitment checks took place before staff started work. Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

Good

Is the service effective?

Our findings

People and visitors were very complimentary about the home and the nursing, care and support provided by the team of staff. Comments included, "I have great faith in the staff," and "Staff are very pleasant and helpful." One visitor said "Staff take time with [my relative]. I have complete confidence in them."

People received care from staff who felt supported to carry out their role effectively. The Training and Development Officer told us the staff induction was carried out in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff meet in their daily working life. It was developed jointly by Skills for Care, Health Education England and Skills for Health**.** These standards need to be met before they can safely work unsupervised. A staff member told us, "The induction was very comprehensive. If I am uncertain about something I am encouraged to ask about it."

Registered nurses were supported to update their nursing skills, qualifications and competencies. One member of staff told us she had been supported to attend additional training on palliative care. The registered manager told us that they had worked to reach the Gold Standards Framework (GSF). GSF is a training program that promotes good practice in end of life care. The GSF awards recognition to health and social care providers who have completed this training. The registered nurses told us that they had the skills to look after the people living in the home and would access training they felt they needed through the home or externally if required. The registered manager told us staff training had been reviewed with an emphasis on providing further specialist training to ensure the needs of people were appropriately responded to.

People and their relatives told us they thought staff were appropriately trained to meet their needs. One person said, "The staff know what they are doing." Another said, "The staff are well trained." Staff told us they were up to date with their mandatory training and the records we looked at reflected this. People were supported by staff who received regular assessment of the quality of their work. The staff we spoke with told us they were used to being observed carrying out their roles and that they found it helpful and constructive to receive the feedback from it. This ensured people received effective care and support from competent staff.

We observed the staff handover between shifts and saw how people's day to day health needs were planned for and prioritised. The registered nurse led the afternoon handover and described to the care staff the support that people had received during the morning. During the handover the registered nurse advised staff of changes to care plans, such as a fluid monitoring chart put into place. These charts are used to record how much fluid a person has consumed. They advised staff how frequently they should offer fluids to this person. The care plan and monitoring chart were specific measures that ensured the person received effective care and were supported to remain in the best possible health.

Staff told us that they felt well supported and felt they could speak to senior staff in the home and that they would be listened to. Staff confirmed they received regular supervision and they were clear about their roles and responsibilities around the home. Staff had received a recent individual supervision and these were recorded. Systems for regular supervision and annual staff appraisal were firmly embedded.

Staff were able to communicate effectively with people because people's communication needs had been assessed and relevant training and guidance had been provided for staff. We observed staff interact with people with a wide variety of needs and did so patiently and effectively.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had submitted DoLS applications in relation to some of the people living at the home and these were currently being processed by the relevant authority. People's rights were protected as the registered manager understood and followed the legal requirements in relation to DoLS.

Policies were in place in relation to the Mental Capacity Act 2005 (MCA) and DoLS. The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. They confirmed they had received training in these areas and demonstrated a good awareness of the code of practice and were able to demonstrate this in relation to a best interest decision to

Good

Is the service effective?

pursue a course of treatment. Clear procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make specific decisions for themselves.

Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs. The care plans contained details of how to manage and provide person specific care for their individual needs.

Some people had discussed with their GP their wishes regarding cardiopulmonary resuscitation (CPR). CPR is an emergency treatment that can sometimes re-start the heart and circulation of blood and breathing following a cardiac or respiratory arrest. We saw appropriate documentation was in place to support these decisions. We were told decisions were reviewed together with the documentation for all people by the GP, so that the decision reflected their current needs.

People's dietary needs and preferences were recorded. People told us that their favourite foods were always available. The chef told us "We can cater for vegetarian, soft or pureed and any other special diets. We are able to meet any dietary requirement." Some people followed specialist diets based on their particular healthcare needs. People's weight was monitored against the special diets they followed. Staff explained people's food and fluid intake was monitored to make sure they did not become malnourished or dehydrated. Health professionals were involved in assessments of people's nutritional needs. Recommendations they had made had been followed through into practice. For example, a person who was able to chew and swallow but was unable to feed themselves was supported to maintain good nutrition and hydration.

Some people used modified eating aids. The aids and adapted equipment such as plate guards and special spoons were used to help encourage people's independence when eating and drinking.

People were encouraged and supported by staff to eat and drink. Staff acknowledged the difficulties some people living with dementia had to communicate what they wanted to eat. We were told, "For those that need the support with eating, if they turn away or do not show their usual interest in eating a meal we know that can be significant." During mealtimes we saw this reflected in sensitive and responsive staff practice. We arrived at the end of a leisurely breakfast time. In the dining room people were eating at their own pace, some with assistance and others independently. One person received 1:1 assistance from a member of staff who showed great skills in putting the individual at ease. They ensured the person was comfortable and fully consulted with all aspects of the support they received, for instance in where their napkin was placed so that it was fully accessible. We passed by a person who was being nursed in bed and heard the care staff gently encourage them to have more to eat and drink.

People spoke positively about the quality of the food. People said, "The staff come and ask what I want and the food is marvellous" and, "The food is good. There are always choices and you can have breakfast whenever you like." One relative told us that the food "Always looks very nice. They have a good diet". There was a varied menu, which was planned and changed on a regular basis and reflected the season. People were involved in planning the menu and it was a regular topic of discussion in residents and relatives meetings. Staff used their knowledge of people's likes and dislikes where they were unable to make a choice.

Good

Is the service caring?

Our findings

We saw positive and caring interactions between staff and people throughout the inspection. People responded positively to the staff. We saw staff sit and talk and make time for people. We observed one member of staff sitting with a person talking to them about their recent trip to a local garden centre. We saw another staff member sit with a person who had difficulty communicating and assist them with a puzzle they were working on. Staff communicated in a way that showed they had a genuine interest in listening to what people had to say.

The provider told us the home was situated on a site that had a long religious history with close links with the Catholic Church. Care plans documented each person's religion and whether they wished to practice their chosen religion. A priest regularly visited the home and conducted Mass for those who were not able to attend the church in the grounds. There was a ecumenical prayer room in the home. The home provided pastoral, emotional and spiritual support to people and their families. The provider told us people who were not Catholic were welcome and we saw that a Church of England service was also held at the home. The provider told us people from all faiths and none were welcome at the home and would be supported to practice their faith in a way they wanted to. This meant people could be reassured that their spiritual needs were met in a supportive and caring way.

People were supported by staff who understood their life history and the things that were important to them. The knowledge was used by staff to form positive and meaningful relationships with people. Staff interaction with people showed they knew about each person over and above their care and support needs. Staff were able to describe the interests of the people they cared for. One member of staff said, "It's not just about the care they receive, it's about knowing them as a person."

People received support from staff who were able to describe the steps they took when providing care to preserve people's privacy and dignity. Everyone we spoke with told us the staff respected their privacy and maintained their dignity. We saw information regarding dignity in care was available within the home. Staff members had received specific training to ensure that people's dignity was maintained at all times throughout the home.

People and their relatives told us they were involved when decisions were made about their care and that care needs were always discussed with them. For example, people could say if they did not want to receive personal care from a particular gender of staff and this was recorded in the person's care plan. People we spoke with told us they were given a choice of male or female member of staff to help them with their personal care. One person said, "There are times you have to have male staff for your personal care but they always maintain your dignity." All of the people we spoke told us they felt their dignity was maintained by all staff at all times.

People were provided with information about how they could obtain independent advice about their care. The registered manager ensured that if required, people were supported by an Independent Mental Capacity Act Advocate (IMCA) to make major decisions. IMCAs support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People could have the privacy they needed throughout the home. There were many quiet areas where people could sit and talk with relatives or to sit alone if they wished to. There were no restrictions placed on the times friends and family could attend the home.

Good

Is the service responsive?

Our findings

People told us that the staff responded to their needs and concerns. A relative said they visited regularly and were updated with any changes or issues that might affect them. People's care plans clearly identified their needs and reflected their individual preferences for all aspects of daily living. People told us they felt able to do the things that were important to them and staff supported them in following their hobbies and interests. People told us there were many trips provided for them. We saw the garden was well used in the summer.

Staff told us that care was personalised and confirmed that, where possible, people were directly involved in their care planning. Where people could not be directly involved due to their dementia, their family had been involved in providing important information to help care staff with the delivery of people's care. We saw evidence of this in care plans. One relative said, "The home listened to what I had to say about [my relative]." The care plans contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including information on falls, nutrition, pressure area care and moving and handling. These had been reviewed and audits were completed to monitor the quality of the completed care and support plans. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the speech and language team (SALT).

The provider had thought about and put into place innovative processes that enabled staff to respond to people's needs at the home. For example, one lounge was themed around the 1940's. Walls held pictures from the period, big band music played in the background and newspapers of the time were available. A large screen was erected along one side of the room that developed the theme still further by having a full size representation of a 'typical' front room of the time, complete with fireplace and furniture. We heard that the image could be changed to another decade or theme in response to people's needs. Signs around the home, for example the bathroom, were clear and there was contrast between the sign and the surface it was mounted on. They were at eye level and well-lit. Specialised equipment was provided in the bathrooms that ensured that all people were able to access the baths and showers. In this way the environment was friendly, stimulating and accessible for all, including those living with dementia.

People's care records were written in a person centred way. A person we spoke with told us, "Staff have got used to me now and know what I like." Another person said, "Staff get me up if I want to get up and they help me outside if I want to go out. I might not get up tomorrow, I will see." The records identified people's preferences and choices in relation to daily activities such as times they liked to get up and go to bed, personal care needs, food preferences and social activities.

Planned care was provided that was responsive to peoples changing needs. People's records were stored on an electronic care record system which included records of the care provided. Records of daily care people received were comprehensive and covered all aspects of support. For example, people's fluid intake and repositioning charts were completed.

People were provided with information about the complaints process in a format that met their needs. Details of the complaints procedure were in the reception area and within people's service user guides. People knew how to make a complaint and the registered manager told us they encouraged people to raise concerns with them either in residents' meetings or privately. Procedures were present to manage and respond appropriately to any changes that were required following receipt of a complaint. Complaints were handled and responded to appropriately and any changes and learning were recorded. A relative told us, "If I was unhappy I would talk to the manager."

People had an active and varied social life in the home, which encouraged them to develop relationships with others and to avoid being socially isolated. There were active and motivated activities staff who discussed the opportunities that were available for people to take part in a wide range of daily activities. These included activities around the home, in the garden or further afield. Each weekday listed four activities at 9am, 11am, 2pm and 3pm. At the weekend two activities were scheduled on each day. They included activities as diverse as, outdoor/indoor exercise, film show (complete with popcorn), board games and hand massage. People were given choices about the

Good

Is the service responsive?

activities on offer and were asked if they wanted to participate in them. Although not all people living with dementia were always able to tell us they enjoyed activities on offer we saw they usually engaged in them with enthusiasm. As well as group activities, based on interests and lifestyles, people were supported to maintain their hobbies and interests. One person said, “I like to be left to my own devices and this is respected. I go down to parties and gatherings”.

Because of the additional needs of people, the provider had thought about ways of involving and capturing their views. Resident and relatives meetings were held which involved discussion around an agenda but were also used as an opportunity for a social gathering with the provision of tea and refreshments. Minutes were recorded and action points were raised on, for example, activities or the menu and were seen to be followed up. For people who had additional communication needs staff had also sought feedback from relatives and other significant people to discuss how the individual’s care and treatment needs were being met. The registered manager said, “The feedback from others with an outside view is absolutely valued by us.”

Good

Is the service well-led?

Our findings

People spoke positively about the management team in place at the home. One person told us they always saw the registered manager at the home and another person said if they needed to raise anything with them they would do but had never felt the need to do it. Staff spoke positively about the management team and particularly the registered manager. One relative described him as, "Amazing". One member of staff said, "I can talk to the manager at any time. I find them supportive."

Management was visible and active within the home. The registered manager was regularly seen around the home, for example, lending a hand at lunchtime. They were seen to interact warmly and professionally with people, relatives and staff. People told us the manager was available to discuss any concerns that they may have about the care they received. The registered manager told us they had an 'open door' policy for people, their relatives and staff. They told us they had many ways of communicating that included resident and staff meetings. People appeared relaxed in the company of the registered manager and it was clear they had built a rapport with individuals for whom they expressed a great deal of respect. For example, as they showed us around the home they greeted one person who he met in the corridor by name and commented to them, "You look stunning today". The person, who had made special effort in their appearance, responded with appreciation and evident satisfaction at the comment.

On a day to day basis, the registered manager provided the guidance and leadership required to maintain a well led service. In the absence of the registered manager or a deputy, a senior nurse was identified to lead the shift with the managers providing on-call support. The provider was known and recognised by staff as a regular visitor and the registered manager commented they felt supported and valued by the provider.

The provider completed structured visits and used a quality auditing tool to review the service. Audits were recorded with a timescale for response and review, if appropriate. There were a number of quality assurance systems in place, including falls, incidents, safeguarding, complaints, accidents, cleaning and maintenance. Incidents were looked at and analysed with regards to the number of incidents, falls or hospital admissions. Information following quality assurance checks was used to aid learning and drive quality across the service. For example, the pressure area care policy was reviewed and amended so that cushion types used in the home matched the kind of pressure relieving mattress used.

The registered manager could explain how they met their CQC registration requirements. They explained the process for submitting statutory notifications to the CQC to ensure that they were sent in a timely manner. This meant we had the most up to date information available about incidents that had occurred at the home.

The registered manager was committed to on-going improvement in the service and was able to describe key challenges looking forward. Throughout the inspection process itself the registered manager was open and responsive to the issues we discussed. The registered manager told us, "People comment favourably on the feel of the home. I am lucky to have a team who work hard but there is always room to improve and today the inspection has provided a chance for us to improve still further."

The provider had clear values and principles established at an organisational level. All staff had a thorough induction programme that covered the Orders history and underlying principles, aims and objectives. These were reviewed and discussed within staff meetings and supervision sessions with staff. The provided remained abreast of developments in health and social care. For example, they talked knowledgeably about the relatively new statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and treatment. The Duty of Candour is to be open & honest when untoward events occur. The provider was able to describe unintentional and unexpected scenarios that may lead to a person experiencing harm and was confident about the steps to be taken, including an oral notification, followed by a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.

The provider used innovative ways to provide care and support for people and their relatives. The provider told us how they had responded to the challenge of better understanding and supporting people who were living with dementia by being part of the National Institute for Health Research Care Home Network. Working collaboratively with partners it aimed to improve the well-being of people living

Good

Is the service well-led?

with dementia by participating in research in key areas such as managing pain in people with dementia and prioritising sleep disturbance as a major issue in caring for people with age related diseases.