Barchester Healthcare Homes Limited

Park View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Park View provides 24 hour care, including personal care for up to 108 adults. This includes nursing care for older people and younger adults who may be living with dementia. The service is a large purpose built property. The accommodation is arranged across five units over two levels. There are four units for people living with dementia and complex needs all providing nursing care and one unit for people living with dementia. There were 104 people living at the service at the time of our inspection. At the last inspection on 22 August 2014 we found the service met the required standards.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We inspected Park View on 9, 10 and 16 June 2016. This was an unannounced inspection. At this inspection we found one breach of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 regarding supporting staff.

People and their relatives told us they felt safe using the service. Staff knew how to report safeguarding concerns. Risk assessments were completed and management plans put in place to enable people to receive safe care and support. There were effective and up to date systems in place to maintain the safety of the premises and equipment. We found there were enough staff working at the service and recruitment checks were in place to ensure new staff were suitable to work at the service. Medicines were administered and managed safely.

Staff did not always receive supervisions in line with the provider's policies and procedures. Staff did not always receive up to date training to carry out their role. Some staff did not have a clear understanding of application of the Mental Capacity Act (2005).

Appropriate applications for Deprivation of Liberty Safeguards had been made and authorised. People using the service had access to healthcare professionals as required to meet their needs.

People were offered a choice of nutritious food and drink. Staff knew people they were supporting including their preferences to ensure personalised care was delivered. People using the service and their relatives told us the service was caring and we observed staff supporting people in a caring and respectful manner. Staff respected people's privacy and dignity and encouraged independence. People and their relatives knew how to make a complaint.

Regular meetings took place for staff, people using the service and their relatives. The provider carried out satisfaction surveys to find out the views of people and their relatives. The provider had quality assurance systems in place to identify areas of improvement. Staff, people and their relatives told us the registered

manager and management team were supportive and approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and their relatives told us they felt the service was safe.

There were robust safeguarding and whistleblowing procedures in place. Staff understood what abuse was and knew how to report it.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People had risk assessments in place to ensure risks were minimised and managed.

The provider carried out regular equipment and building checks.

There were appropriate arrangements in place for the safe administration of medicines. We have made a recommendation about the management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always receive up to date training and appropriate support through supervision meetings. Staff did not always have a clear understanding of the application of the Mental Capacity Act (2005) to practice.

People's health and support needs were assessed and reflected in care records.

People were supported to maintain good health and to access health care services and professionals when they needed them.

People had access to enough food and drinks.

Staff received appraisals and training to support them in their role.

Is the service caring?

Good

The service was caring. People told us the service was caring and

staff treated them with respect and dignity.

Care and support was centred on people's individual needs and wishes. Staff knew about people's interests and preferences. However we did not see how people who may identify as lesbian, gay, bi-sexual or transgender would be supported by the service. We have made a recommendation regarding best practice.

People using the service were involved in planning and making decisions about the care and support provided at the service.

The service enabled people to maintain links with their culture and religious practices.

Is the service responsive?

Good

The service was responsive. People's health and care needs were assessed and individual choices and preferences were discussed with people who used the service.
Peoples care plans were regularly reviewed.

People were able to take part in a programme of activities in accordance with their needs and preferences.

People were encouraged and supported to provide feedback about the service.

There was a complaints process and people using the service and their relatives said they knew how to complain.

Is the service well-led?

Good

The service was well led and had a registered manager. Staff told us they found the registered manager to be approachable.

Records were accurate and kept up to date.

Effective systems were in place to monitor the quality of the service.

Park View

Detailed findings

Background to this inspection

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

On both days of the inspection, the inspection team consisted of two inspectors and two specialist advisors. A specialist advisor is a person who has professional experience in caring for people who use this type of service. The specialist advisors were specialists in nursing and social care. Before the inspection we looked at the concerns raised and information we already held about this service. This included details of its registration, previous inspections reports and information the provider had sent us. We contacted the host local authority to gain their views about the service.

During the inspection we spoke with 23 people and seven relatives of people who used the service. We spoke with 31 members of staff. This included the registered manager, two deputy managers, six registered nurses, a senior care worker, nine care workers, five housekeeping staff, the chef, assistant chef, administrator, receptionist, activity co-ordinator, activity assistants and maintenance person. We also spoke with two health care professionals visiting the service.

We examined various documents. This included 18 care records relating to people who used the service, ten medicines records, 15 staff files including staff recruitment, training and supervision records, minutes of staff meetings, audits and various policies and procedures including adult safeguarding procedures. We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. When asked if they felt safe at Park View, one person replied, "Yes." Another person said, "It's safe here, they [staff] are good." One relative said, "I know [My relative] is in a safe place. I don't have to worry too much." The service had a safeguarding policy and procedure in place to guide practice. Safeguarding training for staff was mandatory. Staff told us and records confirmed they completed the relevant training. Staff were knowledgeable about the process for reporting abuse and knew who to notify. The service had a whistleblowing policy and procedure. Staff we spoke with knew how and where to raise concerns about unsafe practice at the service. They told us they would be confident to raise any concerns. One staff member said, "I would report anything like abuse or bad practice to the nurse in charge or the manager. We've got a Barchester whistleblowing line but I know I could also call CQC or the borough if nothing was getting done." Another staff member said, "I wouldn't think twice about alerting the safeguarding team."

Risk assessments were carried out for people using the service. People's risk assessments were robust, detailed and identified the risk and actions needed to minimise and manage the risk. Risk assessments were reviewed six monthly or sooner if a new risk was identified. These assessments included risks associated with specific medical conditions, pressure areas, mobility and falls, behaviour that challenges the service and nutrition. For example, one person had a risk assessment in place for the inability to use their call bell due to visual impairment. The risk was rated as "Medium", and an action plan was put in place which stated, "[Person] has a sensor alarm in her room which goes off if she puts her feet on the floor." The sensor alarm alerted care staff and the person would be assisted.

Another person had a risk assessment in place in relation to dry skin and the risk of pressure damage. There was an action plan in place to "Reduce the risk of pressure damage", which stated, "Actions to take if skin becomes damaged, any abnormalities found, staff will report to person in charge and photo will be updated on skin inspection record. Referral to be made to district nurse." People at risk of skin damage had waterlow assessments within their care plans. A waterlow assessment gives an estimated risk for the development of a pressure ulcer. We saw records in care plans for people with skin damage, with photographic documentation to monitor their skin and relevant referrals to health professionals.

People with diabetes had risk assessments in place to manage their condition and guidance for staff of how to respond to their symptoms. These risk assessments contained advice and action plans on how to respond to symptoms of high and low sugar levels and what to do in an emergency. For those assessed as at risk of falls, care plans contained a 'falls diary' which was completed whenever someone had a fall. This information was analysed and referrals made to the appropriate health professional.

One person was documented as "Putting anything into their mouth when hungry." This person had a risk assessment in place stating, "Staff need to observe [person's] whereabouts and not sit her with people at meals time who are eating fish [due to an allergy]."

The service had a robust staff recruitment system. The provider had a staff recruitment procedure in place.

Staff were employed subject to the completion of various checks including references, proof of identification and criminal record checks. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people using the service.

The service had procedures in place to address any instances of poor practice. The registered manager told us and records confirmed that appropriate disciplinary or capability action had been taken to address poor practice and ensure safety of people using the service.

Infection control policies and procedures were in place. The registered manager told us and records showed audits were carried out monthly by the deputy managers. Infection control procedures were discussed in staff meetings. Staff we spoke with were clear about infection control procedures including those put in place when people using the service had symptoms of a suspected infection. We observed staff washing their hands and removing aprons before leaving peoples rooms or moving between different areas of the service. We saw staff wearing aprons and gloves when serving meals, carrying out cleaning or preparing to support people with personal care. Cleaning rotas included cleaning of all areas of the service and records confirmed this was carried out. Housekeeping staff we spoke with told us about the process for ensuring the service was clean and the risk of infection minimised. This meant the service had processes in place to minimise the risk of the spread of infection.

People and their relatives told us they felt there were enough staff to meet people's needs. One person said, "Yes, they are always here." Another person said, "I do not have to wait for a long time.' A third person told us, "The staff have time for you, they never rush." One relative said, "There's enough staff. I think more at night would be nice, but there's enough." Staff told us and records confirmed there were sufficient staff on each shift to meet people's needs. Staff sickness or absence at short notice was covered by a bank of staff employed by the service. We looked at staffing rotas which reflected this. One member of staff told us, "There are enough staff on each unit. If we need cover we arrange it, we have bank staff too and we try to use the same ones each time because they know our residents." During our visit we saw staff provided the support people needed, when they required it.

The premises were safe. The service had two maintenance staff who with the registered manager were responsible for the building safety checks. Any issues identified were addressed by the maintenance staff or specialist maintenance contractors. There were systems in place for the maintenance of the building and equipment to monitor the safety of the service. Checks included audits of the environmental health and safety. For example records showed boiler, water hygiene and electrical checks were carried out annually. Other checks on equipment such as hoists, nurse call system, water temperature and fire alarms were carried out monthly or weekly as required. We saw records confirming faulty equipment was removed from use and repaired or replaced. The maintenance staff told us they "Walked all units daily checking for any faulty equipment or hazards." They said staff on each unit made a log of repairs which were collected each morning and "Job sheets were produced and prioritised." All units and communal areas of the service were checked daily by the maintenance person and weekly with the registered manager. Records of health and safety checks included detailed weekly room and window guard checks. All maintenance records were clear, well recorded and up to date.

On the second day of our inspection one relative we spoke with raised concerns about the security of the building. The registered manager was aware of these concerns and had reminded staff about ensuring the garden doors were secure at the end of each day. On the third day of our inspection we noted the registered manager had taken immediate action and an additional security key pad and alarm had been added to the garden door. Staff we spoke with were aware of the additional security system. We were satisfied this had been addressed by the service.

Medicines were managed and administered safely. We looked at Medicine administration records (MAR) and observed medicines administration rounds on three of the five units within the service. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. People using the service had individual MAR which included their photograph, name and information such as any allergies, pain chart, weight chart, body map and transdermal patch map for medicines administered via skin patches. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

People told us they received their medicines when needed and their individual requirements were met and discussed with the nurse administering their medicines. One person said, "I do not have to worry, I get my tablets at the right time." Another person said, "The nurse reminds me what my medicines are for before I take them." While observing medicines administration one nurse told us, "I get to speak to each and every resident and get information regarding their presentation during the interaction."

Records showed all staff who administered medicines had the appropriate training and their competencies were reviewed. The provider carried out weekly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken.

Medicines were stored securely within locked trolleys kept in a treatment room in each unit. This area had a wall thermometer and records showed the temperature of the room was checked daily. This was seen to be within the recommended storage range for medicine. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. In one unit the fridge temperature was outside the effective range, the nurse already identified this and had moved the contents to a fridge on another unit.

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines which the law requires are stored subject to special storage and recording arrangements. The controlled drug register entries tallied with the observed MAR charts and the disposal and refusal register correlated with entries in the observed MAR charts. Disposal via 'doom' boxes was observed. A doom box contains a substance which renders controlled drugs harmless and unusable. There were effective systems in place to regularly check the controlled drugs by use of a hand over record. This was observed during the inspection.

We saw appropriate arrangements were in place for obtaining medicines. The systems in place for ordering of medicines were appropriate and utilised local pharmacy provision. A repeat prescription system that provided a 4 week dosette box for each person was in use. We saw records that medicines were prescribed, ordered and administered in a timely fashion to enable people to have their medicines when they needed them.

Medicines taken as needed or as required are known as 'PRN' medicines. Information was available to enable staff to make decisions as to when to give these medicines. This ensured people were given their medicines when they need them and in a way that was both safe and consistent. Staff observed choices with regard to the request for PRN medicines. We observed one person asking staff for PRN pain relief. The staff member asked them about the pain, where it was located, how long they had it and the severity before getting the medicine and administering it. One person told us, "The nurse talks to me about my tablets and if I need any extra for my back pain." We saw PRN care plans were completed for each medicine people required. This meant the people were not at risk of experiencing discomfort. However, we noted a lack of monitoring of some PRN medicine administration protocols with dates for review incomplete or missing. The system was nonetheless robust and the recording of administration of PRN medicine was accurate and

clearly documented.
When medicines were being administered covertly to people we saw there were assessments and agreements in place which had been signed by the GP. However we noted that guidance for how to administer medicines covertly was not always clear and some decision forms were incomplete.

We recommend the service seeks and follows best practice guidance in the management of medicines in care homes.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive appropriate support they required to carry out their roles through supervision meetings. Supervision meetings are held so staff and their manager can discuss the staff member's on-going performance, development and support needs, and any concerns. Records of supervision meetings showed supervision sessions were sporadic, unplanned and were often used to highlight and discuss errors made by staff. This meant that supervision was not in line with the service's supervision policy which stated, "All staff should have at least one formal supervision session of at least one hour duration every two months, with the consent of the client one of these meeting should incorporate direct observation of the support worker providing support to an individual with whom they regularly work." We did not see records of supervision undertaken in this way.

Staff we spoke with did not have positive experiences regarding their supervision sessions. When asked about supervisions one staff member said, "Don't often get them. Sometimes I get supervision if I'm naughty. It would be nice to get supervision when we do something well." They then explained that supervisions took place if they had made a mistake when supporting people who used the service. Another member of staff told us, "We get supervision when I have done something wrong." This meant, staff were not receiving the appropriate support and supervision necessary to enable them to carry out the duties they are employed to perform. We spoke with the registered manager about this. It was acknowledged that this was an area where improvements were necessary. Following the inspection we received confirmation and saw records that staff supervisions had begun to take place and were scheduled for each staff member until April 2017.

Records showed training courses attended by all staff annually in areas including safeguarding, dementia, health and safety, medicines, moving and handling and infection control. The service had a designated training co-ordinator who carried out group and one to one training with staff as required. One member of staff told us, "The training co-ordinator is brilliant we can ask anything and go over anything we don't understand even after the training session." Not all staff were up to date with required training, however, the registered manager had identified this and had begun to address this. This meant, staff were not always supported to receive training to enable them to fulfil the requirements of their role. We remain concerned that the issues regarding training and staff supervision meetings had not been identified and addressed. The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff appraisals were taking place for this year and the registered manager advised that all appraisals would all be completed by July 2016. Appraisals were detailed and contained information about goals and training needs were identified.

People using the service and their relatives told us they felt the staff were knowledgeable and knew how to carry out their roles. The service had an induction procedure which covered all aspects of working at the service. Prior to the commencement of employment, all staff underwent an induction programme which consisted of two days shadowing a senior carer and one full day training with the internal training

coordinator, which included working through an 'induction pack'. The 'induction pack' contained activities and assessments. The training coordinator told us, "Staff do lots of e-learning. I set them up and they can access the portal from home and complete their training." One staff member who had recently joined the service explained the induction process and said they had found the process useful. They told us, "I've really enjoyed it getting to know the residents and staff. So far I have been learning how to give personal care and shadowed experienced staff."

Staff working at the service had the opportunity to undertake further training appropriate to their role and there were opportunities for staff to develop and change roles within the service. One member of staff told us, "I've been able to progress in this home. There's always opportunities if you want to take them." Another staff member said, "I was encouraged to go for a more senior role and I'm really enjoying it." Care staff were supported to complete the care certificate. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and deputy managers were knowledgeable about the MCA, how to obtain consent before giving care and about completing mental capacity assessments for people using the service. Records showed staff had attended MCA and DoLS training however, some nursing and care staff were less confident in their understanding of MCA and DoLS. Staff were aware of the MCA, but not necessarily its application to practice. The registered manager told us they had discussed MCA and DoLS with staff and were unsure why staff were not confident in their understanding. They told us further information would be provided to staff during team meetings. Following our inspection the registered manager confirmed updates had taken place in staff meetings and staff had received individual information packs about MCA.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection the majority of people who used the service had authorised DoLS in place because they needed a level of supervision that may amount to deprivation of liberty. The home had completed all appropriate assessments in partnership with the local authority and any restriction on people's liberty was within the legal framework. The provider had sent in notifications to the CQC about the decisions of applications submitted for DoLS. Records relating to best interest decisions in the care records of people using the service were reviewed. The decisions were well recorded and included a contribution from and signature of significant others such as their relative.

People using the service told us staff obtained consent before carrying out care. One person told us, "Yes. They ask if it's alright to help me do things." Another person said, "They tell me what needs doing and ask if that's ok." Staff were knowledgeable about how to obtain consent. They told us they would ask permission and explain what they were about to do before carrying out care and we observed staff asking people before they carried out any aspect of care or support. For example we observed one member of staff speaking with a person who was walking around in their nightwear and didn't want to get changed. The staff member spoke with them and asked if they would mind being assisted to go back to their bedroom to find a dressing gown. Peoples care records showed they had signed consent to care where able to do so.

People told us they enjoyed the meals at the service. One person said it was, "Lovely", and told us for breakfast they had eaten, "Eggs and sausage and two slices of toast." They told us there were options every day and that on Fridays they had, "Fish and chips", stating, "We asked for that." A second person told us, "The food is very good, we get plenty. Teas and coffees are offered and we all get on well together. If I didn't fancy eating what was on offer I would tell them and they'd make us something else." A third person told us, "There's always options, they show you what it is on the plate when they're dishing it up so you can choose. The boiled bacon we had yesterday, oh it was lovely."

Care plans contained information about the nutritional and hydration needs of people using the service. Records included monthly weight monitoring charts as well as dietary and food texture needs. The chef explained that for people who have diabetes, "Alternatives to sugar" were used, and for people on pureed or liquidised foods, there was "Always more than one option for them to choose from." Observations showed people were offered different options for their meals during the inspection. Meals for people who required a pureed diet were well presented. One member of staff said, "It's so important to make the meals appetising. We don't just dollop it on the plate. That doesn't look nice. We need to make sure it looks as good as it tastes." People's likes and dislikes in relation to food and drink was clearly documented. For example, one person's care plan stated, "Rice krispies and cold milk with a little sugar for breakfast."

The chef told us there were always ways of making someone a dish they preferred and that, "It wasn't a problem." The chef explained that there was a, "Four week rotating menu, depending on the season and which foods were in season." The chef explained, "People here like traditional foods, such as the older generations. The younger generations prefer foods like pizza and nuggets and we make these for those who want that." He advised that food choices and preferences were relayed to him each week the units by the care staff.

The chef told us about cultural needs stating, "One person here loves pasta and we make a different sauce for their pasta every day." They told us curries were made for one person as this was their preference.

Staff interacted positively with people during lunch. Staff supporting people with their meals did so patiently and chatted with them during the meal offering them more and asking if they wanted a drink. One staff member serving a meal to a person who required support said, "This nice young lady [new staff member] is going to help you today but would you like me to cut your vegetables and meat for you." Another member of staff offered to support a person with their meal saying, "Would you like it now while it's nice and hot. I'm here to help you." The person agreed and the staff member then asked them if they would, "Mind if I place a napkin on you to protect your clothes." People who required a napkin placed over their clothing during meals had these removed promptly once their meal was finished.

Staff asked people if they would like more lunch, one staff member said, "You really enjoyed that, would you like more." People using the service enjoyed the meal. One person said, "Oh it was lovely but I'm saving myself for my pudding." Another person speaking with staff said, "I'm on my second plate, that boiled bacon's lovely but I've still got room for my ice cream."

Staff encouraged a person to eat a meal. They offered alternatives to the menu for the lunchtime. The staff member said, "I know you don't have much of an appetite at the moment but can I tempt you with anything. It doesn't have to be a dinner, anything you fancy?" They then sat beside the person and held their hand talking together for a while. The person chose to have some ice cream and this was brought to them promptly."

The dining room was arranged so people could chose to sit at dining tables or in armchairs in an area where

there was a television. People enjoyed the lunchtime experience and sat at dining tables with their friends or had their meals while watching the television. One person said, "We always have our lunch at the table together and have a good chat. It's nice."

The registered manager told us that in the past people were not happy with the meals provided and the service had consulted with people and their relatives to ensure there was an improvement. We looked at records of surveys carried out about meals. People using the service had chosen to have themed food days from different cultures or to celebrate events such as St Patricks Day or St Georges day. People using the service had access to appropriate meals to ensure their nutrition and hydration needs were met.

Records showed the relevant safety checks were carried out every day in the kitchen, for example temperatures of the fridges, food labelling and expiry date checks and reheating guidelines.

People were supported to access healthcare services and receive on-going healthcare support. People told us they were able to see a doctor if they needed to. One person said, "I just ask the staff if I need to see the doctor." During the inspection one person using the service asked staff if they could be, "Added to the list to see the doctor I need to find out more about going to see a specialist." One relative told us, "They are good here, my [relative] gets to see the GP whenever he needs to." Staff told us and records confirmed GP visits to people living at the service. One person was recorded as having an in-growing toe nail and we saw records confirming that the GP had visited and prescribed antibiotics. The GP attended the service twice weekly and could also be contacted for visits at other times if people became unwell. Records showed visits to the service from various health care professionals such as speech and language therapists, palliative care team and dieticians. There were records of visits from the chiropodist, dentist and optician. Peoples' care records contained information relating to various appointment letters following up from referrals. People were supported to access healthcare services and received support to maintain their health.

Good

Is the service caring?

Our findings

People using the service and their relatives told us the service was caring. One person said, "They are nice to me. They look after me." Another person said, "They [staff] are lovely. They always have time to talk and listen." When asked if they thought the staff were caring a third person said, "I'm very comfortable here. The staff are very good, it's like being at home. It's very comfortable." A fourth person said, "I don't think there's anything to moan about, I like it here, it's like being at home, you come and go as you like."

One relative said, "The staff are brilliantly calm and professional. Really caring." Another relative told us that the home and staff were "very caring" and they were happy with care the service provided. A third relative said, "They [staff] are so kind here and ever so patient."

Staff we spoke with told us they felt it was a caring service. One staff member said, "All the staff here are really caring." Another staff member told us, "I love my job, it's all I've ever wanted to do. We care about the residents and we care about each other." A third member of staff said, "Some residents needs are more complex than others but we care for all of them really well."

Observations showed staff interacting with people in a kind, respectful and personalised way. There was laughter and good natured exchanges between staff and people using the service. One staff member knelt down to make sure they were able to make eye contact with a person when asking whether they wanted a cup of tea. Another member of staff sat beside another person quietly discussing attending to their personal care. Staff described how they developed relationships with people which included speaking with the person and their family to gather information about their life history, likes and dislikes. One member of staff told us, "We share a joke, a bit of banter and have a laugh. If someone is feeling a bit down sometimes they just want you to sit quietly with them and we do that too." One relative told us, "When my [relative] moved in the staff made him feel really welcome. They made a fuss of him and of me too and that made us so comfortable and helped him settle in."

Staff told us how they promoted peoples dignity, choice, privacy and independence. They said they ensured doors were closed and curtains drawn when assisting people with personal care. When asked how they promoted dignity one staff member told us, "No one likes it if you stand and speak over them. I kneel down or sit beside them. Speak just to them not the whole room." We observed staff knocking on bedroom doors and waiting for a response before entering.

The service respected people's privacy. A person using the service told us, "When my family come to visit we get privacy. They always bring them a cup of tea." The person continued, "When I wasn't well they kept calling my family to let them know how I was doing." Staff told us how they ensured people had choices. One staff member said, "It's important that we make sure people have choices. Some residents like breakfast in bed. They do what they choose to do. Some want to have a lie in some mornings and that's fine we just make sure they have their wash and breakfast when they are ready."

Staff provided information and explanations when supporting people with daily living activities. We

observed a staff member explaining to one person the reason they needed to wait a few moments before standing up as they may feel dizzy if they got up too quickly.

Observations showed staff supporting people to remain independent and people were encouraged to participate in activities outside the service. One staff member encouraged someone saying, "I'm so pleased you are helping us advertise the event. Just tell me if you get tired of it and I'll take over."

People were supported to take part in their cultural or spiritual practices. During our inspection 13 people were supported to take part in a religious service in one of the lounges. One person told staff they didn't feel like attending the whole service but wanted to sit just outside the door and listen. Staff sat with people and supported them to participate during the readings and songs.

Staff knew about peoples cultural backgrounds and told us how they supported them. Staff we spoke with told us they felt they could try new ways of sharing different cultures such as different cultural themed activities.

People using the service were encouraged to give their views about the service. The service had a fast track feedback form so that people could give on-going feedback about the service. Records showed changes the service had made displayed in the entrance area of the home. Residents meetings were taking place on average once every two months and we saw records of these. Meetings were used to discuss activities and any concerns and changes within the service.

The service produced a newsletter for people using the service and their relatives. We looked at the most recent issue which included updates on events that had taken place and future events at the service, birthday announcements, dates of meetings, staff member of the month and highlights from relatives meetings.

People's care files showed plans were in place for end of life care and included people's wishes for preferred place of care and specific funeral plans. During our inspection the service was supporting several people who were at the end of their lives and their care plans were reviewed or updated on a daily, weekly or monthly basis to ensure they were receiving the appropriate care in line with their wishes. Staff we spoke with knew peoples wishes. The service had received recognition and accreditation for providing end of life care. Staff told us about bereavement and end of life training they had attended and about the process for arranging support for people and their family with the palliative care team and with end of life facilitators in the local borough.

Peoples individual needs for maintaining meaningful relationships was included in their pre-admission assessment and in care plans. However, the opportunity to seek information about people who identified as lesbian, gay, bi-sexual or transgender (LGBT) was not clear in care files or in pre-admission assessment. One member of staff said, "We would treat them [anyone who identifies as LGBT] the same as anyone else." Care plans, did however, contain information regarding whether or not people had been in committed heterosexual relationships. Analysis of training records showed only 33.13% of staff had received training in equality and diversity. The most recent training had taken place in 2012. In response to these findings the service organised training for 46 members of staff.

We recommend the service seeks and follows best practice guidance on supporting people who identify as LGBT in care homes.

Good

Is the service responsive?

Our findings

All care records reviewed had details of an initial assessment carried out when people came to live at the home and up to date person centred care plans for each person. Staff were knowledgeable about people's individual care needs and had a good understanding of personal histories and preferences. Staff were able to explain how they used the care plans and risk assessments to ensure appropriate care was given to meet people's needs.

Care plans were detailed, personalised and included details about people's individual needs as well as their preferences. For example, each care plan contained a 'Front Page Profile', which had details about medical conditions, religious beliefs and next of kin details. Care plans also contained a personal life history, detailing information such as where the person was born, their families names, any children or grandchildren, family traditions, and any significant memories. Staff we spoke with told us, "We look at the care plan. It has all the information we need, their likes and dislikes, medicines, everything is in the plan." Another member of staff said "Apart from talking to them the care plan is what makes sure we know our residents and what they need."

Each person using the service had a keyworker. A keyworker is a staff member who is responsible for overseeing the care a person receives and liaising with other professionals involved in a person's life. Records showed care plans were reviewed each month and updated as necessary. Where relevant, people's families attended the care plan review meetings and this was documented. This meant people had up to date care plans which reflected theirs needs and preferences.

Care plans contained information about the types of activities people enjoyed, for example, "Likes to have one to one chats every day, enjoys musical entertainment, likes spending time in room watching TV." The service documented the activities that people were doing in an 'activity log' and a recent entry for the person aforementioned stated, "[Person] really enjoyed our 'music moves us' activity today, shaking a pompom and some maracas." People using the service had choice regarding how much involvement they had in activities. One person told us, "They ask me but I do not want to go out, I am happy here in my room. "This meant that the service was responsive to people's preferences.

There was a programme of activities displayed at the service. This included movement and music, cheese and wine afternoons, art and crafts, gardening and bingo. People also had the opportunity to participate in international gardening week and some had been involved in planning the care home open day.

People using the service and their relatives had mixed views about activities at the service. People told us they enjoyed the activities on offer. One person said, "We go outside, we play games, throw the ball. If I get bored, I read my book, I like to read, they give me books. We go downstairs for the activities. We have a little dance." Another person said, "They put bingo on, they have prizes, it's usually toiletries. When the weather is good we go outside. They are planning a BBQ for the summer."

Younger people living at the service told us they wanted more activities on their unit. One person said,

"There could be a bit more going on here." One relative told us they were concerned about the lack of activities for people who were "Bed bound." Another relative of a person with complex health needs said, "They should be doing more activities with them and also provide a shade for them, so they can be taken out into the garden." A third relative told us, "My [relative] has been chosen for person of the month or whatever they call it. He was taken to the garden. This should be provided normally, not just because he was the person of the month."

The registered manager told us there were a variety of events and activities on all units. People using the service were asked what activities they liked and this was "accommodated." They told us they would consult further with people using the service and their relatives.

The service had a resident house cat. The cat remained mainly on the ground floor of the service and some people were involved in caring for and feeding the cat. We saw people making a fuss of the cat during our visit. One staff member said, "People do get involved and feel responsible for her."

People were given the option to decorate their rooms in their own individual styles and most rooms were personalised with peoples own furniture. One person using the service told us, "I've got pictures in my room. The home put them up for me when I asked them. Everything is always nice and clean. I've got my own bed cover. When my [relative] comes here they're very friendly with her." This person asked if we wanted to see their room. They wore the room key around their neck and told us they liked to keep their room locked for privacy and that, "The home were happy for me to do this." Another person told us, "My room has everything I need and I love my own pictures and bits and bobs." A third person told us, "I think my room is the best one. Look at all my pictures. Me and my [relative] planned it out" This meant the service gave people choice and encouraged individuality.

The service had a complaints policy and procedure. People using the service and their relatives said they knew how to complain if they needed to. One relative said, "I've complained to the manager. It was responded to in writing." The management team and staff were able to explain how they would deal with a complaint. We looked at records of 21 complaints received by the service between February 2015 and April 2016. All complaints received had been responded to and resolved in line with the providers' complaints procedure.

Good

Is the service well-led?

Our findings

The service had a registered manager who had been working in the service for one year at the time of our visit. 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.

Staff told us they enjoyed working at the service and found the management team supportive. Staff said the management team of the service had changed over the last year. They told us they saw this as positive. One staff member said, "The manager tells us about any changes needed and why it's necessary. We are able to understand that it's not change for the sake of it, there's a reason." Another staff member said, "There's been a few changes but its good." A third staff member said, "If it's wrong then it needs to be expressed and we are told what the issue is and how we need to change things. We suggest the changes too and then work together to improve things."

Staff told us they found the management team knowledgeable and approachable. One staff member said, "I am happy here, the management is supportive." Another staff member said, "All of them (management team) are open and transparent." A third staff member said, "You can ask them anything and they will help you, they really know about nursing and care." Staff members' described the registered manager as "Supportive", "Helpful" and "Approachable."

People using the service and their relatives knew the management team and told us they found them approachable. One person said, "Managers are good, they come round all the time and have a chat." Throughout our inspection we saw the management team interacting with people who used the service and their relatives. The registered manager knew people who used the service and each person by name and had conversations with them. One relative said, "The manager is very approachable and easy to talk to. Although this is a business you don't get that feeling." Another relative said, "If I wasn't happy I would go downstairs to the office, [registered manager] listens to you."

The service had two deputy managers. Both had been in post for three months but had worked as nurses at the service prior to this. One was responsible for the three units supporting younger adults and people with complex needs. The other deputy manager was responsible for the residential and nursing units in the home. They had joint responsibility for clinical practice and we observed they worked well together and with staff at the service. Staff we spoke with were complimentary about the deputy managers. Nurses we spoke with told us they felt supported in their role and felt they had good clinical leadership from the deputy managers. One nurse told us, "They (deputy managers) are brilliant. My deputy is always available to guide us, show us and discuss how to give the best nursing care." Another nurse said, "The deputy visits us regularly on the unit, [deputy manager] is very good." A third nurse said, "We get really good clinical guidance here."

The management team told us they felt supported by senior management. They said they had regular visits

and audits carried out to improve the service. The focus had been on improving the quality of the service for people and staff. There were support structures in place for nursing staff which included internal and external peer support. The provider had a clinical regional nurse who provided training and support for nursing staff. The management team attended conferences for adult social care providers. They met with registered managers of care homes for older people within the borough and attended provider meetings to ensure they kept up to date with best practice.

Staff said they found the culture in the service open and supportive. They said they could discuss any concerns about clinical or care practices and ask if they were unsure about any aspect of their work and felt listened to and valued in their role. One staff member said, "I do feel as though I am listened to. I can make any suggestions to the manager." Another staff member said, "The door is always open. It is good here, we all work here as a team." A third staff member said, "It's like a little family here, we all know each other, we get on. It's a friendly place." A fourth staff member speaking about a deputy manager described them as, "Diplomatic and patient, gets the job done and treats all of us with dignity and respect."

The management team were complimentary about the staff team. The registered manager told us how they built relationships with staff by getting to know their personality and the skill mix of the team. They told us they worked hard to have a culture which was open and supportive. Staff were nominated by their peers and people using the service for "Staff member of the month" and good practice and team work was recognised and units received "Oscar awards" in recognition of this.

The service sought feedback from relatives about the service. Meetings took place at the service. We saw records of a relatives meeting in February 2016 and discussions took place around the furniture of the service, night staff and activities. One relative we spoke with told us the meetings were "A good way of letting the home know what you're concerned about and it's a way of getting to know what's going on." Relatives told us they could speak with the management team outside of the meetings and didn't have to wait to raise any concerns or ask questions. Relative's surveys were also carried out. The most recent survey was for 2015 and noted that overall relatives were satisfied with the standard of care provided, quality of life, safety, and staff professionalism.

The service worked in partnership with other agencies and health professionals. One health professional told us, "I am happy with this home, the nursing care is excellent." They said they found the service to be "Proactive" regarding peoples care and treatment. Another health professional told us the service had improved in the way assessments were completed and communicated well to ensure people received appropriate care. Both health professionals told us they were satisfied with communication and documentation in the nursing records and knowledge professionalism of staff.

The management team and staff told us and records showed monthly team meetings had taken place. Team meetings were categorised by department and unit. For example, we saw a recent "Admin Staff Meeting", which took place in April 2016 and discussed aspects such as how to manage enquiries about prospective placements. There were records of a "Nutrition and Hydration", meeting in April 2016 which discussed any concerns about weight loss or gain of people using the service and what actions would be taken. There were records of recent meetings for nurses and senior carers from each unit, a night staff meeting, a ground floor meeting, an activities meeting and meetings for each unit within the service.

The service also had daily "Stand up" staff meetings. These meetings were attended by a representative from each unit and included staff from all departments of the home such as maintenance, kitchen, administration and housekeeping. Records showed discussions included accidents and incidents, clinical overview, staffing, scheduled discharges, management updates, occupancy and resident of the day. Staff

told us these meetings were "Very useful" and took place daily unless there was an emergency situation such as a medical emergency.

Quality monitoring systems were in place and records were accessible and up to date. The registered manager and deputy managers had responsibility for completing audits. Records of audits included care planning, risk assessment, nutritional needs, wound care, infection control, falls monitoring and medicines management. As part of the quality monitoring there was a 'Resident of the day'. This person had their care file including care plans and risk assessments reviewed, maintenance checks completed in their room, and they received a special meal and activity of their choice. Clinical record audits took place weekly for a percentage of people using the service. This included updates on people's nursing care needs.

Accidents & incidents were managed by the service. We saw records of incidents that had taken place involving people who use the service. One person was recently recorded as having scratched themselves. A body map was completed and the actions taken were clearly recorded, for example, "The area was cleaned and dressing was applied." Relatives we spoke with told us they were always informed if there was an accident involving their relative. One relative said, "My [relative] has had two falls and I got a telephone call immediately. They told me what had happened and what they were going to do to prevent any more accidents."

We noted recommendations had been made and recorded following accidents and incidents to prevent reoccurrence. Serious incidents were reported to the local authority safeguarding team and the Care Quality Commission as appropriate. Staff we spoke with knew the procedure for reporting accidents and incidents.

The provider had service improvement action plans from each audit which were used to improve quality of service delivery. Action plans were updated weekly or monthly as required and covered areas such as risk assessments, medicines audits, and infection control. Action plans were detailed and included of staff discussion, the action needed, dated action was taken and the staff member responsible Staff we spoke with were aware of the action plans. The record of the most recent bi- monthly quality audit carried out by the provider showed issues had been identified and agreed actions put in place. For example, daily stand up meetings should be recorded, and percentage for learning and development completion was low. The actions for improvement had been completed or in progress were recorded in a timely manner.

During the inspection the registered manager was open about areas of improvement. Throughout the inspection we requested records and information from the registered manager, deputy managers and administration team which was provided promptly and with detailed explanations. All staff we spoke with were helpful, co-operative and open.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive such appropriate support, training, professional development, supervision as is necessary to enable them to carry out their duties they are employed to perform.18(2)(a)