Bupa Care Homes Limited

Amerind Grove Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 November 2017 and was unannounced. The service was registered to provide accommodation and personal care for up to 168 people. Amerind Grove Care Home consists of five separate bungalows but only three of them were currently being used. These three bungalows were called Picador (residential care for people living with dementia), Capstan (nursing care for people living with dementia) and Kingsway (the general nursing unit). The maximum number of people that could be accommodated at any one time was 106 and at the time of our inspection there were 103 people in residence.

Amerind Grove Care Home was re-registered under a new legal entity in January 2017 and this is the first inspection of the service since then.

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.

People were safe. Staff received safeguarding adults training and knew what to do if there were concerns about a person's welfare. They knew how to report any concerns they may have regarding the health and welfare of people. When concerns had been raised the service cooperated with the local authority in any investigations that had taken place. The service encouraged the staff to speak up if they had any concerns.

Risk assessments were completed as part of the care planning process. Where risks were identified there were plans in place to reduce or eliminate the risk. We saw staff performing safe moving and handling procedures during the inspection. For each person a personal emergency evacuation plan was written detailing the level of support the person would need in the case of an emergency. The risks of employing unsafe staff were reduced because of robust staff recruitment procedures.

The premises were well maintained. Regular maintenance checks were completed to ensure the building and facilities were safe. Checks were also made of the fire safety systems, the hot and cold water temperatures and equipment to make sure they were safe for staff and people to use. The management of medicines was safe meaning that people received their medicines as prescribed.

Staffing levels in each of the bungalows were regularly reviewed and amended to ensure the staff were able to meet all care and support needs. The number of staff on duty took account of the level of dependency of each person and any additional activities that were planned to take place. Staff confirmed they had enough time to meet people's needs although there were times in the day when things were very busy.

Medicines were managed safely and there were safe systems in place for the ordering, receipt, storage, administration and disposal of medicines.

The home was clean tidy and fresh smelling. One of the bungalows has had two outbreaks of infections and the staff took the appropriate action to prevent further spread.

The service was effective. There was a robust induction training programme for new staff and those new-to-care staff completed the Care Certificate. There was a mandatory training programme for all other staff to complete to ensure they had the necessary skills and knowledge to care for people correctly.

The capacity of each person to make decisions was assessed as part of the care planning process and they were always asked to consent before receiving care. People were encouraged to make their own choices about aspects of their daily life. We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were provided with sufficient quantities of food and drink and asked about their likes and dislikes. Specific dietary needs were catered for. Where people were at risk of losing weight, the staff monitored this regularly. There were good arrangements in place to ensure people saw their GP and other healthcare professionals as and when needed.

The service was caring. Staff had good working relationships with the people they were looking after and showed genuine care in their approach to people and their families. People were kept at the centre of all decisions made about their care and they were listened to. Any suggestions they made were acted upon.

People were given the opportunity to take part in a range of different meaningful social activities. There were group activities and external entertainers visited the service on a regular basis.

The service was very responsive to people's individual care needs and adjusted the service delivery when people's care needs changed. The service was particularly good at taking into account the person's previous life and had forged many meaningful links with the local community. There were good assessment and care planning arrangements in place, which meant people were provided with a person centred service that met their own care and support needs.

The service was well led. The staff team was led by an experienced and enthusiastic registered manager and a senior management team. There was good leadership for the staff. Staff meetings ensured they were kept up to date with changes and developments in the service.

There was a regular programme of audits in place, which ensured that the quality and safety of the service was checked. These checks were completed on a daily, weekly or monthly basis.

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 were safe and protected from concerns The staff team knew what to do if concerns were raised and acted to prevent further harm. Any risks to people's health and welfare were managed well.

There were sufficient staff on duty each shift to meet people's care needs and keep them safe. The recruitment procedures ensured only suitable staff were employed.

The management of medicines was safe and people received their prescribed medicines as planned.

The premises were clean, tidy and fresh smelling. Where outbreaks of infection had occurred, the appropriate action was taken and measures put in place to stop further spread.

Is the service effective?

Good

Is the service effective?

The service was effective.

Staff were trained and well supported enabling them to carry out their role.

The service was aware of the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and worked in accordance with this. People were asked to consent before staff helped them with tasks.

People were provided with sufficient food and drink and were able to make choices about what they ate and drank. They were assisted to see their GP and other healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them.

The care staff had good relationships with people and talked respectfully about the people they looked after.

Is the service responsive?

Good

The service was responsive.

People received a person centred service where assessment and care planning arrangements took account of their specific individual needs. Their care and support was amended when their needs changed. People were involved in care planning and had a say in how they wanted to be looked after.

A programme of meaningful social activities was arranged for people to participate in – these included group activities and one to one sessions. People were listened too and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Good

The service was well led.

There was good leadership and management in place. People's views and experiences were seen as paramount to the success of the service. Staff were well supported.

There was a programme of checks and audits in place to ensure that the quality of the service was measured. Any events that occurred were analysed to see if there were lessons to be learnt.

Amerind Grove Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The inspection was unannounced and was undertaken by three adult social care inspectors, two pharmacist inspectors and two experts by experience. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of service. This was the first inspection of Amerind Grove Care Home since it was registered under a new legal entity in January 2017.

Prior to the inspection, we looked at the information we had received about the service since January 2017. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR) which was submitted in September 2017. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

Prior to our inspection we contacted 16 health or social care professionals plus others who were involved in the service. Eight people responded to us and told us about their views and experiences of working with the service. This helped us plan our inspection and their feedback has been included in the main body of the report.

During our inspection we spoke with 23 people to varying degrees and also spent time observing the interactions between staff and people and their visitors. We did this to assess what the quality of care was like for those people who could not describe this for themselves. Some people were able to tell us about their experience of living in Amerind Grove Care Home whilst others were living with dementia. During the inspection we spoke with 25 relatives.

We spoke with the registered manager, the deputy manager and other staff in senior positions. We also spoke with 17 other members of staff (qualified nurses, care staff, activities staff, kitchen and domestic staff

and the maintenance person).

We looked at 10 people's care files and other records relating to their care. We looked at seven staff employment records to check recruitment procedures and checked staff supervision and training arrangements. We looked at key policies and procedures, the audits completed to ensure the quality and safety of the service was maintained. We looked through the minutes of meetings with the staff, the 'residents' and relatives.

Good

Is the service safe?

Our findings

People and relatives we spoke with on Kingsway and Picador said they felt safe living there or that they felt their relative was safe living there. If there had been any safety issues these had been dealt with quickly and effectively. People said, "It's nice here – I've no complaints", "I feel completely safe here- if I have any fears I ask my son – he knows everything", "It's very good here" and "I understand that I'm here now so I have to make the most of things. I get real support from the staff here".
People and relatives in Capstan said, "I did not feel safe when I first came here and had an unexplained fall. It has changed in the last two/three months and now I am happy. My family complained to CQC and safeguarding and now we are fully consulted and involved and care is good. After that fall crash mats and a sensor mat were put in place", "They (person) are safe - the staff are always on the ball and know what is going on", "The staff are lovely they make me feel so safe" and "Safe, Oh yes you might have to wait a few minutes if it's not an emergency but someone is always there for you".

Relatives told us, "I am happy enough but mum can't accept it", "It is clean here but sometimes the cutlery and glasses are smeared", "I check things very closely for my own peace of mind", "Initially mum had people wandering in and out of her room at night. She has her door locked now and is much happier. It was dealt with promptly and well" and "Staff take mum very seriously and listen to her even though it probably hasn't happened. She had a UTI and was very confused- she thought she had been assaulted. Safeguarding was contacted and she was asked if she wanted the police. They dealt with it very well".

Safeguarding training was completed by all staff and they knew about the different types of abuse and how a person's behaviour may change if they were being harmed. This was important because many people at Amerind Grove Care Home were either living with dementia or had a degree of cognitive impairment. The staff we spoke with were aware of their responsibility to keep people safe and knew what action to take if abuse was suspected, witnessed or a person made an allegation of harm. Staff referred to the whistleblowing policy would report any concerns they had to the registered manager or the deputy manager. Information was displayed in each of the three bungalows informing staff, people and their visitors how to report directly to the local authority. Staff also knew they could report directly to the Police and the Care Quality Commission. The safeguarding team at Bristol City Council reported the service worked well with them and where required, protection plans were followed to safeguard people.

The provider had a 'speak up' policy and this enabled the staff to raise any concerns they had and be taken seriously. Posted were displayed in each part of the service and staff confirmed their awareness of the policy.

Risk assessments were completed for each person as part of their care plan. For example, the risk of malnutrition or dehydration, falls, pressure damage to skin and any moving and handling tasks the care staff needed to complete. Where a person needed assistance to move or transfer from one place to another, a moving around plan was written. These plans set out the equipment needed to complete the task and the number of care staff required. We witnessed staff performing moving and handling equipment during our inspection, and they were doing this competently. Risk assessments were undertaken before the use of bed

rails was considered in order to ensure the use of bed rails did not pose a greater risk for the person. For one person we saw that a safe smoking assessment had been completed. The care plan detailed the measures in place to remove the risk but still allow the person to have a cigarette. All risk assessments were reviewed on a monthly basis and amended where necessary. For each person, a personal emergency evacuation plan (a PEEP's) had been prepared. These set out the amount of support the person would require in the event of a fire and the need to evacuate the part of the home they lived in.

There was a monthly programme of maintenance checks in place and on a six monthly basis the head of estates visited Amerind Grove and completed a full health & safety of the utility services, the premises and all equipment. These checks ensured people lived in a safe place and the staff worked in a safe place. A fire risk assessment was last completed by an external contractor in March 2017 and all actions had been signed off. There was a programme of weekly, monthly and quarterly checks of the fire safety systems and hot and cold water supplies. We saw there was a fire emergency folder in each of the bungalows and these included a list of the people living there and their PEEPs. The kitchen staff had a schedule of daily checks to complete and these included fridge and freezer temperatures, hot food temperatures and food storage arrangements. Kitchen staff and housekeeping staff had cleaning schedules of daily, weekly and monthly tasks. These measures ensured people lived in a safe and clean environment.

The staffing levels in each bungalow were arranged separately and consisted of qualified nurses, senior care staff and care assistants. A dependency score was determined for each person and the numbers of staff on duty each shift was calculated from this. Staff confirmed that staffing levels were adjusted when the workload increased. Catering and housekeeping staff, activity and maintenance staff and members of the senior management team were also on duty to meet people's daily living needs.

The service had a number of bank staff who could be called upon to fill any vacant shifts. The service had needed to rely upon agency workers because of staff vacancies but this was now reducing. The registered manager hoped that by the end of the year they would not need to use any agency workers because of recent staff recruitment.

Safe recruitment procedures were followed. Pre-employment checks ensured unsuitable staff were prevented from being employed. Prospective employees were always interviewed and an interview assessment made, written references were requested from previous employers and a Disclosure and Barring Service (DBS) check was made. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

At this inspection we checked medicines storage, medicines administration records (MAR) and medicines supplies for 19 people, and topical cream application records for four service users. We saw the home was managing medicines safely.

Staff recorded the administration of medicines on MAR charts. We observed medicines being given at lunchtime and saw that they were given in a safe and caring way. The MAR charts we saw were completed accurately, showing that people received their medicines in the way prescribed for them. Staff recorded on separate charts when creams and ointments were applied to people. There were body maps and guidance to inform staff on how these should be correctly applied.

Allergies were recorded for people, and medicines had clear directions how they should be administered. Some people had medicines prescribed on a 'when required' basis. There was guidance for staff on when it would be appropriate to give doses of these medicines for each person. Staff could give some non-prescription medicines to people, so that they could respond to their minor symptoms in a timely way.

However we found one preparation which had passed its expiry date. This was removed immediately during the inspection when we pointed this out to staff.

We looked at records of four people with limited mental capacity to make decisions about their care or treatment and who would refuse their medicines. There were records of assessments of their mental capacity and best interest decisions to give them their medicines crushed and hidden in food or drink (covertly). Care plans provided information about how medicines could safely be administered in this way. We reviewed records of two people living with diabetes. People's blood glucose levels were monitored and recorded daily.

There were suitable arrangements for ordering, receiving and disposal of medicines, including those requiring extra security and recording. Medicines were stored safely and securely. Staff monitored temperatures to make sure medicines were safe and effective. Liquid medicines, inhalers and eye drops were annotated with the dates that they were opened, so that they were used safely.

There were detailed policies in place to guide staff on looking after medicines. Clinical and management staff carried out regular medicine audits, to help identify areas for improvement. We saw an effective system of reporting and investigating any incidents or errors, to help prevent them from happening again. Staff regularly received medicine management training and had checks to make sure they gave medicines safely.

All three bungalows were clean, tidy and fresh smelling. One relative told us, "The home is always clean and never has any odours". Two of the units had recently had outbreaks of diarrhoea and vomiting and the service had taken the appropriate action and informed the relevant authorities of the events. The clinical services manager was the lead nurse for the prevention and control of infections. The registered manager had organised a letter to be sent out, reminding visitors to the service to refrain from visiting if they were unwell, in order to prevent a further outbreak. All staff received infection control training as part of the mandatory training programme and quarterly infection, prevention and control audits were undertaken. A root cause analysis investigation was completed following each of the outbreaks in order to identify where improvements were required.

Good

Is the service effective?

Our findings

We asked people and relatives at Amerind Grove Care Home if they thought staff were good at their jobs. People said, "Certain members of staff are better than others", "I think there are enough staff around" and "I get great support from staff here". Relatives told us, "Staff here are amazing. The problems here are those that are everywhere at the moment – poorly paid staff who are very overworked", "Mum has mobility problems. The staff encourage her to walk as much as she can. They have put this in her care plan – I was involved in her care plan", "No complaints – it is like a big family here. If there are any problems they will phone me up" and "Staff are very accommodating. Maintenance got a new TV remote for her very quickly".

Staff were regularly supervised where work performance and any training and development needs were discussed. There was a cascade system of supervision in place with the registered manager supervising the senior members of the management team (the deputy manager and heads of department), the deputy supervising the nurses and the 'unit manager' nurses/team leaders supporting the care staff. Staff confirmed these arrangements and said they were well supported by their colleagues. At the start of each shift the staff coming on duty received a full handover report from the staff going off duty. These arrangements meant staff were made aware of any changes in people's care and support needs. However, qualified nurses told us they did not generally get to work alongside the care staff and "work out on the floor". This was discussed with the registered manager and regional manager at the end of the inspection.

New staff completed an induction training programme at the start of their employment. The programme followed the Care Certificate Framework and had to be completed within 12 weeks of the start of their employment. The Care Certificate was introduced in April 2015 and covers a set of standards that social care and health workers must work to. We saw evidence that new members of staff had completed this training. Staff we spoke confirmed their induction had prepared them for their role and they had been given a mentor who signed off their progress in the programme.

Initially new staff 'shadowed' more experienced staff and were required to complete a probationary period before their employment was made permanent. The probationary period can be extended if necessary to ensure staff had the appropriate knowledge and skills to carry out their role effectively. Staff confirmed these arrangements.

There was a programme of mandatory training all staff had to complete and courses were then refreshed on a yearly, two or three yearly basis. The programme nutrition and hydration, food safety, moving and handling, fire safety, health & safety including infection control, safeguarding, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff whatever their role, completed a one day 'person first dementia second' training. Qualified nurses completed clinical training for example, syringe driver training, venepuncture, catheter care and stoma care. The training programme ensured staff had the necessary skills to meet people's needs. Care staff were encouraged to undertake additional training where this proved beneficial to the service and person or staff member. This included health and social care diploma qualifications (previously called a National Vocational Qualification (NVQ)).

One health care professional said the care staff were responsive to support from the care home support team (NHS) and had engaged with teaching sessions and assisted with new initiatives such as the early warning scoring system for unwell people and the revalidation process for nurses with the Nursing and Midwifery Council (NMC).

MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. An assessment of a person capacity to make decisions was carried out when a new person moved in to the service and was kept under review as part of the care planning review process. One of the senior nurses had taken a lead role regarding DoLS. Referrals were submitted to the local authority as soon as it was identified the person could not consent to living at Amerind Grove Care Home. Best interest meetings were held where decisions needed to be made in respect of a person's care and support needs and they lacked the capacity to do this themselves. We saw records in people's care files where decisions about personal care and medicine administration had been made. We found that the service was working within the principles of the MCA and applying for DoLS appropriately.

Staff were aware of the need to ask for people's consent and we heard them asking people for their agreement before they provided any care. Examples included, "Would you like a cup of tea or coffee?", "Where would you like to sit today?" and "Are you going to come across to Kingsway for the church service? People were encouraged to say how they wanted to be looked after and their preferences were respected.

We asked people about the food and drink they were provided with. The feedback we received was generally positive. They said, "We get lots of things. The food is very good. I have most of my meals in my room", "The food is up and down. It is not incredibly imaginative but they use fresh fruit and veg. The support her with her iron deficiency as she gave up eating meat and have supplemented with pulses and beans etc", "Problems maintaining her weight. I have mentioned it to staff and they provide fortified drinks but she doesn't like them" and "She eats the same things all the time. They are very good and accommodating. She has lost weight and they keep offering health drinks but she is refusing these".

One relative was concerned their family member did not have enough to drink and they often found them with no available drink when they visited. They were also concerned that the fluid intake monitoring chart was not always completed in full. This was pointed out to the staff in Capstan. We did not receive any comments from other relatives and the other fluid intake charts we looked at were completed properly.

Each person was assessed in order to identify any risks in respect of nutrition and hydration. This was then reviewed on a monthly basis. Body weights were checked on a monthly basis or weekly if the person was not eating well or was losing weight. Food and fluid intake charts were completed where the care staff needed to monitor how well a person was eating or drinking. Where required people were referred to the GP or other healthcare professionals and fortified foods and drinks were provided. People were also asked about food preferences and any food allergies. A 'resident nutritional requirement assessment' form was completed and a copy of this was given to the kitchen staff. The chef demonstrated a good insight into people's individual needs.

People were provided with a well-balanced diet and plentiful supplies of hot and cold drinks. There were two meal choices at lunch time, preferred to as the premium choice, plus other alternatives. The menu plan included fish meals, red and white meat dishes, vegetarian meals and softer foods. People were able to eat their meals in their own bedrooms but were encouraged to have their meals in the dining room or lounges to make it a social occasion. A supply of snack foods and fruit were available in the kitchenettes and hot

drinks were served mid-morning with biscuits, after lunch and mid-afternoon with homemade cakes.

We observed meals being served in Picador. Twelve people were seated at the dining room tables whilst eight were seated in arm chairs with individual side tables. One person was assisted to eat their meal. This was done appropriately with the member of staff seated. Good eye contact was maintained and conversation made throughout the meal. The staff wore aprons over their uniforms. The dining tables were well presented and attractive with linen cloths, table mats, metal cutlery and glasses. There were no menus on the tables. The only menu was by the door into the lounge. This was written and no pictorial guidance available.
We noticed that the staff told people what was available but did not show plates of food to show what the food looked like. This would be useful for people living with dementia. When food arrived staff did not always tell people what it was or only in the broadest terms, for example "soup", "sausages" or "sandwiches". We saw one person who was removing the coleslaw from the cheese and coleslaw sandwich. She told us she did not like coleslaw. It would have been better if the staff had accommodated this preference.

The menus were seasonal and on the whole prepared using fresh fruit and vegetables but frozen food products were used. Afternoon cakes and birthday cakes were homemade. Alternative meals were always available if a person did not like the planned meals.

There was a contract in place with local medical practices to provide GP services to the home. Each of the bungalows received a weekly visit from a GP who would then see and review the healthcare needs of those people identified by the nurses. We were told the service worked well with healthcare services to ensure people's health care needs were met. Examples included dieticians, dentists, foot care practitioners and district nurses. The service was supported by the mental health in-reach team and the care home liaison team.

Amerind Grove Care Home is a care home with nursing. People will either be living with dementia or have general nursing care needs. Although the service had five bungalows only three were in use at the time of the inspection. Each of the bungalows had bedrooms and communal facilities and a plentiful supply of nursing equipment to aid people's comfort and allow the staff to move them from one place to another safely. The buildings were purpose built care homes and were each designed around the needs of the older person and in Picador and Capstan particularly, for people living with dementia.

Good

Is the service caring?

Our findings

People told us, "They really are lovely. All of them are really good", "She is lovely, really lovely (named member of staff). She knows my age and everything", "Privacy and dignity is not a problem" and "I can have a bath or shower whenever I want. Last Sunday after I'd had the sickness bug they asked me if I wanted a bath. It was sheer joy. The best bath ever! It was kind and thoughtful to offer ".

Relatives told us, "The care side of things – no problems" and "The nursing care- no problems at all", "(named manager) is excellent. I am comfortable with how she deals with things", "I am involved in her care plan" and " When I take her home for the weekend staff tell me " Look if it's too much for you bring her back" but I am old fashioned she is my wife and I'm very hands on with her care". Relatives and staff told us they would recommend Amerind Grove Care Home to friends and family.

One social care professional said when they visited they found people to be well cared for and staff were always available to help people with any problems. People had told this person they were happy and the staff were nice and looked after them well. The also said the registered manager really cared about people and "wanted to make their time at Amerind Grove Care Home the best possible".

We observed people being treated with dignity and respect and relatives confirmed this was always the case. Some of the relatives commented on the staffing levels and lack of staff at times which meant unacceptable waits for assistance with personal care. We observed lots of smiles, shaking of hands and hugs between staff and the people they were looking after throughout the day and it was lovely to see staff making people feel special and valued – not always in words but in their actions too. It was evident some people appreciated the tactile way carers interacted with them. While others were treated just as well but less tactile, this showed the care staff knew people's likes and dislikes and which way they needed to interact with them. People were encouraged to be independent but care staff were ready to assist when necessary.

It was evident people were treated well. We noted that people looked well cared for with clean clothes, hair and fingernails. Most of the ladies had varnished finger nails. They were all smartly and appropriately dressed. Spectacles were being worn and some ladies had their handbags with them. All staff interacted with people in a friendly and caring manner. Staff appeared to know the people they were looking after well and used their first names. There was lots of joking and banter between people and the staff team. We noted that the staff always spoke and acknowledged people when they were in the same areas.

Personal care was always delivered in privacy with bedroom doors closed. It was evident the service not only treated the people they cared for respectfully but were also respectful to visitors and families. Staff told us they were treated well by the providers, their colleagues and the management team.

During the inspection we observed staff having caring interactions with people. We saw a member of staff sitting on a bench in the corridor having a good chat with a person. On another occasion there was a lovely interaction between a member of care staff and a person who wanted to walk without their walking frame.

The staff member said, "No darling - you need to use this. Come and have a cup of tea". The person was guided back to the lounge area. Care staff told us about a married couple who had to be looked after in different bungalows because of their individual specific health reasons. They were assisted to meet each day but because of a recent stomach bug this had not been possible. During the inspection staff were able to assist the two people to meet up and the pair of them sat in the lounge holding hands having a cup of tea together. They said the couple normally had their lunch together as well.

In each of the bungalows there were notice boards where letters and thank you cards were displayed. In one of the bungalows the following three comments were made. "Thank you to (named staff member) and all the staff for making it a special day for my brother", "I would like to thank you for the kindness and love you have shown to (named person) all the time she stayed with you. The support to us and x in this sad time was excellent" and "Thank you all so much for the love and care you gave (named person) during his stay with you". There were white boards in the main entrance of each bungalow where relatives could write up comments. Comments included, "The house staff are very lovely and kind", "It is a lovely place to live and I enjoy visiting" and "All the staff are good and cannot do enough for (named person)".

The service looked after people with palliative care and end of life care needs. Nursing staff were competent in using syringe drivers to enable pain relief medicines to be administered and ensure people were kept as comfortable as possible. Arrangements were made for end of life medicines (called anticipatory medicines) to be available in readiness for when people needed them. Anticipatory medicines included pain relief and other medicines, to manage distressing symptoms. This meant the service was prepared for a sudden deterioration in a person's condition and there was no delay for them receiving the treatment they needed. There was also a training programme for care staff to complete in respect of end of life care.

Good

Is the service responsive?

Our findings

People said, "They could not do more for me", "I was very unwell a couple of weeks ago and they couldn't have cared for me any better", "If I get pain the nurses always bring me my tablets. Every time they go round with the trolley that ask me if I need them" and "The staff are trying to get me to walk better because I want to go and live in my own home again. They encourage me to walk".
Relatives told us, "They have a relative's support group meeting every two months. I find it really useful. It provides emotional support for us. The (Named manager) is very supportive" and "Occasionally they let themselves down with silly little things. I have to remind them and then they react. I keep a close eye on things. I would give the service 9/10".

People's care and support needs were assessed before they were offered placement in Amerind Grove Care Home. These assessments were undertaken by either the deputy manager or the clinical support nurse. These measures ensured the service was the right place for the person and that they were looked after in the right bungalow. The assessment also ensured the staff team had the required skills and experiences and any specific equipment was available. The assessment covered all aspects of the person's daily life, any healthcare needs and the person's expectations. The information gathered during this assessment was used as a basis for further assessment on admission and then completion of the care plan.

A plan of care was prepared for each person and these set out their specific care and support needs. One health care professional said the introduction of new care documentation and the staff approach to care planning had ensured there was more person centred towards each person's specific care needs. We looked at a sample of plans in each of the bungalows and found them to be accurate and containing sufficient information to instruct the staff on how to care for the person. The plans were person centred and it was evident the person or their representatives had been involved in the care planning process. Care plans were reviewed on a monthly basis. This meant people's care plans remained up to date and the care staff were able to respond to any changes in how the person was looked after.

Some additional care records were kept in people's bedrooms and these included food and fluid charts, topical medicines administration charts and repositioning charts. Those we looked at had been completed well and the nurses told us there was an expectation they checked all these forms at the end of a shift. We were able to evidence on some of the forms that the nurses had countersigned to show the chart had been completed correctly.

The service employed three activity organisers (AO), one bank AO and a 'residents experience manager'. One health care professional said the appointment of the residents experience manager had been a very positive move and their commitment and enthusiasm to improving people's live was a credit to the service. They said this also applied to the unit managers and the supportive management team.

The AOs were each allocated to one of the bungalows but they liaised together in organising the programme. People were supported to go over to one of the bungalows if there was something going on there they wanted to participate in. They not only arranged group activities but also spent time with people

on a one to one basis. This time may be used chatting, reading something aloud to them or hand massage and nail painting. One of the AOs told us they maintained social information regarding each person in a booklet named 'My time at Amerind Grove'. When the person passed this was given to family as a record of their time at Amerind Grove Care Home.

We observed one of the activities staff going round with guinea pigs in their 'carriage' – an adapted baby's pram and a number of people were enjoying stroking and making a fuss of them. Despite this good level of interaction with those people the member of staff failed to notice that one person was sat in their chair, slumped forward, with their head resting on the table. However, another member of staff noticed and attended to this person, sat them back in the chair so they were not in danger of falling out or hurting themselves.

An activities notice board in each of the three bungalows highlighted the various activities that were taking place. For example there were visits from local nursery school children on Monday, Swimming on Wednesdays, a social get together in one of the bungalows with quizzes and chat led by a volunteer on Wednesdays and Saturdays and Film Club on Thursdays. There was a hair salon called 'Pin up Curl' in the main administration building and a hair dresser visited the service each week. We were told that relatives were able to use these facilities with their family member.

Throughout each of the three bungalows there were photographs displayed of visits to a garden centre, people swimming, of trips out to a local café and a museum and people dancing in the lounges. One of the care staff told us the dancing was also a popular activity.

There was a mixed use of memory boxes in both Picador and Capstan where people were living with dementia. Some of the boxes contained items of importance to that person and an indication of the person's life whereas others were completely empty. A staff member said this was due to some families not contributing items. It would be nicer if activities and care staff were able to add a photo of the person from one of the activities or something they had made, rather than leave the box empty.

The service had extremely good links with the local community. Many of the people at Amerind Grove Care Home had previously lived in the local community. The registered manager told us those people who either choose not to go out or were nursed in bed had expressed an interest in meeting with individuals and groups from the local community. Locally baked pies were delivered to the service when the company which made them was celebrating their 75th anniversary, this being significant because many people would have eaten these throughout their life. As a result it had been arranged for a local nursery group to visit twice a week, and for other school pupils from two nearby schools , one to visit weekly and the other twice monthly. People were encouraged and supported to visit a local community centre for a sporting memories group and also a local church. The registered manager also told us the local girl guides troop were interested in visiting the service and participating in social activities with people.

A local vicar visits Amerind Grove Care Home for bible classes and two dogs from a pet therapy organisation visit on a regular basis. In order to give something back to the community as well, one of the empty bungalows was used by a local lunch club on a weekly basis. The registered manager said there was no reason why any person who lived at Amerind Grove Care Home could not attend this luncheon club in order to meet up with old friends.

External entertainers visited the service and examples included musical entertainers, a massage therapist, active for life sessions and pet therapy visits. The service was supported by a very active group of volunteers. They provided a befriending service and large scale activities on Wednesday and Saturday mornings. One of

the visiting services told us that "people were very responsive to what they did, particularly those who were confined to bed".

The service held a 'resident and relative's meeting on a quarterly basis, chaired by the registered manager, and supported by heads of department. Actions were taken at these meetings and an improvement plan put in place to ensure that the service continued to evolve to meet the needs of the people and their family.

People told us if they had any concerns or complaints they would feel able to raise these with either the care staff, the nurses and any of the senior staff members. Some said they would rely upon their relatives to do this. One relative said they had to raise when their family member had first moved in, but the issues had all been addressed.

There was a robust complaints policy in place, and all complaints were answered within 21 days. Each complaint was thoroughly investigated and the complainant was provided with a written outcome which may include apologies where there were failures or learning outcomes. Each complaint was recorded, and if the concerns raised required a safeguarding referral this was actioned. We found that all written complaints were managed quickly and effectively with a written response made within the 21 day timescale. Concerns raised with the registered manager were also documented and managed promptly with all actions evidenced. If a person, relative or another health professional raised a concern with the registered manager it could be escalated to a complaint and a full investigation would take place.

Good

Is the service well-led?

Our findings

The people we spoke with did not make any direct comments about how the service was run but their relatives did. They thought the home was very well run and the registered manager and senior staff provided good leadership for the staff team. Their comments included, "They are always willing to chat if we have a query and although we have not had to complain or raise a concern we are sure they would listen and take notice if we did", "The manager and deputy are visible, available and approachable", "We would be comfortable talking to the manager – he and the deputy are very approachable and easy to talk to" and "The manager is around and his door is always open. He is very kind and approachable".

The staff team were led by a registered manager who had been at Amerind Grove Care Home since April 2015. They had already successfully completed the National Vocational Qualification in leadership and management at level five and was currently studying the QCF at level seven. They were supported by a clinical lead nurse/deputy manager, a clinical support nurse and other heads of departments. Each of the three bungalows had a unit leader, nurses, senior care staff and care staff. The registered manager told us before the inspection they were responsible for all aspects of the service and for the safety of each person, their relatives, the staff team and any other visitors. A daily walk-around was completed by either the registered manager or one of the senior managers and it was evident from going round the building during the inspection that the registered manager knew people well.

One health care professional said they had been very impressed with the progress the service and stated in their opinion the service was "safe, effective, very caring, very responsive and very well led". They added that day to day management in a care home was always work in progress but Amerind Grove Care Home had definitely moved in the right direction.

The service had a quality assurance policy handbook. This document set out the framework for quality assurance and how this was implemented. The purpose of the framework ensured people who lived at Amerind Grove Care Home we firmly embedded at the centre, with four key areas, care, people, service and life, assessed and monitored. There was a programme of daily, weekly, monthly and quarterly checks in place. These included clinical walk-around each day, a 'Take 10' meeting each day with heads of department, a 'resident of the day', updates to well-being and activity boards and 'you said….we did' boards, and a full programme of audits.

The programme is led by the registered manager (the home/general manager), monitored by the regional director and validated by the provider's compliance and governance inspector. Improvements identified through this process were recorded upon the Home Improvement Plan (HIP). The HIP was revisited on a monthly basis and completed tasks signed off.

The audit programme included monthly medicines audits, care plan audits, staff supervision and training, fire safety, laundry and housekeeping reviews. These measures ensured the service monitored the quality and safety of the service.

Bupa runs a quarterly pulse survey asking staff whether they would recommend Bupa as a place to work and a report is produced comprising of an overall score and any verbatim comments. The results were shared with the team and actions implemented based on the feedback. A selection of people and relatives participated in an annual customer satisfaction survey. The results were collated and analysed and shared with the staff team, people and their relatives. An action plan was agreed in respect of those issues highlighted and then monitored until any agreed actions had been completed.

The registered manager and the management team held regular staff meetings to pass information on about any service issues within Amerind Grove Care Home that needed to be addressed, or to introduce changes to improve how the service was delivered. Staff were actively encouraged to engage in discussions about the service and share ideas on how the service may be improved. Each of the three bungalows had their own team meetings led by the unit manager.

The registered manager and the deputy were aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about. Both were aware when notifications about deprivation of liberty applications had to be submitted to the CQC.

Amerind Grove is one of 122 BUPA homes being sold to HC-1, another care provider. As a result of this the home management team was engaging with people and their families, staff and other professional with regard to the sale. Each person and their family and all staff members had received letters in regard to the sale and posters with weekly updates were displayed. We found that the management team were offering as much support as they could to allay fears. There was also a dedicated telephone line and e-mail address for staff to use if they needed to.