WCS Care Group Limited

Fairfield

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?	Outstanding ☆

Summary of findings

Overall summary

The inspection took place on 17 and 18 February and was unannounced.

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.

The service provides accommodation and personal care for up to 36 older people, who may have dementia. Thirty-six people were living at the home at the time of our inspection.

People were at the heart of the service. The provider's philosophy, vision and values were understood and shared across the staff team. Staff received training in the provider's values and philosophy, which included, 'play, make their day, be there and choose your attitude'. People were supported to maintain their purpose and pleasure in life. People's right to lead a fulfilling life was enshrined in a charter of rights, which was displayed in the entrance to the home.

The provider was innovative and creative and constantly strived to improve the quality of people's lives, by working in partnership with experts in the field of dementia care. The provider had researched and reflected on how international exemplar services provided care and planned to refurbish the home in accordance with current best practice principles.

Planned improvements were focused on improving people's quality of life, based on the research and experience of experts. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences.

All the staff were involved in monitoring the quality of the service, which included regular checks of people's care plans, medicines administration and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence. The provider shared their learning with all the homes in the group.

The home was divided into three 'households', each with their own lounges and dining rooms. Each household was individually supported by a care co-ordinator and three care staff. Care co-ordinators were part of the duty management system, which meant there was a named manager available to respond to issues and to support staff, seven days a week.

There were enough staff on duty to meet people's physical and social needs. The registered manager checked staff's suitability to deliver personal care during the recruitment process. The premises and equipment were regularly checked to ensure risks to people's safety were minimised. People's medicines

were managed, stored in their own rooms and administered safely.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. Staff understood the risks to people's individual health and wellbeing and risks were clearly recorded in their care plans.

Staff received training that matched people's needs effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people who were assessed as not having the capacity to make all of their own decisions, records showed that their advocates, families and healthcare professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because people were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs and people knew staff would support them to maintain a balanced diet.

Staff were attentive to people's appetites, moods and behaviours and were proactive in implementing individual strategies to minimise people's anxiety. Staff ensured people obtained advice and support from healthcare professionals to minimise the risks of poor health.

Staff took time to understand people's life stories and supported and encouraged people to celebrate important personal and national events. People were supported to maintain their personal interests and hobbies and to maintain links with their local community. The provider employed a team of exercise and activity co-ordinators who were dedicated to supporting people to make the most of each day.

People and their relatives were involved in planning their care and support, which ensured their care plans matched their individual needs, abilities and preferences. Care staff understood people's individual motivations and responses.

People who lived at the home, their relatives and healthcare professionals were encouraged to share their opinions in a format that was appropriate to their needs, to make sure their views drove planned improvements.

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. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who had the relevant training and skills for their roles. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Care staff were kind and compassionate towards people and encouraged them to take pride in their lifetime's achievements. People were encouraged and supported to live with meaning and purpose every day. Care staff respected people's individuality and encouraged them to maintain their independence in accordance with their abilities.

Is the service responsive?

Good

The service was responsive. People and their relatives were involved in planning their care and support. People's preferences, likes and dislikes were understood by the staff from the person's point of view. People were supported to maintain relationships that were important to them and to engage with the local community. People's views were regularly sought, listened to and used to drive improvement in the quality of service. Complaints and concerns were listened to, taken seriously and responded to promptly.

Is the service well-led?

Outstanding ☆

The service was very well led. The provider's philosophy, vision

and values were shared by all the staff, which resulted in a culture that valued people's individual experiences and abilities. The provider worked with other specialist services and organisations to ensure people were at the heart of the service. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences.

Fairfield

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.

The inspection took place on 17 and 18 of February 2016 and was unannounced. The inspection was undertaken by two inspectors.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with eight people who lived at the home and six relatives. We spoke with the registered manager, five care staff, two care co-ordinators, two activity co-ordinators, the cook, two service managers and the deputy director of operations.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed two people's care plans and daily records to see how their care and treatment was planned and observed how care and support were delivered in the communal areas.

We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home, because there were always enough staff to support them. A relative told us they were confident their relation was safe because the registered manager put the right measures in place to protect people from abuse, for example, they had a lockable drawer to keep their possessions safely.

Care staff told us the measures and actions they took to minimise risks to people's safety were relevant, proportionate and individual to each person. They told us making a person feel safe was as important as protecting them from actual harm. For example, one member of care staff told us, "Sometimes [Name] shouts out so we sit with them and hold their hand and re-assure them. Having a conversation makes them feel safer."

People were protected from the risks of abuse. Care staff told us they had training in keeping people safe from the risks of harm and they knew the actions to take if they had any concerns about people's safety. Care staff told us they could report their concerns to the manager, or to the provider, if they were not taken seriously. Care staff were confident they would be protected from discrimination if they challenged any poor practice because they had read the provider's whistleblowing policy.

The registered manager assessed risks to people's individual health and wellbeing. Where risks were identified, people's care plans described the actions care staff should take to minimise the risks. For example, one care plan we looked at identified a specialist mattress would reduce the risk of the person developing sore skin, and bed rails would prevent them from falling from their bed. Care staff told us a specialist supplier had set up the mattress to the person's specific requirements. We saw the bed rails were in place, in accordance with the plan. We saw care staff made sure people had buzzers close to hand, removed items that people might trip over and made sure people's walking frames were beside them, which minimised risks to their safety.

Care staff reported accidents and incidents to the registered manager and recorded them in people's personal daily records and the handover book, to ensure all staff were aware and took action to minimise the risks of a reoccurrence. Detailed records of accidents and incidents included the location and time and identified the probable cause of the incidents and the actions taken. Actions included referring people to healthcare professionals to check for changes in people's health, eyesight or hearing. Care co-ordinators reviewed people's risk assessments at monthly care plan review meetings to ensure any changes in their care and support were included in the person's updated care plans.

The registered manager analysed the reports to identify whether there were any patterns or trends. The analysis showed the most recent accidents had all been due to people's individual mobility or health conditions. The premises were not a factor, which demonstrated that care staff took effective action to keep the home tidy and free from trip hazards and minimised the risks of accidents and incidents.

People told us there were enough staff to support them when they needed support. One person told us, "I

use the bell when I need to and staff come quite quickly." The registered manager analysed people's needs and abilities to determine how many staff were needed on each shift. Care staff were allocated to each household, according to their skills and experience. The care management book showed care plans were reviewed, and when a person's needs changed, the number of care staff was also reviewed. The registered manager told us the provider listened to their views about staffing levels and agreed to the additional staff hours.

The registered manager told us they had recently arranged for an additional member of staff to start work an hour earlier in the morning, to cover the busiest time of day. They planned for an additional member of care staff and a housekeeping assistant to start an hour earlier than the usual morning shift, to ensure there were enough staff to support everyone according to their needs and preferences. A relative told us, "Staffing has been up and down. It is different now." Care staff told us they thought there was enough staff to meet people's needs. They told us the additional member of staff, and some recent recruitment had improved staffing levels and they no longer needed to use agency staff. We saw there were enough staff to support people with their physical and emotional needs. Care staff had time to talk and socialise with people, which improved their well-being.

The provider's recruitment process ensured risks to people's safety were minimised. Records showed new staff underwent an application and interview process so the registered manager could check their skills and experience, and that their behaviours would fit well with the team and ethos of the service. Staff told us the registered manager checked their identity and right to work, obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

The provider assessed risks to the premises and equipment and took action to minimise the identified risks. Records showed the provider had implemented a system of regular checks of the premises, the fire alarm and essential supplies such as the water, gas and electricity. The registered manager told us, "Property management services do a regular check, and book contractors and advise who and when the work will be done." We saw a door that would not stay open on the first day of our inspection had been fixed on the second day. Equipment, such as hoists, slings, wheelchairs and walking frames, was serviced by the supplier and staff regularly checked equipment was safe and fit for use.

Care staff knew about the provider's emergency policy and procedures. They knew the actions they should take in the event of a fire because they had training in fire safety and practised the routine. One member of care staff told us, "We have regular fire drills. We locate the source on the fire panel and we move people to a safe zone. The doors close automatically when the alarm goes off."

People told us they had their medicines when they needed them. One person told us, "I have my tablets here with me. When I wanted my pain killers staff came straight away." Care staff told us only trained staff administered medicines. The registered manager told us they planned to have all staff trained in medicine administration to provide seamless care.

Medicines were delivered from the pharmacy with a medicines administration record (MAR), which listed the name of each medicine and the frequency and time of day it should be taken. Care co-ordinators signed to say when people's medicines were administered, or recorded the reason why not, for example, if a person declined their medicines. Written protocols explained how care co-ordinators should check for signs of pain in those people who were unable to express themselves verbally. A member of care staff told us, "You can see when people are in pain. You can see it in their faces, in their body language and they might be holding their head or stomach."

Medicines were managed and administered safely. The provider had recently implemented a new system for managing medicines. Instead of using the traditional trolley, everyone had a lockable cabinet in their own room to store their own medicines, which offered a more personalised service. The registered manager told us the focus was on the individuals' needs and meant people were able to have their medicines straight away, particularly in the morning, and did not have to wait. During our inspection we saw care co-ordinators collected people's medicines from their rooms and took them to wherever they were in the home.

Good

Is the service effective?

Our findings

People told us they were cared for and supported effectively, because staff understood their needs and abilities. One relative told us care staff had supported their relation so well they were able to walk again after a period of immobility. Another relative said, "The staff are brilliant. [Name] is doing so well here."

People received care from staff who had the skills and knowledge to meet their needs effectively. Care staff told us they felt prepared for their role because their induction programme included observing experienced staff, training, reading people's care plans and getting to know people. A member of care staff told us getting to know people was the most important aspect because, "Everyone is different. You want to know so as not to upset people."

The registered manager told us all new staff were required to complete the Care Certificate' during their probationary period, unless they had already obtained a nationally recognised qualification in health and social care. The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

Staff attended training in subjects that were relevant to people's needs, such as moving and handling, food hygiene and care how to care for people living with dementia. Care staff told us their training gave them confidence in their role. They told us training was available to ensure they could support people effectively, whatever their need. The provider's recently issued annual training plan, showed training was available for a wide range of needs and conditions that staff could access on-line or at trainer led sessions.

Care staff told us they had regular opportunities to discuss their practice, training needs and any concerns at one-to-one meetings with their manager. A member of care staff told us, "We have questions and answers, then a discussion. You can tell them anything, anytime. They are easy to talk to. You can make suggestions and they listen." Care staff told us they felt supported and had annual meetings with their manager, to discuss their personal development plan. One member of staff told us their personal development plan had given them the confidence to transfer from one of the provider's homes when a suitable, more senior post was advertised. They told us they were supported in their new role by attending a leadership training course and regular meetings with their peer group to, "Share ideas, aims and goals."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager understood their responsibilities under the Act. In the two care plans we looked at, we saw the registered manager had completed risk assessments for people's understanding and memory, to check whether people could make their own decisions or whether decisions would need to be made in their best interests. Records showed, for example, people, or their legal representatives, signed to say they consented to how they were cared for, but the decision for most people to live at the home had been made in their best interests by a team of healthcare professionals.

The registered manager had applied to the supervisory body, for the authority to deprive 27 people, of their liberty, because their care plans included restrictions to their liberty. For example, they could not go out independently, because they did not recognise risks to their safety outside of the home. The registered manager was awaiting the supervisory body's decisions at the time of our inspection.

The registered manager kept a copy of the documents issued by the courts so they could be confident that people's relatives and representatives had the legal right to make decisions on their behalf. People' liberty, rights and choices were not restricted unnecessarily. For example, one person who had the capacity to understand the risks of going out alone, told us they could go out whenever they felt well enough and wanted to.

The registered manager told us some care staff had received formal training in the MCA and DoLS and some were awaiting training. In the meantime all staff had been issued with fact sheets to ensure they were familiar with the concepts and understood the principles. We saw care staff followed the code of conduct of the Act and asked people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff maintained eye contact and watched the person's facial expression and body language, to understand whether they consented to support. A member of care staff told us, "We make a plan (for care), but people change their minds. We encourage them, but can't make them."

People were supported to eat and drink enough and to enjoy mealtimes. People told us, "The food is quite good" and "I get plenty of hot meals. The cook is very good." A relative told us "The food is lovely. They will get her something else if she doesn't like the choice." We saw fresh fruit, snacks and drinks were available in the dining rooms all day. People were supported to eat their lunch in the dining room, which offered them an opportunity to socialise. Care staff were able to sit and eat with people to make each mealtime more of an occasion. A member of care staff told us they liked to have a meal with people as it gave them an opportunity to be sociable. One person told us they had particularly enjoyed a Chinese supper one evening because, "The manager joined us and she's really nice."

People were supported to maintain a balanced diet that met their needs and preferences. The cook told us menus were agreed by the provider, in consultation with nutritional specialists, and offered a balanced diet to help people with small appetites maintain their weight. Records showed there was a wide and varied choice of dishes at every meal. People's preferences, likes and dislikes were recorded in their care plans and care staff shared this information with the cook. The cook told us no-one had any allergies, or had expressed any cultural or religious preferences currently, but they would be able to cook for any dietary requirement.

The cook told us care staff asked people to choose their main meal in advance, but said, "If the choice is unusual I go and check that people really do mean what they have chosen. I encourage people to ask for anything" and "I go into most dining rooms daily to see for myself if people are eating what they chose." At lunch time we saw staff checked people still wanted their original choice before serving and asked whether

they would like a second helping of food and drinks. Lunch was served and eaten at a leisurely pace and staff were alert to changes in people's habits and appetites. One person had chosen a sandwich, instead of a hot meal. When they started pulling the crusts off, a member of care staff offered to cut them off. A second member of staff commented, "[Name's] taking the crusts off? Put it in the care plan", which meant all staff would be aware of this person's preference in future.

Relatives told us they were satisfied their relation had the amount of food and drinks they needed. One relative told us, "[Name] has never complained about the food. [Name] needs assistance with blended food now and staff are very careful about the temperature and take their time." At lunch time we saw people who needed assistance with eating were served first and there were enough care staff to assist them one to one. A relative told us they were pleased because their relation had put on some weight. Care staff monitored people's weights and their appetites and sought advice from healthcare professionals, such as a dietician if, they were at risk of poor nutrition. One care plan we looked at showed the person had been prescribed nutritional supplements, which care staff recorded in the person's food and fluid chart. We saw care staff offered the person food first and the supplement after their meal, in line with the dietician's advice.

A relative told us, "They get on the phone straight away if there is a problem. They tell us about falls, GP visits, the dentist and dietician." People were supported to maintain their health and were referred to healthcare professionals, such as GPs, dieticians and podiatrists, when needed. A member of care staff told us, for example, they would ring the person's GP if they regularly declined a medicine. Staff handover meetings were led by a care co-ordinator and care staff from each household attended. Staff shared information about people's health needs, appointments with healthcare professionals and the advice the professionals gave, which ensured all staff were aware of changes in in how to support people's health needs.

Good

Is the service caring?

Our findings

People and relatives told us care staff were kind and caring. One person told us, "It is a lovely homely environment." Staff demonstrated through their words and actions that people mattered and were important. Relatives told us, "The staff are brilliant" and "The staff are really lovely. They are all pleasant, polite and smiley."

People made their own decisions about how they lived their lives. One person told us, since moving in they had made friends and had been supported to change rooms so they could live in the same 'household' as their friends. The provider had planned to organise the home into four smaller 'households', two on each floor, each with their own lounge and kitchen diner, to promote a sense of belonging. However, people in the two households on the first floor had decided they preferred to live as one larger household. The provider had rearranged the fittings and furniture to enable people to live in the way they preferred. One person told us they liked the larger dining room and lounge, because it felt more purposeful to go to different 'destinations' in the home.

The registered manager and staff had decorated the hallways and communal rooms to help people find their way around and to promote memories and conversations. One wall was decorated with black and white photos of 1950s movie stars. Another wall was decorated with a seaside theme. This was specifically positioned within eyesight of a person who spent time in their room, to promote memories of a period of their life they were proud of.

Care plans were written from the person's perspective, so staff understood their needs and abilities from the individual's point of view. Care plans included a personal profile, entitled, 'This is me', as promoted by the Alzheimer's Society. The profile included a brief history for each person and details about their preferences, likes, dislikes and people who were important to them. People's relatives were encouraged to share their memories of their relation, so staff could get to know them better.

Staff and relatives had supported people to make memory boxes with photos and memorabilia outside their bedroom doors. This helped people remember which room was theirs and enabled staff and visitors to start conversations with people about topics that interested them. We saw people's rooms contained their treasured possessions and photos, which reminded them of their important relationships. One person told us they were pleased that staff had taken the trouble to hang their favourite pictures and pieces of craftwork in their room, because this enabled them to share their memories and pleasure with others.

People were encouraged to maintain their preferred routines. One person told us they got up when they wanted, went to bed when they wanted and chose when to bath or shower. A relative told us, "They asked about their daily routine. They let them do as much as they wanted to do." People and relatives told us care staff treated them with respect and promoted their dignity. We saw care staff were thoughtful and adjusted people's clothing, for example, when they supported them to mobilise, to protect their dignity.

Relatives told us they could visit at any time and always felt welcome. They told us their relations were

always cared for and dressed as they would have expected when they arrived. Relatives told us, "[Name] is always in a clean nightie and clean sheets" and "[Name] is clean, shaved and looks well."

Good

Is the service responsive?

Our findings

People told us the manager and staff were responsive to their needs. One person told us they had the opportunity to visit before they moved into the home, which they found reassuring. A relative told us they had felt supported to re-arrange the furniture in their relation's room to best promote their sense of security. A relative told us, "[Name] has settled in really well. The girls are regular faces. [Name] loves them."

People and relatives told us they were involved in planning their care and support. The registered manager visited people at their own home or hospital, to assess their needs and to understand how they wanted to be cared for and supported. The registered manager and staff were flexible and responsive to people's individual needs and preferences and ensured people were supported to live the lives they wanted, in accordance with their abilities. A relative assured us, "They came out to the home and asked about [Name's] daily routine. They let [Name] do as much as they wanted to do."

People were invited to regular meetings with the registered manager and staff to discuss how the home was run and to ask for their suggestions for events they would like to attend. Minutes of a recent meeting showed people discussed activities, cleanliness, the food and their mealtime experience. Actions taken in response to people's views included some people taking a more active role in food preparation, such as making scones and peeling potatoes.

People told us they were supported to maintain their interests and preferred pastimes. One person told us they liked to spend time in their own room listening to the radio, doing word puzzles and playing dominoes or quiz games with care staff. They told us care staff were observant and supportive of their interests. They told us, "[Name of staff] gave me a book of word searches when they saw I liked them." The person showed us their memory folder that staff had helped them to put together, which contained photos, medals, ribbons and pieces of craftwork they had made. The person took pleasure in showing us the folder and was pleased that staff had helped them to keep their precious memorabilia in one place.

A relative told us, "There's always something going on here." The registered manager had recruited two activity and exercise coordinators, who had attended accredited training to deliver a programme of personalised activities and exercise for five hours a day, seven days a week. We saw everybody had a 'daily activities planner' in their room to remind them of the opportunities for purposeful activity and socialising them every day. A relative told us, "The activity co-ordinator does exercises with [Name], squeezing a ball and stretching their arms out." During our inspection we saw people taking part in a quiz, which generated a lot of conversation and laughter. A member of care staff told us, "It used to be more task focused, now we have lots more time with people. I like to take my break chatting to people."

People were encouraged to maintain links with people who were important to them and with the local community. One person told us care staff had supported them to attend their young relative's wedding. The pleasure the person had experienced in attending the wedding was obvious in their voice and in the photos we saw of the event. A relative told us their relation went out to the local supermarket with staff, which maintained their interest in the world outside of the home. During the afternoon of our inspection a group of

people went to the local heritage centre for tea and to spend time in a different place with different artefacts to engage them. We saw press cuttings of people with a cake that was auctioned for Armistice Day and of people enjoying a Hawaiian themed party for the national care home open day.

Staff kept a daily diary with photos for each person in their own room, which was available for people and their relatives to look at and remind them of events and activities they had attended and enjoyed. A relative told us, "We look at the blue book to see what [Name] has been doing. There are always photos of [Name] smiling and enjoying themselves." People's care plans included a social history record, which outlined people's previous lives, family, work and experiences. This gave valuable information for staff to know and understand how people might choose to live their lives.

People were asked whether they had any specific cultural or religious needs during their initial needs assessment, and there was a dedicated page in the care plans to record these. In the care plans we looked at, people had not requested support for any specific cultural practices. A member of care staff told us, "No-one currently has said they would like to go out to church, but we have a service here. We hold it in different rooms, and people can spend one-to-one time if they prefer."

Monthly care plan reviews included a review of risks to people's health and wellbeing and care plans were updated when people's needs changed. Relatives told us they could visit whenever they liked and always felt welcome. Relatives told us, "It's homely" and "It's clean welcoming and the reception is great. All the girls are really sociable."

The provider's complaints policy was shared with people and their relatives and was displayed in the reception area. There was a 'comments, suggestions and complaints' book in reception, so anyone could leave feedback about the service. No-one had made a complaint in the books, but they had written some compliments.

People and their relatives told us they were confident any concerns would be dealt with appropriately. One relative told us, "We have no concerns, but if I have, I just say and they sort it out. It's great." Records showed the registered manager responded to complaints promptly and took action to resolve them. One relative told us they were satisfied with the registered manager's response to their complaint. The registered manager had shared the information about the complaint, their investigation and the resolution with the staff to make sure the problem would not re-occur.

Outstanding ☆

Is the service well-led?

Our findings

People and relatives told us they were happy with the quality of the service. They told us they were able to influence changes at the home. A relative told us, "I'm going to put my name down to come here when I need care. It works really well."

The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The questionnaires asked what people thought of the food, their care, the staff, the premises, the management and their daily living experience. The provider took action to improve the quality of the service based on the results of the surveys. For example, in response to issues raised about laundry and staff availability at weekends and evenings, the provider had introduced a seven day laundry service and a seven day duty manager system. This meant people, relatives and staff had a senior member of staff with the appropriate authority, to refer to between 7:00am until 10:00pm, seven days a week.

People were encouraged to share their opinions informally through comment cards in reception and via a hotline number to the Chief Executive. The provider made sure people knew they listened to people's views. They explained the results of the surveys and the actions they had taken in response to the questionnaires and comment cards through a regular newsletter that was posted in reception. We saw the duty manager's name was displayed in the reception area, so visitors knew who to ask for if they had any concerns, whenever they visited.

The provider's service manager monitored the quality of the home through regular visits. They checked the registered manager's records, looked around the home and spent time listening to what people and visitors had to say about the service. For people who were not able to express themselves verbally, a service manager spent time sitting and observing, using a recognised care evaluation tool, which allowed them to assess whether an individual obtained a good outcome from any everyday event or interaction with care staff. Records showed this resulted in an action plan for care staff, including referring the person to an optician and a prompt for care staff to initiate more conversation with the person, to ensure the person obtained maximum benefit from every interaction.

The provider sought feedback about the quality of the service from other agencies, for example, from Age UK. Records showed an expert by experience from Age UK had spent time at the home observing and listening to people's experience of the service. The provider responded to feedback that medication trolleys 'rattling' along the corridors was not a good experience for people. The provider had already taken action and provided everyone with a locked cupboard in their own room, so their medicines were always with them. The registered manager was monitoring the impact of the change to identify whether it took more time overall, to establish whether more staff should be trained in medicines administration.

People and care staff told us the methods for supporting people to give feedback and to feel involved in managing the home were effective. The registered manager told us the refurbishment plans included an extension with additional bedrooms and redecoration and refurbishment throughout the building, with

designated areas as indoor 'destinations' for people to socialise and interact. The registered manager told us people had chosen the wallpaper for the lounge and then enjoyed watching, and advising, while care staff wallpapered. One member of care staff told us, "Changes in the environment have made a difference. People and families and staff are happier. They have had a say and feel involved. They feel their ideas are listened to."

The registered manager understood their legal responsibilities. They sent us notifications about important events at the service and their provider information return (PIR) explained how they checked they delivered a quality service and the improvements they planned.

The provider's improvement plans included a clearly described staff retention and development programme. They had appointed care co-ordinators, to improve management level skills and support at the home and to support staff's career development. Care co-ordinators were attending a leadership training programme to ensure they were equipped with the skills and knowledge they needed to be successful in their role. The programme included care co-ordinators across the provider's group of homes meeting together to share information and ideas. A care coordinator told us they enjoyed the training and appreciated the opportunity to develop their skills and understanding.

Care staff told us they felt well supported. They said they attended regular meetings and received the training and development they needed to be confident in their role. They told us they felt well informed about the home, their responsibilities and areas for improvement. A member of care staff told us, "The manager is approachable and supportive. They operate an open door policy." Staff had been consulted about proposed changes and their opinions were taken into account. For example, the proposed new uniform, of different coloured t-shirts to denote their roles, did not include pockets. The provider listened to staff's feedback and agreed the uniform would include a bag that clipped around their waist.

Relatives and staff told us the managers were approachable and supportive and the registered manager operated an open and listening culture. One person told us, "I like them (the manager), they are really nice." A relative told us, "If they (the management team) say they are going to do something it gets done."

The provider's vision and values were imaginative and person-centred and put people at the heart of the service. The Chief Executive had personally delivered training sessions to managers about their vision, values and philosophy, 'To make a difference,' and training was planned for all staff. The training included all staff signing up to, "Play, make their day, be there and choose your attitude" (by parking the personal). The vision and values included a charter of what people should be able to expect of the organisation. Not all the staff had attended the training, but the ethos had already cascaded down to them through the management team's leadership and behaviour. A relative told us, "We are more than happy and the staff are brilliant."

The provider promoted an open culture by encouraging staff and people to raise any issues of concern with them, which they always acted on. All the staff team were involved in monitoring the quality of the service through regular audit checks of, for example, people's care plans, the premises, equipment, food and medicines. Where gaps or omissions were identified in recording, staff were reminded of the importance of keeping good records at group or one-to-one supervision meetings. Care staff told us, "It's a good company overall. People you work with count, make a difference" and "I love working here. It doesn't feel like work."

The provider had created cleaning and safety audit schedules for daily, weekly and monthly checks with designated responsible staff. The registered manager's role included checking that staff monitored and reported their findings to make sure appropriate action was taken when necessary and to minimise the risk

of a re-occurrence. Records showed, for example, medicines errors, accidents and incidents were analysed by the individual affected, the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring individuals to healthcare professionals, refresher training for staff and sharing information with relatives, the local safeguarding team and CQC.

The registered manager delivered monthly reports to the provider so the provider could be assured that care was delivered and monitored consistently across the group of homes. The provider produced monthly statistics for a range of indicators, which enabled managers to compare their performance and learn from others. For example, the provider monitored how many people were at risk of poor nutrition, the number and causes of accidents, incidents and falls and how complaints were handled. The registered manager attended regular meetings with other registered managers to discuss the monthly reports, to reflect on their practice and share ideas.

The provider learnt from their experience and took action to improve. When issues arose at any of the homes in their group, they investigated the issue and applied their learning across all the homes. For example, the provider had recently reviewed and updated their policy for assessing people's mental capacity and for how they recorded when they made decisions in people's best interests. The updated policy and procedures were shared immediately by email and then through workshops for all staff who were responsible for implementing the policy. The registered manager had enacted the policy and completed mental capacity assessments for everyone at the home. They had subsequently applied to the supervisory body for the proper authority to restrict the liberty of those people who were assessed as not having the capacity to recognise risks to their wellbeing.

The provider followed guidance from specialists in the field of residential care, such as the Social Care Institute of Excellence. The provider had adopted recognised tools and methods to ensure people received care in accordance with the latest best practice. For example, they used recognised assessment tools to understand people's lifestyles and activity levels, in order to develop an individual profile of a person's interests, likes and dislikes and to diagnose their level of ability and interest to plan how to present activities at the 'right' level.

The provider's emphasis was on continually striving to improve by implementing innovative systems and practices. A management team had visited an internationally recognised provider of excellence in dementia care, to learn about their methods and planned to introduce their methods into the home. The Deputy Director of Operations told us how the provider's experience was used to promote and influence best practice in dementia care. An organisation that offered training in care staff led activities and exercise programmes had recently used one of the other homes in the group to film a teaching video, to demonstrate how the programme could be used.

The Deputy Director of Operations told us about the progress they were making with the provider's improvement plans, as described in the PIR. The provider had worked with an external specialist in dementia care, to develop a leadership training programme to encourage and support change, creativity and innovation. The recently appointed care co-ordinators at the home were all attending the course at the time of our inspection.

The provider's plans included planned to replace it with an 'acoustic monitoring system'. When a call bell is pressed, a message is sent directly, but silently, to care staff's work mobile phone so they know who needs attention. The monitoring system includes voice recognition, which can be programmed to a person's voice if they are unable to use the call bell, and can be monitored remotely.

The provider planned to deliver up to date training in, for example, end-of-life care and management of specific conditions such as diabetes, epilepsy, strokes, "Or anything that reflects residents' needs." The Deputy Director of Operations told us the new training would be followed by appointing trained staff as champions in individual specialisms, such as dignity, dementia care and Parkinson's care, to cascade their knowledge and skills. Staff had been asked to reflect on their interests and to consider whether they would like to become a champion in a particular specialism.