SHC Clemsfold Group Limited

Upper Mead

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Upper Mead on 21 November 2018.

Upper Mead is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Upper Mead is registered to provide accommodation for people requiring nursing and personal care for up to 48 older people and people with dementia support needs.

Upper Mead is a large, purpose-built premises and is split across two floors. People live on both the ground and the first floors. There is a self-contained area on the ground floor of the service where people with dementia support needs live called 'Chestnut Unit'. At the time of the inspection there were 39 people living in Upper Mead, nine of whom lived in 'Chestnut Unit'.

The service was last inspected in May 2017 and was rated 'Good' overall and 'Good' in all domains.

The service had 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.

Upper Mead is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have yet been reached.

Between May 2017 and November 2018, we inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and reported on what we found. We used the information of concern raised by partner agencies to inform our planning regarding certain areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

At the last inspection, we identified that people's care plans contained varying levels of detail and that plans

regarding people's 'stimulation' and 'activity' lacked person-centred information and that this was an area for development. At this inspection we checked to see if improvements had been made to address these issues.

People and relatives told us that staff knew them well and understood who they were as individuals and that their care reflected this. However, there remained a lack of person-centred detail in some care plans, care plans had not always been reviewed and there was a reliance of some staff on verbal handover information instead of reading care plans. This presented a risk that staff might not always know or understand how to provide personalised care that was responsive to people's needs.

There were recently revised quality assurance systems in operation. However, these were not yet embedded and operating effectively. The provider's governance framework had not been able to ensure that staff at all levels understood and had carried out their responsibilities successfully. Quality and safety risks were not always acted on in a timely manner or monitored and managed effectively.

For example, issues found during this inspection regarding risk assessments and staff training and knowledge had not been identified or acted on in a timely manner. Issues in some areas of practice, such as updating care plans to include more person-centred detail, required additional work; despite being noted for development at the last CQC inspection and noted for action in successive internal provider audits.

Staff were offered training and had spot checks, supervisions and appraisals from the registered manager, nurses and senior carers. Most staff we spoke with said training and supervisions occurred regularly and helped give them the knowledge they needed to be able to support people effectively. However, one staff member we spoke with said they felt they required more training and support to be able to improve their skills in some areas of practice. We saw that some other staff member's training records showed their training required updating or was outstanding.

There were systems and processes in place to keep people safe from abuse. All staff we spoke with understood how to recognise signs of abuse and their responsibilities to report any concerns to the registered manager or other senior staff. Some staff were not confident during our discussions about who they could speak with outside of the provider's organisation if they were concerned about people suffering from abuse.

People had assessments that identified potential risks to their safety and how to support them to manage these in the least restrictive way. Staff we spoke with displayed a good knowledge and understanding of how to safely manage risks to people. Some people's risk assessments were lacking detail compared to others that we sampled or were requiring review. The registered manager was aware of this and work was currently underway at the service to review and add more detail where this was the case.

People had assessments of their physical, emotional and social support needs, including any specific care and support decisions that related to protected characteristics under the Equality Act 2010. Some assessments contained only high-level detail about people's social needs and personal backgrounds. This is an area for development.

The service was operating within the principles of the Mental Capacity Act (MCA) 2005 and adhering to the correct processes regarding authorisations for any necessary Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The service had sufficient numbers of staff to meet people's needs safely and there were safe recruitment practices. Medicines were managed safely. The premises were clean and hygienic. Infection control and risks associated with the safety of the environment and equipment were identified and managed appropriately.

People told us they had a good quality of life and their support helped them to achieve good outcomes. Relatives told us they thought the service was effective. One relative said, "We have had other family members live here and we have always been happy with the care."

People's healthcare and eating and drinking needs were being effectively met. Adaptations had been made to the physical environment in the main service and within Chestnut Unit to help meet the needs of people living there.

People told us staff were kind and caring and respected their privacy and dignity. Staff supported people with compassion, involving them in decisions about their care and promoting their choice and independence wherever possible.

People had support to access group activities at the service. People told us they enjoyed these and the activities that were offered were relevant to them and reflected their social and cultural interests. People were encouraged and supported to maintain social and personal relationships with important people in their lives. Visitors were welcome at any time and relatives told us that they saw their family members regularly.

The registered manager told us that it was important that the service was integrated into the local community, to help avoid people becoming socially isolated once they had moved in. Neighbours and community groups were regularly invited to help provide and take part in activities for people at the service. This had helped the service build strong relationship links with people and organisations in the local area.

The service supported people to have effective support with planning, managing and making decisions about their end of life care, according to their express wishes. Complaints were managed appropriately and used to see how to improve the service in future.

There was a positive, inclusive and open team culture. Staff and management were committed to providing high quality care to people and creating a homely and supportive atmosphere at the service. People and staff spoke highly of the registered manager's leadership and felt involved in developing the service.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take, alongside the imposed provider level conditions, at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems and processes to help protect people from abuse were not always effective.

Some people's risk assessments did not contain enough detail and required reviews to help keep people safe.

Medicines were managed safely.

There were safe recruitment practices and enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff training and knowledge about how to effectively support people required updating or was outstanding.

People had assessments of their physical, emotional and social support needs, including any specific care and support decisions that related to protected characteristics under the Equality Act 2010.

People told us they had a good quality of life.

People had effective support with their healthcare needs.

Is the service caring?

Good

The service was caring.

People's privacy and dignity were respected.

Staff were kind and compassionate and involved people in decisions about their support.

Staff listened to people and communicated with people in appropriate and accessible ways.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always contain enough personalised detail about the support they wanted and needed in all areas of their lives.

People were encouraged and supported to maintain social and personal relationships with important people in their lives.

People knew how to make a complaint and any complaints were dealt with appropriately.

People had support to access relevant activities and the service had build strong links with the local community.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance and governance systems were not always operating or being managed effectively.

Risks and quality issues at the service had not always been identified or acted on.

There was a positive, open and inclusive team culture.

People, staff and relatives were involved in developing the service.

Upper Mead

Detailed findings

Background to this inspection

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

This inspection took place on 21 November 2018 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

For this inspection we did not request a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

During the inspection, we spoke with seven people using the service, three support workers, the activities co-ordinator, three registered nurses, the deputy manager, registered manager and a regional operations director. We reviewed care plans and risk assessments for three people receiving personal care support and 'pathway tracked' them to understand how their care was being delivered in line with this.

We spoke with four relatives of people using the service and a visiting GP on the day of the inspection. We obtained feedback via email from the local authority safeguarding team and a social worker about their professional experiences of the care being provided at the service.

We observed the support that people received in the communal areas, including lounges and dining areas of

the service.

We reviewed an additional two people's care plans and risk assessments, medicines records for all people using the service, staff training, supervision and recruitment records and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas and other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe here because there is always someone about." A relative told us that due to their experiences of the service providing care to more than one of their family members they felt confident to say that, "We know [name] is safe here."

There were systems and processes in place to keep people safe from abuse. There was a 'Safeguarding Adults at Risk Policy' that contained information to support staff to understand and be aware of different types of abuse, including discriminatory abuse, and who to contact about safeguarding concerns both internally and externally. This policy and other information about safeguarding people was available to staff in the service office. Staff had also received safeguarding training to help them know what they could do to help people and prevent abuse if they thought it was occurring.

All staff we spoke with understood how to recognise signs of abuse and their responsibilities to report any concerns to the registered manager or other senior staff. However, despite this information and other support available, some staff were not confident during our discussions about who they could speak with outside of the provider's organisation if they were concerned about people suffering from abuse. We raised with this the registered manager who took steps to refresh the staff's learning and re-direct them to where they could find this information.

The registered and deputy manager told us that any issues regarding people's safety were discussed on a day by day basis and in team and management meetings every month. Records confirmed that any concerns were reviewed by the registered manager and reported to the local authority safeguarding team. This helped staff and other relevant agencies be aware and agree the best way to act to keep people as safe as possible.

People had assessments that identified potential risks to their safety. People, or people acting in their best interests, were involved in deciding how to take appropriate actions to manage these risks. This process helped to make sure that people's personal freedom and independence were respected as much as possible while finding solutions to keep them safe. Staff we spoke with could demonstrate a good knowledge about how to manage risks to people safely and were confident that any changes to help keep people safe were promptly verbally communicated with them by senior staff, nurses and management.

However, some people's risk assessments were lacking detail compared to others that we sampled. For example, some risk assessments lacked person-centred detail to comprehensively show how people's choices should be respected when managing risks to their safety. Some risk assessments required updating to show that risks to people had been reviewed to ensure any changes necessary to keep people safe had been made. The registered manager was aware of this and work was currently underway at the service to review and add more detail to people's risk assessments where this was the case.

Where applicable, people had risk assessments that contained information about how to manage any behaviours that may challenge. Best practice advice and support had been sought from health and social

care professionals such as the dementia crisis team and psychiatric nurses to identify preventative actions to reduce the risk of people coming to harm if they became challenging. These actions were recorded in people's care plans. This helped staff be aware of why and when people might display these behaviours and how they could positively support people to prevent them from occurring.

Staff we spoke with displayed a good knowledge and understanding of how to safely manage risks associated with individual's behaviours that may challenge. A relative told us, "[name] is in the smaller dementia unit, they are very conscious of his safety." Nurses' notes recorded how staff managed challenging incidents in ways that aligned with the best practice recommendations in their risk assessments.

For example, for one person there was a risk that if their emotional anxieties and distress were not managed safely and continued to escalate to extreme levels, they may become physically challenging. In this event, as a last resort, they were prescribed medicines to help calm them. Records showed that although the person regularly became distressed, staff had identified the triggers for the challenging behaviour and acted to successfully de-escalate the situations using approved distraction techniques. This approach prevented the need to use chemical restraint medicines to help calm them before they were necessary, meaning the person was kept safe while avoiding disproportionate control and restriction of their freedom.

Staff and nurses completed daily carer's and progress notes about people's care. If an accident or incident occurred details of this were recorded on a separate form. Any notable incidents were reported internally to the registered manager, nurses or senior support staff. If necessary, the registered manager then reported these to external agencies such as the local authority. These reports were then reviewed internally and externally and actions agreed and implemented to keep people safe. The registered manager discussed actions and learning from incidents with staff. This helped to gain a further opportunity to identify any actions needed and look at themes to learn from to prevent things going wrong in the future.

Staffing numbers were typically allocated using a dependency tool to assess the amount of support people required, according to their individual needs. Rotas were managed flexibly so if there were concerns that people required more staff support to ensure they were kept safe, this would be arranged. Staff and people told us the staff team had remained stable since the last inspection, with low numbers of staff leaving. We sampled rotas for the recent months prior to this inspection that confirmed this and showed minimal need for use of agency or other auxiliary staffing. This meant people received consistent support and reduced the risk of staff working at the service who may not have the right knowledge and experience to meet their individual needs.

People said they felt they were always sufficient numbers of staff available. A person said, "They answer the bell as soon as they can and straight away at night." Staff told us although they could be busy at times, they felt staffing levels were safe and there were no undue delays in people receiving the support they needed. We observed this to be the case during our inspection, with adequate staffing levels meaning people's needs were met in a timely manner.

Medicines were stored safely and securely. There were systems for managing, ordering and disposing of medicines and these were operating safely. Registered Nurses were responsible for supporting people with their medicines and had annual medicine administration training. Each person had their own Medication Administration Records (MARs). This included details about how their medicines were taken or used and how often. Nurse used this information to help make sure that people received their medicines safely and as intended. People had recently reviewed guidance for when to offer and administer any prescribed 'as and when required' (PRN) medicines, including topical creams. This helped to ensure that people were receiving PRN and creams only when it was necessary.

People had regular reviews of their medicines with GPs and other healthcare professionals. People had assessments detailing the level of support they needed to take their medicines safely. People were involved as much as possible when taking their medicines, according to their choices and levels of need. Where it was safe for them or they chose to do so, some people self-administered their medicines. Staff took steps to involve people who required full support to take their medicines by making sure that people were aware of what their medicines were and why they needed them.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Health and safety and fire checks of the communal areas and people's rooms took place regularly. Staff carried out regular fire alarm tests and fire drills. People had Personal Emergency Evacuation Plans (PEEPs) in place so staff knew how to support them safely in the event of a fire.

There were full time maintenance staff, which helped to ensure prompt action was taken if property repairs were needed. Equipment used at the service such as people's wheelchairs, commodes, shower chairs, air mattresses and other moving and positioning equipment such as hoists were checked regularly to make sure they were safe to use.

The premises were clean and hygienic. There were separate cleaning staff and communal areas and people's bedrooms and bathrooms were cleaned daily. Staff received infection control training and used plastic gloves and aprons when supporting people with personal care tasks. Suitable bags, containers and disposal equipment were available and in use by staff to manage any hazardous waste.

There were safe recruitment processes. All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Staff also submitted applications, references and passed a competency based interview prior to being offered a position. There was then a further induction and probation period to support staff and assess their suitability to work safely.

All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Requires Improvement

Is the service effective?

Our findings

People told us they had a good quality of life and their support helped them to achieve good outcomes. Relatives told us they thought the service was effective. One relative said, "We have had other family members live here and we have always been happy with the care."

There were systems and processes in place to help make sure that staff had the right skills, knowledge and experience to effectively support people. Staff had an induction and probation programme that met Care Certificate Standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

The induction and probation included attending initial taught courses at the provider's training centre. Staff then received support from the registered manager and internal learning and development teams to successfully complete further work based competency assessments. Staff were expected to achieve their care certificate within a three-month timeframe, after which their probation period continued for a further three months to help ensure they were demonstrating the required skills to meet people's needs.

Staff were offered training and had spot checks, supervisions and appraisals from the registered manager, nurses and senior carers. Most staff we spoke with said training and supervisions occurred regularly and helped give them the knowledge they needed to be able to support people effectively. However, one staff member we spoke with said they felt they required more training and support to be able to improve their skills in some areas of practice. We saw that some other staff member's training records showed their training required updating or was outstanding.

We raised this with the registered manager who spoke with the staff member to arrange for immediate extra supervision. The registered manager was aware of where staff training was outstanding and showed us arrangements were in place to book staff onto any outstanding training as soon as possible.

The Mental Capacity Act (MCA) 2005 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. We checked to see if the service was operating within the principles of the MCA and found that it was.

People's mental capacity to be able to make decisions about different activities was assessed. Where they were not able to make certain decisions, the person with authority to act in their best interests in this area had been identified and involved in making any decisions about their care. Staff received MCA training. A GP who regularly visited the service told us that in their experience staff had, "Good awareness of where there is capacity for people to make specific decisions."

However, although they had relatively recently had MCA training, some staff we spoke with were not confident to talk about the consent and decision-making requirements of this legislation. We raised this with the registered manager who immediately arranged for refresher MCA training to be delivered for these staff.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The registered manager had carried out the correct assessment process and submitted applications for DoLS for people who required them. Any conditions on authorisations to deprive a person of their liberty were being met, and considered how to support people in the least restrictive way.

Staff liaised with people, relatives and health and social care services and professionals to help assess people's support needs and choices. This helped to gather information about people's physiological, psychological and social needs to identify how to deliver the best possible support to meet people's individual needs. Detail from this process was then recorded in care plans and risks assessments and made available for staff. Some assessments we sampled showed only high-level detail about people's social and personal needs had been formally recorded.

Relatives told us despite this not being reflected in the formal assessment information, staff had taken steps to gain this information subsequently. Staff we spoke with demonstrated a good level of knowledge about people's social and personal needs and choices and could explain how to effectively support them in these areas of their lives. People said staff knew how to support them according to their needs and preferences. One person said, "I am happy that staff know what they are doing." A social worker told us that, in their experience of working with the service, "Staff have a very good understanding of people's individual needs."

We discussed this with the registered manager who explained that often assessments were completed at short notice and focused on healthcare needs as a priority, particularly if a person was moving to the service from a hospital setting, which could limit the amount of detail about social and personal needs that was initially recorded.

People were supported to achieve outcomes they needed and wanted. People's assessments recorded any specific care and support decisions that related to protected characteristics under the Equality Act 2010. This process helped to make sure these were recognised and respected. Staff told us about the importance of respecting people's equality and diversity rights when supporting them to achieve their choices. One staff said, "Everyone is different you cannot be prejudiced".

Many people who moved to Upper Mead did so following referrals from other health and social care organisations. People living at Upper Mead were periodically required to leave the service temporarily or permanently to seek more intensive healthcare support. The registered manager, nurses and senior staff worked with other organisations and staff to share information and co-ordinate people's support effectively during these processes. For example, staff liaised with health and social care professionals to provide and maintain any technology or specific equipment people required. For example, walking aids or specialist mobility equipment. This helped make sure people's needs and choices were met and their independence was promoted.

Registered nurses and staff observed and discussed people's wellbeing with them daily and recorded this in daily notes. The service had, as of November 2018, introduced a monthly standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). If appropriate, alongside NEWS, specific information about people's health, such as weight or bowel movements was also

recorded. These systems, including NEWS, allowed staff to monitor people's health.

People's healthcare monitoring information was shared between staff during twice daily handovers and with visiting health professionals, such as a local GP who came to the service weekly. This allowed staff and healthcare professionals to review and act if needed to make sure people's health needs were effectively met. Nurses also used this information to support people to access healthcare services as quickly as necessary outside of regular check-ups, if their observations and monitoring records indicated this was needed.

People said this was effective in meeting their needs quickly. One person said, "They get the doctor for me, they come here." A relative told us, "If there has ever been a problem with [name's] health they let us know and get the Doctor in. They've always reacted quickly." A GP told us, "The staff are timely at typing up notes and are very well organised. They are very good at taking people's observations and escalate any concerns appropriately."

People had a 'Hospital Passport' that contained information about their health and communication needs. This was designed to be shared with healthcare staff to help maintain consistent support for people, especially if they were attending appointments independently. Staff also attended external appointments to share information about people's healthcare issues directly. This also helped to make sure that staff could support people to understand medical professionals' advice about their treatment options and what the outcomes could be.

People were involved in decisions about what they ate and drank. People were consulted with about menus and offered two choices at each of their daily meals. If these two choices were not to their liking, they would be provided with an alternative. If people had cultural or religious dietary preferences then these were respected and a bespoke menu offered. People could eat in a main dining room or in their rooms. Mealtimes were not rushed and some people took the opportunity to enjoy these as social occasions. One person said, "You can eat your food anywhere. I always come down for food because I don't want to be a recluse."

People had support to identify any risks associated with their eating and drinking needs and had nutrition support plans that included details about how to manage any risks safely. For example, staff had arranged referrals to speech and language therapists (SaLT) to assess people thought to be at risk of choking or aspiration and identify the best ways to avoid this. The SaLT advice and guidelines were included in their nutrition plans and this was then shared with the chef, who prepared the meals that were pureed or could be easily mashed prior to eating. People with any other eating and drinking related needs, such as diabetes or those whose weight required stabilisation, were also assessed and the chef was aware of how to meet their needs. For example, preparing fortified smoothies with cream and powdered milk or only using specific low or non-sugar ingredients.

The service had a communal dining room, lounge and a courtyard garden in both the main areas of the service and there were similar spaces which were self- contained within the Chestnut Unit. People used these areas to take part in activities and meet with other people and visitors. In the Chestnut Unit, people accessed the self-contained communal areas independently if they chose and were often supported to access the main areas of the service with appropriate support from staff.

People could also spend time in their bedrooms if they wanted to have some time alone or 1:1 with staff or visitors away from the communal areas. People had personalised their bedrooms with their own pictures, photographs, fixtures and fittings. There were plans to re-decorate and replace fixtures in areas of the service in colours and styles based on people's preferences, as well as plans to build a conservatory to allow

people an alternative communal social space.

Adaptations had been made to the physical environment in the main service and within Chestnut Unit to help meet the needs of people living there. Large distinctive signs with contrasting colours had been installed at places such as junctions in corridors or on doors, to help people navigate their way around. The management had re-decorated the main lounge of Chestnut Unit to paint over two of the walls that had been decorated in very vivid imagery that was felt by people to be too striking and many expressed a dislike of it. This helped older people and people with dementia to be at ease in the service and remain as independent as possible.

Throughout the service, there were wide corridors and doorways, a lift between floors and a ramp to the garden to allow people who used mobility equipment to move around easily and as independently as possible.

Good

Is the service caring?

Our findings

People said staff were caring and respected their privacy and dignity. One person said, "The carers are kind and respectful". Another person said staff were "Very kind, pleasant and helpful".

People told staff about how they liked to be supported and their care plans contained some details of their personal history. This helped staff understand what was important to people as individuals and helped them to be able to support them in an empathetic manner. One staff said, "In the afternoons we have time to sit and talk with people and get to know about them and what they like." People said this approach made them feel that they were being supported by caring staff. One person said, "I'm nicely looked after and they are good to talk to."

Staff communicated with people in accessible ways. Staff established eye contact, used appropriate language and gave them time to respond during conversations. Staff were positive and friendly during interactions with people and used appropriate gestures and touch to acknowledge what people were saying. One staff said, "Body language is important and you should always go to the person's level. If needed, speak a bit louder and clearly, making sure you are not talking too fast." People said they found staff were patient, easy to talk with and understood them. One person said, "I have some nice and funny chats with the carers. They make me laugh."

Staff showed concern for people's well-being. Staff regularly enquired about how people were feeling and if they were warm and comfortable. Staff listened to what people told them and offered appropriate support based on their responses, such as adjusting or fetching extra items of clothing. People said staff would take time to check on their emotional well-being and offer reassurance if they were experiencing feelings they wanted to talk about. A relative told us they found staff to always be compassionate, "If I am sitting in [name's] room, I see the carers will always come by and pop their head round the door to check they are ok".

Staff offered information, explanations and asked for permission when supporting people with daily tasks to help involve people in decisions about their care. One person said, "I don't like being told what to do or dictated to. I get the help I need here." Other people told us staff encouraged and enabled them to make their own choices. One person said, "I do things for myself".

Staff understood that this approach was important as it helped promote people's personal freedom. One staff said, "We want to look after people and keep them safe and well but also to live as independently as possible." People gave us examples of how staff respected their independence, such as respecting their choice of mobility equipment so they could move around how they liked and with as little support as possible.

The registered manager regularly discussed with staff about the importance of supporting people to ensure their dignity was maintained in other areas of their lives. People's wishes regarding if male or female staff supported them with personal care tasks were respected. People and their relatives told us they thought staff always respected people's dignity. One person said staff gave them appropriate time and space to

allow for their dignity and that, "They always knock and close my door during personal care."

People's right to privacy was upheld. For example, some people told us how they chose to stay in their rooms as they did not always want to socialise in the main communal lounges and staff respected this. One person said, "You don't have to join in if you don't want to. You're not forced to do anything."

There were data protection and record keeping polices and staff and management's practice in this area of compliance were regularly audited. This helped ensure people's personal information was stored, used and shared correctly and in ways that respected their confidentiality and privacy.

Requires Improvement

Is the service responsive?

Our findings

The registered manager and senior staff and nurses carried out assessments of people's needs. Where appropriate, other relevant people such as family members and health and social care professionals were also involved in this process. Assessments also included gathering information about any protected characteristics under the Equality Act 2010. Details about how to meet people's communication needs when sharing information about their support, in line with the principles of the Accessible Information Standards (AIS) was also gathered.

This information was then recorded in separate care plans according to the area of need, which were made available to staff. This process was designed to helped ensure people's choices would be respected as much as possible and they would be provided with person-centred care.

At the last inspection, we identified that people's care plans contained varying levels of detail and that plans regarding people's 'stimulation' and 'activity' lacked person-centred information and that this was an area for development. At this inspection we checked to see if improvements had been made to address these issues.

People and relatives told us that staff knew them well and understood who they were as individuals and that their care reflected this. However, at this inspection we found that it remained that some people's care plans continued to contain varying levels of person-centred detail about their stimulation and activity choices. We also found that detail about people's social backgrounds and personal preferences was sparse in some care plans. Some people's care plans required review. We were also told by staff that they and others had not had time to read people's care plans and relied solely on the informal methods such as speaking with staff and people to gain this information.

The lack of person-centred detail in care plans, inconsistent reviews and a reliance of some staff on verbal handover information instead of reading care plans, presented a risk that staff might not always know or understand how to provide personalised care that was responsive to people's needs.

For example, a staff member told us about a recent incident where they and a colleague had been unsure about if a person required support to drink from a beaker with a lid or not. Neither staff had read the person's care plan, which at the time of the incident advised that the person should be given a beaker with a lid. This was required to make sure the person's dignity was not compromised as they were prone to spilling drinks. The drink was then given to the person without a lid, without it being checked further that this was correct. This left the person's dignity at risk of being compromised.

The failure to make sure that everything reasonably practicable to make sure that people who use the service receive person-centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed this with the registered manager. They were aware the level of person-centred detail in care

plans was not consistently sufficient. They advised work was on-going to create more personalised care plan information. The registered manager explained that all staff had been given a clear directive and time to allow them to read people's care plans. They immediately arranged that they would re-visit this with the staff team and provide appropriate support to help ensure they were aware of the mandatory directive to read all care plans and had done this as soon as possible.

Although care plans were not always updated to reflect this, people's care was reviewed daily and nurses and care staff kept individual daily notes to record information about people's support needs. There were twice daily handovers at the change of each shift and these were used as an opportunity to check progress notes and verbally relay information, to see if any changes to people's support was necessary. The registered manager and senior staff would either attend handovers or walk around to speak with staff at least once a day to share information and further review people's support. This helped all staff to be aware if people's needs had changed and meant any arrangements to provide additional or increased support could be made quickly and without delay.

People also had more formal reviews of their support monthly and annually to check they were happy with their care, their needs were being met and they were achieving the best possible quality of life. For some people, appropriate consent was sought to involve relatives and other health and social care professionals in reviews to help explain about the support people wanted and needed. This helped people to remain in control of the planning and delivery of their support as much as possible. A social worker told us, "Upper Mead have a good track record of appropriately involving other professionals when required. I have had meetings with a GP, Court Appointed Advocate and families. All reviews have been positive in terms of the level of care and support provided to the residents. Feedback from family members has also been positive."

People had support to access group activities at the service. There was a designated activity co-ordinator who arranged daily activities for people living in both the main service and Chestnut unit. People told us they enjoyed these and the activities that were offered reflected their social and cultural interests. One person said, "I like the church services here, it's important to me". Another person said, "There's plenty of entertainment. I love the sing-songs." People living in Chestnut Unit were invited to attend all activities in the main service if they wished, although staff told us that sometimes people chose not to do this as this could be overwhelming for them.

Activities were offered that included choices that were appropriate for people's support needs. For example, people in Chestnut Unit found arts and crafts relaxing, so these activities were regularly arranged. There were dementia focused activities available, such as reminiscence sessions including music and chats from significant periods in people's lives. The activities co-ordinator told us that the creation of 'Life Story' books and other more detailed personalised information about people would help to further inform them of relevant activities to arrange for people.

People were encouraged and supported to maintain social and personal relationships with important people in their lives. For example, the service had arranged for a shared room to be made available for a couple, so they could continue living together whilst receiving the level of support they both needed. Visitors were welcome at any time and relatives told us that they saw their family members regularly.

The registered manager told us that it was important that the service was integrated into the local community, to help avoid people becoming socially isolated once they had moved in. Neighbours and community groups were regularly invited to help provide and take part in activities for people at the service. This had helped the service build strong relationship links with people and organisations in the local area. A social worker told us the service represented an important resource for the community and gave an

example of how, "A person who was living locally enjoyed attending events at the service so much that they chose to move in as soon as they could."

The service supported people with planning, managing and making decisions about their end of life care. People had a specific care plan that included details about how they wanted to be supported when approaching their end of life. This included any religious or spiritual wishes. People's end of life care was regularly reviewed with people to make sure that any changes in their preferences were updated and followed accordingly. Staff respected people's end of life wishes and provided any appropriate emotional reassurance for people, their families and other service users during this period.

The registered manager and nurses followed an end of life way pathway of care that involved liaising with local hospice organisations and health professionals once it was identified that people required end of life support. This ensured that all necessary resources and equipment were readily available and accessible so people would receive the correct palliative care and pain management as their condition developed and changed towards the end of their life. This helped to make sure people would have as comfortable and pain free a death as possible.

There was a complaints policy and this was available to people. People told us they rarely had cause to make a complaint, but were confident they knew how to do this and that they would be listened to if they ever had to do this. The registered manager told us any complaints that were received were used to look to see how to improve the service in future.

Requires Improvement

Is the service well-led?

Our findings

The provider had recently introduced revised quality assurance and governance systems across many of their services. These were in operation at Upper Mead and were currently in the process of being embedded. There were daily, weekly and monthly audits of service performance by the registered manager. There were audits carried out by the provider's internal 'Quality Team' approximately every six months. These audits were designed to identify how well the service was performing in line with current best practice guidance and legal and contractual requirements. This helped to monitor the quality and safety of the service performance and standards of care being delivered.

Quality team audits were modelled on the CQC Key Lines of Enquiry (KLOE) prompts and ratings characteristics. Information from these processes was then reviewed and any necessary actions to address issues were added to service development plans. Quality audits were monitored at senior management level within the organisation, to help ensure risks and regulatory requirements were understood and managed appropriately. There had been recent changes to the provider's governance framework and the service now had support from a recently appointed regional manager to support the service at a local level to complete actions on development plans.

However, these quality assurance systems were not yet embedded and operating effectively. The provider's governance framework had not been able to ensure that staff at all levels understood and had carried out their responsibilities successfully. Quality and safety risks were not always acted on in a timely manner or monitored and managed effectively.

For example, issues found during this inspection regarding risk assessments and staff training and knowledge had not been identified or acted on in a timely manner. Issues in some areas of practice, such as updating care plans to include more person-centred detail, remained requiring improvement despite being noted for development at the last CQC inspection and noted for action in successive internal provider audits.

The failure to ensure quality assurance and governance systems were operating effectively is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager had a clear vision that the service should be "like a home" and staff should deliver support that met people's needs in an empathetic and positive manner, promoting inclusion and choice, to allow people to live the best life as possible. Staff were committed to helping realise this vision and understood the values that they were expected to display to do so. One staff said, "You must be caring and always give people choices". Another staff said, "We look after people well and always involve the person (in their support)."

People and their relatives told us they thought the leadership of the registered manager promoted a positive, caring and inclusive culture at the service. One person said, "The registered manager is brilliant." Another person said, "It's just a nice place to be." A relative said "I think they're very good at the care of the

patient. All the team talk to me, they're very welcoming."

Staff had meetings, supervisions and appraisals to discuss issues at the service and help them understand what the responsibilities of their roles were. Staff were encouraged to reflect on their practice and contribute ideas to help improve or maintain their own performance levels and overall standards of service delivery. The registered manager said they wanted to make sure that, "If staff are not happy they can say, or if there has been a bad situation we can de-brief about this honestly. We wouldn't be where we are without being a team. I value staff opinions and how they feel, I never leave an issue. It is all about using this feedback to make improvements."

Staff said they found these processes useful and supportive and they helped to create an open and positive team culture. One staff told us, "The registered manager is great. I feel well supported, supervisions occur regularly and discussions are open." Another staff said, "We all work together, there is a feeling in this team that we are working with the right people. The registered manager will listen to you." Another staff said, "Morale is good and I know I can ask for help from any of my colleagues, no problem."

Staff told us that the registered and deputy manager made sure they were approachable and available while in the service. Staff also had support from nurses and senior care staff, who were allocated to work on each shift and had delegated responsibilities to support the formal staff supervision processes. There was a 24 hour on-call service for when the managers, nurses and senior staff were not on-site to support staff.

The registered manager told us it was important to recognise staff achievement and regularly thanked staff for their work. They explained that at Upper Mead the team had decided that they did not want specific individual prizes for exceptional work, although this could have been arranged. Instead, the staff chose to share acknowledgement for any significant workplace achievements by going on group social outings. This helped maintain staff motivation and build a sense of a shared team culture, with everyone working together towards a common goal.

Staff well-being and equality and diversity rights were respected. One staff told us how the registered manger had helped arrange extra leave to support them through a difficult emotional period. Staff told us that any differences within the staff team were respected and everyone was valued equally and that this expectation was positively promoted by the registered manager.

People and their relatives told us open communication about what was and wasn't working well was encouraged and their views were listened to and acted on. There were readily available feedback forms for people to complete in the entrance of the service and directions about how people could do this on-line. The registered manager had also sent out more comprehensive surveys to invite people to share ideas about improving and developing the service. They gave the example of how this had been successfully acted on when they had re-decorated areas of the service based on people's feedback following a previous survey.

Staff and management worked positively with external agencies to support effective partnership working, aimed at improving people's overall provision of care. A social worker told us the registered manager and deputy manager, "openly accept the need for need for transparency and have assisted with any request made by my colleagues and myself in terms of sharing information, arranging social care reviews and ensuring staff are available during arranged visits." A GP told us they had "Built a really good relationship" with the service. They said that in their experience, staff also worked well with other healthcare professionals following referrals that had been made via their surgery. This effective partnership working helped improve consistency in people's care and offered all agencies involved an opportunity to learn from each other and

develop their services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to do everything reasonably practicable to make sure people who use the service receive person centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.