Park Avenue Healthcare Limited

Park Avenue Care Centre

Inspection report

Park Avenue Care Centre
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Date of inspection visit:
15 March 2016
16 March 2016

Date of publication:
29 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 March 2016 and was unannounced. At the last inspection of the service on 25 March 2014 the provider was meeting all regulatory requirements inspected.

Park Avenue Care Centre provides care and accommodation for up to 51 older people living with dementia who may have nursing, care and support needs. At the time of this inspection there were 45 people using the service.

There was no registered manager in place. The previous registered manager had left the service in January 2016 and a new business manager had been appointed who was in the process of applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were asked for their consent before they were provided with care or support. People's capacity to make decisions was assessed in line with guidance and the law. Applications for Deprivation of Liberty Safeguards authorisations had been appropriately made in line with current guidance. However, there was a breach of regulation as records in respect of decision making, where people may lack capacity to decide for themselves, were not always fully completed. You can see the action we have asked the provider to take at the back of the full version of this report.

People and their relatives told us staff were very caring, kind and gentle. We observed enthusiastic staff that were sensitively focussed on people's individual needs. Professionals commented on the distinctive caring ethos and that staff seemed to enjoy their work. The service used person centred dementia specific approaches on a daily basis to increase people's well-being. People were not rushed and their privacy and dignity was respected. The home was awarded commend status on a recognised framework for end of life care and their end of life care was sensitively and appropriately managed.

People and their relatives told us they felt safe at the service. Staff understood signs of abuse or neglect and knew how to report concerns. Individual risks to people were identified and monitored.

There were processes in place to manage emergencies. The premises and equipment including emergency equipment were routinely checked and maintained. Robust recruitment checks were in place before staff started work to reduce the risk of unsuitable staff being employed. Medicines were safely managed. There were enough suitably qualified staff to meet people's needs. We observed that no one was waiting for care and support throughout the day and call bells were answered promptly.

Staff received regular supervision, appraisal and suitable training across a range of areas and told us they felt supported to enable them to carry out their role.

People had plenty to eat and drink and were encouraged to be independent or supported where needed at their own pace. People at risk of malnutrition or dehydration were monitored and their weight checked regularly. The home worked with a wide range of health and social care professionals to meet their health needs.

People's needs were assessed to ensure they could be safely met. Care and support was planned to meet their individualised needs. There was a regular activities programme, which had been recently extended to include a wider range of opportunities for stimulation and interaction. Further improvements in the range of activities offered were in the process of being introduced.

People, their relatives and staff and health professionals all told us the service was well led. The management team looked for ways to constantly improve the service. The views of people at the service, relatives, staff and visiting professionals were sought and used to make improvements. Complaints were responded to in line with the provider's policy. People knew how and where to complain if they had a problem. There were systems in place to monitor the quality of the service and issues identified were acted on. The quality monitoring system was in the process of being reviewed at the time of this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People or their relatives told us they were safe. Staff knew what to do if they had any concerns about possible abuse or neglect.

Risks to people were assessed and plans put in place to reduce the likelihood of them occurring. Medicines were safely managed.

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

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff had received training on the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but best interests' decision making was not always recorded.

Staff received regular training in areas specific to the people they supported and told us they were well supported through supervision and appraisal to carry out their roles.

People enjoyed the food and that there were choices available. People's fluid and food intake was monitored and appropriate action taken if people lost weight. People had access to a wide range of healthcare services to ensure their day to day health needs were met.

Is the service caring?

Good

The service was very caring. People, their relatives and professionals all commented on the caring and gentle manner of the staff. Interactions we observed demonstrated that staff knew the people they cared for very well and were characterised by humour and sensitivity.

People displayed high levels of wellbeing and contentment. Staff used recognised dementia specific person centred approaches to improve people's well- being. People were consistently treated with respect and dignity and their individuality valued.

People were involved as far as possible in their care. The home was part of a recognised framework for end of life care with commend status and staff had been trained specifically in this area. People, received compassionate end of life care in line with their wishes and needs.

Is the service responsive?

Good

The service was responsive. People had an individual care plan to meet their needs. The care plans were reviewed and up to date to reflect people's current needs.

People's needs for stimulation and social interaction were recognised and the new manager had taken steps to introduce a wider range of activities to suit everyone's tastes.

People knew how to make a complaint if they needed to and complaints were responded to and acted on.

Is the service well-led?

Good

The service was well led. People, their relatives and healthcare professionals told us they thought the home was well run and the new manager was approachable.

The provider sought the views of people, their relatives' staff and professionals to improve the quality of the service through surveys and regular meetings.

There were audits to monitor the quality of the service and these were in the process of being revised to increase their effectiveness.

Park Avenue Care Centre

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.

This unannounced inspection took place on 15 and 16 March 2016. There were two inspectors and a specialist dementia advisor on the first day of the inspection and two inspectors and an expert by experience on the second day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the provider. This included notifications received from the provider. A notification is information about important events that the provider is required to send us by law. The provider had 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 contacted the local authority responsible for monitoring the quality of the service and two health and social care professionals who visited the service. We used this information to help inform our inspection planning.

During the inspection we spoke with six people using the service and their relatives. Not everyone was able to communicate their views to us and so we observed the care and support in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five members of care staff, four nurses and two student nurses, one domestic staff, two catering staff, the administrator, maintenance person, the new business manager, the clinical manager, administrator, the development manager and the regional manager for the service. We looked at ten people's care records, seven staff records and records related to the management of the service. These included medicines administration records, audits and minutes of meetings. We also spoke with two health care professionals visiting the service during the inspection and a further health professional following the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe living at Park Avenue. One person told us "I feel very safe here; there is nothing to worry about." Another person said "Everyone is so friendly; I think it's a great place." Most people at Park Avenue were not able to express their view but we observed throughout our inspection that people seemed very comfortable and relaxed with staff and each other. Relatives also confirmed this view. One relative commented their family member was "Absolutely safe here. I have no concerns whatsoever about their safety."

Staff received safeguarding adults training. They were able to describe the process for identifying and reporting concerns and could give examples of the types of abuse that may occur. They explained that if they saw something of concern they would report it to the nurse in charge or the manager and record the incident. Staff understood what their responsibilities were under whistle blowing. One staff member told us that they felt they had "A responsibility to report matters of concern and keep reporting, up the line if necessary, including to the Care Quality Commission."

Risks to people were assessed and monitored. Risk assessments were completed, such as, for risk of falls, or malnutrition. Where risks were identified there was a plan to minimise or prevent them occurring which was specific to each person. For example, where a person was assessed to be at risk of falling, there was guidance for staff about how best to support them safely, while continuing to allow for as much independent movement as possible. For another person who was nursed in bed, their risk prevention plan included the need for the call bell to be within their reach at all times. We observed this to be the case throughout our inspection. Tools to monitor risks such as food and fluid charts or repositioning charts were completed as care was provided to ensure accuracy. The home had taken part in a challenge rolled out by the provider to reach 100 days with no pressure ulcers and had reached almost a year without one developing.

Accidents and incidents involving the safety of people using the service and staff were recorded, and acted on to reduce the risk of reoccurrence. Records showed staff had taken appropriate action to address concerns and referred to health and social care professionals when needed to minimise the reoccurrence of risks. We looked at the records and saw there had only been one serious injury in the last year which had been appropriately responded to.

There were arrangements to deal with risks in relation to emergencies. The provider had a business contingency plan to provide guidance and contact details to staff for a range of emergencies. There had been a recent fire safety inspection in December 2015 and the provider told us there were no concerns and they were waiting for their report. We were therefore unable to verify this at the time of writing this report. Staff had received regular first aid and fire safety training and fire drills had been held to ensure staff were familiar with what to do in the event of a fire. The manager told us they were in the process of refreshing staff training on the use of fire evacuation equipment. Regular checks and servicing was carried out of fire safety equipment. The first aid boxes were checked regularly to ensure the availability and safety of the contents.

Risks in relation to the premises or from equipment used by people were monitored through a programme of regular recorded checks and external servicing. The manager conducted a daily walk around the home and we saw they reported any issues they identified to the maintenance team for action. Requests were then prioritised according to urgency by the provider's maintenance team. The provider used mattresses that adjusted the setting required automatically. However we found three mattresses that did not self-regulate and one had not been checked to ensure it was at the correct setting for the person concerned. This had not impacted on their care as the person's skin integrity had remained intact and not deteriorated. We discussed this with staff who recognised the over sight and the possible risks New self-regulating mattresses were ordered where they had not been in place and system of checks was put in place until the new mattresses arrived.

The provider had safe staff recruitment systems to reduce the risk of unsuitable staff being employed. Thorough background checks were carried out before staff started working at the home. We looked at the personnel files of seven staff and saw completed application forms, which included references to their previous health and social care experience, their qualifications and their full employment history. Records included health declarations and Disclosure and Barring Service certificates [DBS], two employment references, and proof of identification. In addition, where relevant, records contained evidence of the right to work in the UK. Staff we spoke with told us they were not allowed to work until their DBS had come through. Nurses' records confirmed their professional registration with the Nursing and Midwifery Council [NMC] their identity and training record.

Medicines were safely managed. Medicines were stored securely in locked medicine rooms that only authorised staff had access to. Medicines that required refrigeration were also stored appropriately and safely. Temperature checks were carried out to ensure medicines were safe and fit for use. Controlled drugs were also safely kept securely and in line with guidance.

Medicines were administered safely including topical creams. There were no gaps in the administration of medicines identified across all three floors. Allergies were clearly recorded to reduce risks of inappropriate medicines. Controlled drugs registers were checked daily and completed correctly. People's medication was regularly reviewed to ensure it remained appropriate to their needs. Arrangements for the covert administration of medicines followed guidance and included consultation with relatives where appropriate the GP and pharmacist. A pain assessment tool was used to help provide a detailed assessment of people's pain levels. We found there was minimal use of anti-psychotic medication or sedation across the home. Nurses completed a twice yearly observational medical competency assessment to ensure they remained competent to administer medicines.

There were enough staff to meet people's needs. People who could express their view told us there were enough staff. One person said "There are plenty of staff." Another person commented "They respond quickly when I need it" Most people could not express their view about this and so we observed the care throughout the day and found there were always staff to provide care in the communal areas and people nursed in bed or who chose to sit in their rooms were checked regularly. Call bells were not heard frequently but when they did they were quickly responded to. Staff were able to support people's needs in a timely way and spend time interacting with them.

Staff also confirmed they thought there were enough of them to meet people's needs safely. One staff member told us "Staffing levels are quite good; there are always enough of us around if a resident needs extra support." Another staff member told us, "There are definitely enough staff; the shifts are well managed with the tasks allocated to us all." We were told that the service did not employ agency staff and any additional cover came from within the current staff group. A dependency tool within the electronic care

planning system helped monitor and identify the levels of care and support needed and any changes needed. The regional manager told us staffing levels could be flexed if the needs of people changed.

Requires Improvement

Is the service effective?

Our findings

People were asked for their consent before care was provided. Throughout the two days we observed nursing and care staff seeking consent both prior to and when delivering their care. Relatives confirmed that staff always sought permission before and during care and support.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training on MCA and they were familiar with their responsibilities and the need to obtain consent. A staff member told us how they "Assumed everyone was capable of making decisions, at least in some parts of their life." They told us how they tried very hard to make sure a person was getting what they preferred, for example, a care worker told us; "I get out two different outfits and give the resident time to choose by putting the clothes into their hands so that they can feel them." Another care worker said they, "I will demonstrate each part of what the activity is which helps the resident to understand better." We heard care workers offered choices to the person they were supporting, and it was evident that people were given time to internalise what was being offered and make their choices without being rushed to do so.

Capacity assessments were undertaken in line with MCA for separate decisions and these were available on people's records. However, documentation to record decisions taken in their best interests was not always located in people's care records. Three care plans we looked at did not detail how the best interests' decision was reached; what the reasons for reaching the decision were or who was consulted to help work out the best interests. Where people's dementia journey meant they were at risk of neglecting their personal care needs and consent for personal care fluctuated; staff told us about a range of individual approaches they would take including seeking the advice of the community mental health team. These approaches were not detailed in two of these care plans and so would not be available for unfamiliar staff. For a fourth person a best interest's decision had been made with regard to their finances but this decision was not documented and there was no copy of a power of attorney or any clear record as to who had responsibility for the decision making about their finances.

Accurate records of decisions taken in respect of people's care were not always available. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had followed the requirements for DoLS. Staff were aware of their responsibilities under the DoLS and had completed assessments and submitted application forms to request for DoLS to the relevant Supervisory Body. In some instances an authorisation had been refused as the home was considered to be offering the least restrictive options. Other applications had been approved and were monitored to ensure any conditions were met. This meant that staff protected people who lacked capacity to make decisions for themselves and that they were not unlawfully restricted.

People and their relatives told us they though staff were competent and skilful. A relative said "All the staff seem well trained and good at their jobs." Another relative commented "The recruitment and training must be very effective as the staff are wonderful."

Staff had the knowledge and skills to enable them to support people effectively. All staff had completed an induction programme. Those staff who had been employed since October 2015 were placed on the new Care Certificate Standards (CCS); the recognised qualification set for the induction of new social care workers. As part of the induction training staff also underwent a period of shadowing with an experienced staff member to assist them to learn about their role. A manager told us the CCS was "being rolled out to all existing staff, irrespective of their experience, because they need to know updates and changes in legislation." Staff had received dementia specific training including attendance at external courses some at diploma level, which they told us supported them to have greater understanding of the experiences of people living with dementia and how best to support them.

Staff training was up to date in all areas the provider considered essential. A staff member said, "There is no question mark over training – we have to do it because it is all so important." Staff were encouraged to complete additional training for their development and to increase their skills and knowledge; for example levels of the Diploma in Social Care. The clinical manager showed us a record of additional training done by nursing staff to meet people's needs. For example catheterisation, leg ulcer management, wound care, and phlebotomy. Nursing staff had also completed Immunisation and vaccination training. The clinical lead explained "So that we can do our own flu vaccine which will be less confusing for our residents."

Staff told us they received regular supervision; one staff member said, "I have it regularly and find it beneficial. It is a chance to discuss not just the residents, but my training and how I am getting on in general." Staff records confirmed that all staff were regularly supervised in accordance with the provider's supervision policy. We also noted that in addition to regular supervision, staff had an annual appraisal where this was applicable.

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People's nutritional and dietary needs were met. A relative told us "The food always looks lovely and appetising here." We observed the meal time experience on all floors at different times during the inspection. There were menus displayed in the dining rooms and pictures of the dishes of the day were on each table to remind people of the choices available. We saw the meal time was a pleasurable experience; there was a calm relaxed atmosphere. The tables were not laid until just before the meal was served to avoid people sitting too early and then getting bored. People seem to enjoy their meals and were supported in a calm relaxed way by staff. They were encouraged to be as independent as possible through adaptive cutlery and crockery and were not left to wait for long periods for their meal. The manager explained they had recently ordered serving dishes to be used on tables to increase people's independence further. Where people required special diets or different consistencies their food was presented in an appealing manner. People who were nursed in bed were assisted to eat if needed. This was done in an unrushed manner, with the member of staff chatting to the person; they described the food if this was appropriate and supported them to eat in an enjoyable way.

The chef told us that relevant information about people's allergies or medical conditions was passed on by the nurses and we saw this information was accurately available. Staff were able to identify anyone who had dietary requirements such as diabetes and explained how they were supported with healthier options where possible. People who had lost weight were identified quickly and support sought from the dietician and GP to assess for and provide nutritional supplements. People were observed being supported and encouraged to have a choice of drinks and snacks such as fresh fruit throughout the day from readily available supplies.

People's health needs were identified and met through staff working with a range of health and social care professionals. People who were able to express a view told us they saw the doctor or other health professionals if they needed to. Relatives told us the staff were very good at identifying any health problems and keeping them informed. One relative said "They organised the doctor, dentist, optician and chiropodist since (my family member) has been there." The GP visited weekly or more frequently if needed and there was evidence of these visits recorded within multidisciplinary team notes. We saw evidence on care records of multi-disciplinary work with other professionals such as dieticians and speech and language therapists where there were concerns about a person's swallowing. Staff also worked with the mental health team and used a local dementia support tool to assist them to understand and work with some people's behaviours that may require a response.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were caring, compassionate and kind. A relative told us "The staff are absolutely wonderful with everyone there. They are full of kindness and respect. I have nothing but admiration for them." Another relative commented "Nothing is too much trouble to the staff, they are dedicated, friendly and very caring and they go about their work with a smile." People told us they felt "very well looked after" and that the staff were "wonderful".

The health and social care professionals we spoke with as part of the inspection all commented that staff seemed to love their job as they were always smiling. One health professional told us "They [staff] are always really caring and supportive to people." Another health professional remarked on the way a service user responded in a very positive way to staff, they told us the person's mood improved and "Their eyes lit up in recognition when the staff member walked in." A third social care professional told us, "I rate the care here as very good. Staff have a good understanding of people and gauge their mood very well." A fourth health professional explained how proactive they had found the staff in understanding and working with people on their dementia journey.

Most people could not express a view, so we observed how staff interacted with people in the communal areas. We found high levels of well-being throughout the inspection. All three floors had a calm and relaxed atmosphere; people living there appeared content, clean, well groomed and cared for. We observed the care staff successfully adapted their approaches to people who were perhaps feeling a little lost or puzzled by our presence in their home. We saw how relatives had been consulted on their family member's social history and how some of this information was put into practice on a day to day basis. For example, where a person had a preference for a particular radio programme, we heard this playing during our inspection. For another person, we saw their specific choice of reading material was provided. People who were nursed in bed were checked on frequently and staff spent time with them where possible.

We observed the care staff and nursing team had a detailed understanding of people's life experiences which they used to very good effect in their conversations and support with people to help them feel valued. They were able to relate people's past life experiences to their behaviours now. For example how someone's previous occupation or war time experience affected their behaviour, or, the names of significant people or things in their lives. Staff engaged in meaningful interactions with people throughout the day either in the communal areas or in their rooms. People were spoken with at a level and pace that they could manage; interactions were calm, unrushed, and authentic. Staff were attuned to any health needs people experienced that may affect their care. In the communal areas people had familiar possessions that were important to them, for example a photograph or cushion close to them for reassurance and comfort. There was appropriate and sensitive use of doll therapy for people whose dementia experience found comfort in their previous role as a parent of young children at times.

The service used recognised 'Namaste care' sensory person centred approaches for people living with advanced dementia. Namaste was an established twice daily part of the routine of the home morning and afternoon and we observed there were beneficial outcomes for people. During these dedicated times care

staff engaged with people individually and provided hand massage, nail and hair care, and different types of sensory stimulation and conversation. The atmosphere was of peaceful relaxation and stimulation people experiencing this care were relaxed, engaged and happy; we saw no signs of distress or agitation. The programme was tailored to people's individual needs, for some people it could take place in their room; for those who required more sensory stimulation this was provided with a light/bubble tube and suitable music was played. Some people were supported to look at pictures, photographs or exploring objects of interest. During these sessions people were supported with fresh fruit and drink which provided benefits in the possible reduction of urinary tract infections and their circulation was improved through massage and gentle exercise.

People were treated consistently with sensitivity, respect and dignity. We observed people were spoken with respectfully using their preferred name and staff showed an understanding of the importance of confidentiality. Staff interacted with people in a kind and respectful way and were consistently observed to be gentle and discreet in their approach where needed. Relatives told us they were always made exceptionally welcome, greeted warmly and provided with hospitality. Staff gave us examples of how they respected people's dignity by making sure doors were closed and people were covered during personal care. Staff placed a sign on the outside of a person's door when the person was receiving care. A care worker told us, "I always explain what it is I am doing and make sure this is understood before proceeding." Where people required the use of equipment to mobilise such as hoists, staff used a screen for privacy and talked with them to reassure them and explain what they were doing. There were dignity champions among the staff to encourage and remind staff about the importance.

The service had received a number of compliments about the care provided. Some recent comments included "You have created a truly family atmosphere at Park Avenue Care Home where everyone really cares for each other." Another commented on the "laughter, the singing and the personal touch." A professional's response in a recent survey when asked about improvements was, "Can't think of anything. Absolutely the best nursing home that I have visited."

People were involved in their care as far as it was possible. We observed they were consulted about their everyday routines, care and their preferences. Care was taken to try and ensure that people understood the choices available as far as possible for example through simple sentences and repetition or the use of pictorial menus. There were regular resident and relatives meetings where people could express their views. Information about the service was available in the reception area this included a welcome pack, information about Namaste, end of life care and inspection reports. The provider produced a monthly newsletter to provide news and information to people.

The service supported some people who were nearing the end of their life. The service had been awarded 'commend status' through the Gold Standards Framework Programme in August 2014. (A recognised national accreditation programme for end of life care.) The accreditation commented "An excellent home with commitment to high standards of care at all levels." Staff had undertaken training as part of the accreditation and demonstrated knowledge and skills to plan and deliver care to people at this stage in their lives. They worked with relevant professionals as required such as nurses from the local hospice. A professional from the hospice commented on the training they had provided at the end of 2015 and highlighted the proactive attitude of the staff involved and their care and commitment to learning how to develop their work in this area.

People had advanced plans which detailed their final wishes and plans in relation to pain management and other aspects of care. Where appropriate this had been drawn up in consultation with relatives. Where an advanced care plan had been agreed there was a recognised record to share the information about end of

life wishes with the ambulance service and hospitals. This enabled people to spend their last few days in their preferred place of care. Do Not Attempt Cardio Pulmonary Resuscitation forms were completed with the appropriate people or relatives consulted. There were arrangements for as required anticipatory pain relief medicines to keep people as comfortable as possible throughout this time.

Good

Is the service responsive?

Our findings

People and their relatives told us they were provided with personalised care and support that met their needs. Relatives were involved, where appropriate; in the development of care plans and that the plans were regularly reviewed to ensure they remained up to date. One relative told us, "I get invited to meetings and if I am not able to come, then I am told what went on." Care plans were, person centred, and provided clear guidance to staff about how people's care and support needs should be met and about their preferred routines and life history to help staff understand them better. A staff member said, "It is important to be aware of what is in the care plan as it details how best to care for the resident." An assessment of people's needs was carried out before they came to live at the home to ensure that staff could meet all their care and support needs. A relative commented "They(staff) came and spent a lot of time getting learning about my (family member) and what they needed before they went to live there."

People had an up to date plan for their care. We saw staff updated people's records of care throughout the day, recording, for example, what fluids and food people had as soon as they had supported them which increased the likelihood of accuracy of the records. Night staff also recorded on the electronic system, which, we were told, could not be recorded in advance. We asked staff how changes in people's needs, and therefore their care plan, were communicated to staff. A staff member responded, "There is good communication within the team and the nurse tells us whenever there has been a change and we should read the updated care plan." Health professionals commented positively to us on the care plan records as being up to date and informative.

People's spiritual and cultural needs were recognised and there were regular visits from different spiritual representatives. The service worked with relatives to ensure that people's individualised needs in respect of their care were discussed and arrangements in place to meet those needs. For example any dietary needs or access to books in a particular language. People's gender needs were considered and the hairdresser visited regularly. The manager told us they were working on the development of a 'barber, wet shave' experience for men. Staff told us that they received regular training in equality and diversity which supported them to consider, respect and meet people's individual needs.

The provider employed a physiotherapist at the home to work for one to two days each week; we observed them involved in individual exercises with people at the home. They told us they were involved in people's initial assessment to see if there were areas they could help to encourage improvements, such as in people's mobility circulation and balance. We saw from the accidents and incidents records that there were very few instances of falls at the home.

People's needs for stimulation and social interaction were being addressed. People told us they had enough to do. Most relatives told us they felt there was enough stimulation at the home and that the new manager had introduced several new ideas. One relative said "There is always something to do during the day and the staff are very good and spend time talking with them or reading the paper too." Another relative commented "Since the new manager has arrived there are a lot more things going on such as the ballet and keyboards and more exercise." However one relative told us that, whilst there were activities going on, they wished,

"activities could be more person centred in relation to (my family member's) specific needs." We noticed there was also some feedback from relatives in the survey on ideas for improvements that suggested more stimulation and fresh air.

There was an activities coordinator who worked full time at the home. They told us that activities were seen to be the responsibility of all the care staff team and not just the coordinator. They said staff were supportive and saw the importance of activities and the new manager was taking a very active role in supporting their development. There were activity schedules on each floor so that people and relatives were aware of what planned activities were available. These included activities such as baking and creative arts. People were also supported to go out into the community for a walk or to visit a local café and small group outings were arranged. There was a dedicated tea room that staff and small groups of people used to provide a sense of occasion and change in surroundings for people. On the second day of the inspection a local school group visited to join a baking session and egg hunt. For people who were nursed in bed or preferred to spend time in their rooms there were activity planners in their bedrooms which detailed the activities they enjoyed and been engaged in.

The new manager told us that they had identified that the activities provided needed to be widened to ensure everyone's interests were represented and this had been discussed at a recent relatives meeting. Activities had been more home based last year but they had started to address this. Since they had started at the service they had introduced ballet classes which were popular and some people now attended a local singing group. They had also registered for pet therapy and pottery classes which were due to start in the near future. The manager shared with us a number of ideas to develop the activities provided including increasing links with the community and greater involvement of people in aspects of daily living tasks to ensure a variety of individual and group activities to stimulate and engage people.

People and relatives told us they knew how to raise a complaint and felt confident that their issues would be addressed. The complaints policy was displayed in the reception area as well as an easy read format and provided guidance about what to do if you were unhappy with the response. The provider had a dedicated telephone number on the notice board for anyone to call with their concerns. There was a complaints log that showed complaints were recorded and investigated in line with the complaints policy and learning occurred as a result. For example we saw where there had been a complaint about a faulty piece of equipment the manager had investigated and identified the problem in communication to an external manufacturer. They had addressed this to ensure the process worked effectively subsequently. It had also been discussed at staff meetings so that all staff were reminded of their responsibilities.

Good

Is the service well-led?

Our findings

People who were able to express a view and their relatives all told us they thought the home was well run. One person told us "Everything works well here." A relative told us, "The home is being run, as it should be, in a very professional and first class way." Another relative commented, "This is a very well run home. The staff all work together and really seem to enjoy their work." People and their relatives knew the clinical manager and had all met the new business manager and spoke positively of them as being "very approachable," "welcoming" and "They are available and out and about in the home."

There was no registered manager in place at the time of the inspection. The previous registered manager had left at the beginning of the year, after many years as the manager. The deputy manager had become the clinical manager and the new business manager was in the process of applying to be registered manager for the home. The business manager had previous experience as a manager and understood their responsibilities under the Health and Social Care Act 2008.

Staff told us they felt confident they were listened to and their ideas valued. They said the managers worked well together. One staff member said, "The managers here seem to be able to recognise when I need a bit of support," and "I am so glad to be a part of the staff team here." Another staff member commented "The manager is very approachable; she makes herself available to listen." The provider held an employee of the month award to acknowledge staff who had made significant contributions to the peoples' well-being. Staff told us they felt both the business and clinical managers had a clear vision of wanting to provide high standards of care for people living with dementia.

There was a structure of regular meetings with staff to ensure effective communication and foster team work. There were twice daily handover meetings to communicate between shifts of staff and ensure continuity of care. There was a daily 'dashboard' meeting of heads of departments to monitor aspects of care and safety. The new business manager and the clinical manager had held monthly meetings with domestic staff, nurses and care staff to discuss expectations and any issues. Staff told us they felt able to contribute to these meetings or raise any issues at any time. A staff member remarked "The culture here is very open, I feel free to say what I feel." We observed staff worked well together. There was a strong sense of co-operative team work to support and care for people and of staff being clear confident and knowledgeable about their roles. Health professionals commented on the good communication among the staff team and that any recommendations they made were always followed.

There was a programme of audits and performance reports across all aspects of the service to monitor the quality of the service and identify any areas for action. These included areas such as care plans, medicines audits, kitchen, housekeeping, health and safety, staff records and infection control. We saw any actions were identified there was a time scale for follow up and the completed action was recorded electronically. For example, updates to a care plan that were needed. Information relating to accidents and incidents was recorded on the provider's computer system which could identify any trends, patterns or queries for learning. A development manager also audited aspects of the service on a monthly or bimonthly basis and reports were available to the managers and regional manager. Unannounced weekend and night visits were

carried out by the managers throughout the year to monitor the care at these times. No issues had been found this year and the business manager told us any concerns identified would be discussed at staff meetings or in individual supervision or staff disciplinary processes if this was needed. We found some audits were not always completed as fully as possible and discussed this with the regional manager. They told us that the quality assurance system was in the process of being reviewed and improved to ensure its effectiveness and reduced overlap and staff burden in some areas. We will report on these changes at the next inspection.

The home regularly sought the views of people, their relatives, staff and professionals through residents and relatives meetings and annual surveys and acted on the feedback. The survey from 2015 contained mainly positive comments. Areas for improvement were more stimulation, greater use of the tea room and more fresh air. The business manager showed us these areas were being addressed through the increased range of activities. Minutes of residents and relatives meetings showed that they had been asked for ideas for activities and issues they raised had been responded to, for example, a request for staff to wear name badge

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and contemporaneous records of decisions in respect of people's treatment were not always recorded. Regulation 17(1)(2)(c)