Athena Care Homes (Monmouth) Limited

Avocet Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Avocet Court is a residential care home providing personal and nursing care for to up to 153 people. At the time of our inspection there were 84 people using the service. The care home accommodates people across three separate units, each of which has adapted facilities. These were, Cilgerran House and Powys House, which provided general nursing care, and Harlech House which provided nursing care for people living with dementia. There was a separate unit, where the management team, reception and administration, kitchen and laundry were located.

People's experience of using this service and what we found
There were times when people had to wait for their call bells to be answered, following our visits action was taken by the registered manager to develop a system to analyse response times. However, this improved system was not yet embedded to improve people's experiences.

Staff were recruited safely. The service was working to ensure there were enough staff to meet people's needs, this included ongoing recruitment. Risks to people's safety were assessed and guidance provided to staff to reduce the risks of avoidable harm and abuse. Infection control systems reduced the risks of cross infection. The service learned when things had gone wrong and put in systems to reduce them happening again. People received their medicines when they needed them.

People were supported by staff who were trained to meet their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People's health and nutritional needs were assessed, and staff were guided to how these were met. The environment was suitable for the people who used the service.

People told us the staff were kind and respectful. People's rights to independence, dignity and privacy were promoted and respected. Staff knew the people they cared for well, including how their needs were met.

People's care needs were assessed, planned for and guidance was provided to staff on how these needs were to be met. People's preferences were sought and used to plan their care, including their end of life decisions. People had the opportunity to participate in activities. There was a complaints procedure in place and people's concerns and complaints were investigated and addressed.

The service's governance systems helped the provider and the registered manager to monitor and assess the service people received. Where shortfalls were identified, they were addressed. People's views about the service were valued and used to drive improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on January 2019 and this is the first inspection.

The previous rating for this service was good (published 8 June 2018). Since this rating was awarded the registered provider of the service and the name of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part by notification of a specific incident. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The inspection was also prompted in part due to concerns received about such as staffing and care provided. A decision was made for us to inspect sooner than the planned date for the comprehensive inspection and examine those risks. The registered manager had identified shortfalls and actions were taken to reduce future risks. We did find improvements were needed in how long people had to wait for their call bells to be answered, action was being taken to make improvements by the introduction of a system to analyse waiting times.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Details are in our safe findings below.

Good

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was well-led.

Details are in our well-Led findings below.

Good

Avocet Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector, an assistant inspector and an Expert by Experience on both days. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of our inspection a pharmacy inspector also joined the team.

Service and service type
Avocet Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We announced the second day of the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since they registered. We sought feedback from

the local authority and professionals who work with the service, including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and eight relatives about their experience of the care provided. We spoke with 16 members of staff including the regional manager, the registered manager, assistant manager, clinical lead, unit managers, qualified nursing staff, senior care workers, care workers, activities staff, food service assistant and the chef manager. We spoke with three health and social care professionals who were visiting the service. We also observed the interaction between staff and people using the service and people in the communal areas of the service.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The registered manager sent us training records and documents relating to lessons learned. We reviewed these records following our inspection visits.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- One relative said, "I'm very happy, I wouldn't have gone on holiday if I thought I couldn't leave [family member]." One person who used the service told us how staff supported them when they felt unsafe.
- Staff received safeguarding training and they were able to tell us the signs of abuse to look out for and knew how to report concerns.
- Staff said they would feel comfortable reporting signs of abuse and would, "Go straight to the manager, report it to the police or CQC."
- Signs in communal areas explained to staff, relatives and people using the service how to report concerns of abuse and who to go to.

Assessing risk, safety monitoring and management

- People's risk assessments guided staff on how to keep people safe. Risk assessments were specific to individuals, for example, one person used oxygen, their risk assessment reflected this and gave guidance to staff on how the oxygen should be stored, handled and used safely.
- Staff spoken with were knowledgeable about people's risks and how to support them to avoid harm. Staff were able to tell us who was at high risk of choking and what was in place to support these people.
- One relative said their family member's falls had reduced since living in the service and when they had a recent fall, "They [staff] called an ambulance but [family member] didn't need to go to hospital. They do their best to stop [family member] getting hurt, they've lowered the bed, put mats down and they use a pressure mat, you know, alarmed so if [family member] does fall they're aware of it."
- People were safe in the service, because regular checks were made, for example fire safety and legionella checks. We looked around the service and found there were appropriate window restrictors, wardrobes were secure and walking frames had ferrules which were not worn, all of these contributed to minimising risks to people.

Staffing and recruitment

- Staff were recruited safely. Staff had disclosure and barring service (DBS) checks and references in place prior to starting work. These checks were to see if applicants were of good character and suitable to work in this type of service.
- Prior to our inspection we received information relating to an agency staff member who did not have appropriate recruitment checks in place. The registered manager told us this agency staff member was obtained at short notice due to staff sickness. The usual system was the agency sent a profile before the staff member arrived at the home, including information about their training and recruitment checks. The lack of appropriate checks were discovered quickly and the staff member was removed from the service.

● The management team kept the staffing levels under review and adjusted staff numbers to meet the numbers and needs of people using the service. There were staff vacancies and the management team were working to reduce the risks of not having enough staff. This included active recruitment, 13 new staff had been employed who were waiting for satisfactory checks to be received.
● In response to deficits in nursing roles, the service were upskilling senior care staff to be clinical care associates to assist the registered nurses. This included the provision of training in subjects such as wound care, catheter care and diabetes. Food service assistants were provided with the training care staff received to support the care staff where needed.
● Agency staff were also used to address staff shortages. The service tried to use the same agency staff to provide continuity for people and if the staff had not been to the home before they were provided with an induction. One house manager said, "We use quite a lot of agency staff, but we are lucky to use some regular agency. It's like having our own bank staff." Handovers were given to agency staff which detailed people's individual needs. However, some people told us they found the use of different agency staff concerning. One person said, "There's a kernel of people I keep seeing but there's a lot who seem to come and go and I've no idea who they are. It's quite disconcerting having a total stranger in your room at night."
● People's views about if there were enough staff varied. One person told us, "I don't think there's enough staff and they're never the same, different faces all the time. I find it quite hard." Another person told us, "There's definitely not enough… they just seem understaffed sometimes, there's no particular pattern." However, some people thought there were enough staff. One person said, "I think there are enough." One person's relative commented, "I think they have enough. Sometimes they have to get temporary staff in if someone's off sick, but I'd say they have enough."

Using medicines safely
● Staff kept written records when they administered medicines. Staff were trained and deemed competent before they administered medicines, and regular checks ensured people received their medicines safely.
● Staff supported people's dignity because they knew how people preferred to take their medicines.
● Where people were prescribed 'as and when required' medicines there were protocols to assist staff to understand when to administer such medicines and how to assess whether they were effective.
● All medicines were available to be administered and there had been no out of stock items since the start of the current cycle.
● There was a system of reporting and recording medicines errors and action was taken to resolve individual errors.

Preventing and controlling infection
● The home was visibly clean. One person told us, "They keep my room tidy and the toilets are always clean." One relative said "The home is very clean, [family member's] room is cleaned every day… there are no smells here at all." We did identify in the mornings of our visits there were urine smells, but these reduced when the domestic staff had cleaned, for example we saw that one carpet had been cleaned. However, in Harlech there was a constant underlying smell of urine.
● There were personal protective equipment (PPE) dispensers on the walls, and staff used disposable gloves and aprons when preparing to assist people with their personal care needs. We saw staff cleansing their hands using the hand sanitiser dispensers. Toilets had soap and paper towel dispensers with pedal bins for waste. There were signs to remind people to wash their hands and graphics to show them how. Staff provided people with wet wipes to cleanse their hands when making toffee apples and before meals.
● Staff were clear about their responsibilities surrounding infection control and one said it was about "Washing hands, wearing aprons and gloves." Staff had received training in infection control and food hygiene.
● We saw one staff member blowing on a person's food when assisting them to eat, this was not hygienic.

We fed this back to the registered manager who told us they would look into it.

● Infection control audits were completed to assist the management team to identify and address any shortfalls.

Learning lessons when things go wrong

● The service regularly analysed falls to identify trends in areas and times of day. This information was then used to develop actions to try and prevent future falls. These actions were both general and specific to the people that were experiencing falls. Staff were required to sign that they had read and understood the post falls flow chart.

● Records included lessons learned meetings held with the team leaders and nurses. In addition, they were discussed in daily briefing sessions and staff received coaching/clinical supervision sessions.

● There were no lessons learned log being used, however following our inspection visit the registered manager told us this had been given to them by the provider's management team and they had started completing these.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Prior to a person using the service an assessment was undertaken to ensure the service could meet their needs. These assessments were used to inform people's care plans. People's care plans documented their individual needs, including physical, emotional and social needs.

● The assessments were completed with the person who would be using the service, their relatives and other professionals involved in their care where appropriate. One relative said during the assessment process, the staff had asked what their family member's interests and likes were. When the person arrived at the service staff had printed out pictures relating to their interests and had put it on their bedroom door.

● A relative told us a member of the management team and the staff member who had completed their needs assessment welcomed their family member when they first arrived. The relative said, "Within five minutes of arriving, [family member] was sat in an armchair with a cup of tea and a slice of cake."

Staff support: induction, training, skills and experience

● Records showed staff received the training they needed to meet people's needs effectively. As well as the core training such as moving and handling, basic life support and safeguarding, staff received training in people's specific needs including dementia, positive behaviour support and equality and diversity. One staff member said, "I feel supported by the company, they offer really good training."

● Staff received an induction when they started working in the service this included training and shadowing more experienced colleagues. During our inspection there were some new staff working supervised.

● Staff received one to one supervision and appraisal meetings. These provided staff with the opportunity to discuss and receive feedback on their work practice and identify any training needs.

Supporting people to eat and drink enough to maintain a balanced diet

● People's individual dietary needs were assessed and met. Staff spoken with were knowledgeable about people's individual needs and the support each person needed, such as the provision of fortified food and drinks to enhance their calorie intake. Where there were concerns relating to people's weight loss or choking, referrals were made to professionals, including dieticians and speech and language therapists (SALT).

● We spoke with a visiting health care professional, who provided advice, guidance and support relating to people's dietary needs. They had identified, since the service had started using a computerised recording system, there were some issues with how people's food and fluid intake were recorded and the malnutrition universal screening tool (MUST) assessment. We spoke with the management team about this and they assured us they were taking action to improve.

● One relative said their family member's appetite had improved since living in the service. This relative said,

"Since [family member has] been here, [they have] put on weight. The food is fabulous, it's all cooked from scratch." Another relative told us, "[Family member] has put on weight since coming here, and I actually think [family member] has improved quite a lot."

● Mealtimes in the communal dining rooms were relaxed and social occasions. People were assisted by staff with eating and drinking, where needed. The staff were attentive and caring when supporting people and fully explained each step of the process. Where people had their meals in their bedrooms, they were provided the same level of support and attention.

● People were offered choices of food and drink and were offered alternatives if they didn't want the main meal. For example, one person chose to have ice cream instead of their dinner and this was accommodated by staff. Staff encouraged people to eat when they had not eaten much of their meal. There were food service assistants in each of the units and their main responsibility was to ensure people had food and drinks throughout the day.

● People told us they were satisfied with the quality and choice of food provided. One person commented, "The food is lovely and there's always a choice." One person's relative told us how the service had responded to their comments, "[Family member] found the food off putting because the plates and portions were large. We mentioned it to a member of staff and now they give [family member] a smaller plate."

Staff working with other agencies to provide consistent, effective, timely care

● The management team told us how they worked with other health and social care professionals involved in people's care to ensure they received consistent care and support.

● We spoke with visiting health professionals who confirmed the service worked well with them.

Adapting service, design, decoration to meet people's needs

● The environment was suitable for the needs of the people using the service. This included being accessible for people who used equipment to mobilise, such as wheelchairs and walking frames. There was signage on bathroom doors and people's bedroom doors to help them to find the rooms they wanted to access.

● Automatic lighting was activated by movement, in bathrooms and along corridors. There were wide corridors with hand rails on both sides, the hand rails were different colours to the walls, enabling people to identify where they were.

● People's bedrooms were personalised with items from their previous home, including pictures and ornaments, making them familiar for the person. People told us they were happy with their personal space, one person's relative said, "I think [family member] likes their room," their family member was present and nodded.

● There were communal areas where people could use, including lounge/dining areas. These were decorated to reflect special occasions or seasons. At the time of our inspection visits all of the communal areas were decorated with a Halloween theme, with items people had made.

● There was a programme of refurbishment, including replacing carpets when required and the development of a coffee shop in the unit where the offices, kitchen and laundry were based. A staff member told us people would be able to access this to meet friends and family, or just visit it when they wished to.

Supporting people to live healthier lives, access healthcare services and support

● We saw people receiving visits from the dietic assistant and the GP as well as nursing input from staff. Each unit had a designated GP from a local surgery who visited the service once a week, as well as attending to requests for more urgent visits.

● People told us they were supported to see health care professionals where required. One person said, "A while ago my eyes were getting gummed up and I was struggling to open them in the morning. I asked to see the doctor. It took a few days but eventually [they] came and prescribed eye drops for me." Another person commented, "They arranged those [hearing aids] for me and they change the batteries too, but only once

they've stopped working, I have to ask them." One person's relative said how the staff had identified their family member was not well and took action to arrange for a health professional to visit.
● We spoke with visiting health care professionals who told us appropriate referrals were made when there were concerns with people's health.
● Staff we spoke with were knowledgeable about people's health care needs and how their conditions affected their daily living.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● We saw lots of interactions of staff asking people what their choices were, such as where they wanted to be in the service and if they required assistance with their meals. People told us they felt the staff asked for their consent before providing any care. One person said, "If they want to make changes to my care or the doctor wants to change my treatment they talk to me about it first. I am involved with how I'm cared for."
● People's care plans included people's capacity to make their own decisions. Where people did not have capacity the arrangements for the assistance they required in their best interests was documented. People's care plans guided staff to ensure they sought people's consent throughout their care provision.
● DoLS referrals had been made where required and these were kept under review. During our inspection we saw a social care professional visiting one person to assess and assist them in making a particular decision.
● Where a person was experiencing restraint through specialised equipment, it was clearly documented in the care plan that this person had capacity and had consented to this restriction and had been happy for this to be put into place to maintain their safety.
● Staff had received training in MCA and DoLS.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff including agency staff were observed to be treating people with kindness and respect. People told us they felt they were treated well. One person said, "The carers are generally kind. They never get cross or shout and I think they're well mannered."
- Interactions between staff and people were caring. Staff got down on the same eye level as people when talking to them and provided reassurance when a person became upset. Staff used people's preferred methods of communication and supported people to communicate when they were struggling. People were relaxed in the presence of staff, staff were seen to greet people and they understood the importance of touch when reassuring people.
- Staff knew people well, this included where a person liked to have their belongings around them, which was important for their wellbeing and reduced their anxiety. One staff member was walking with a person and talking about their families, the staff member asked the person how many children they had, the person said how many, then they both listed the names and ages of the person's children, who their partners were and if they had children.
- One relative said, "The carers are lovely, they are so warm." Another relative said, "It just seems like you're really welcome here. The staff are very nice and helpful. If something's going on they ring you, even on holiday they keep you informed. You know they are taken care of."
- We saw examples which demonstrated the caring nature of the staff. One person had a stuffed soft cat and dog in baskets near to their feet, they told us they were fond of cats and dogs and they had had their pets for a while. They asked for the dog in the basket and stroked it, smiling as they were doing so. The person said to a staff member, "This dog feels very still, do you think he's alright? He's not dead is he?" The staff member reassured the person and said, "I'm sure he's fine [person's name], he's just sleeping, shall we put him down so we don't wake him up?"
- We saw interactions between a staff member and a person, which showed they had a mutual understanding and a known way of communicating. After lunch the staff member held the top of their own apron between their thumb and index finger and wiggled it from side to side, the person smiled and did the same to their apron, indicating the person was agreeing for the staff member to remove the apron they had worn for lunch.

Supporting people to express their views and be involved in making decisions about their care

- Care plans were detailed in what people's preferences were for different aspects of their care. The records included what was important to people, including their spiritual needs and any specific preferences they had relating to this.
- One person told us how they were involved in their care planning, "I have regular reviews. I think it's every

six months. We go through the care I'm getting and talk through any changes." Another person told us how their choices were respected, "I like staying in my room so that's what I do."

● One person chose not to sleep in their bed due to not feeling comfortable, special equipment had been ordered to allow for pressure relieving to happen whilst asleep in a comfy armchair. Staff said that despite this person being at risk of cellulitis in their legs, it was their choice where she wanted to sleep so they respected this.

● Several people told us how they felt their religious observance was respected. One person said, "I'm a catholic, someone comes here sometimes, I'm not sure how often though." They added they felt this was enough. One person's relative commented, "A priest comes about once a month for holy communion and I think that's probably enough for [family member]."

Respecting and promoting people's privacy, dignity and independence

● Staff did not discuss people in front of others and when people needed support to mobilise, this was communicated discretely amongst the staff and that person received support.

● People were supported with personal care behind closed doors and staff knocked before entering people's bedrooms.

● One person said, "I normally have my door open. If I need help personal care they close the door and draw the curtains, so I have some privacy." Another person said, "I like my room, my [relative] setup the television and I've got everything I need here. I like to have the door open so I can see people walking past, I feel safe here."

● We saw how staff respected people's decisions and independence, and when support was declined, they observed the person and revisited them to check they were safe. An example of this was a person refused assistance with cutting up their meat.

● One person told us, "I have a drawer I can lock just here [they pointed to a bedside cabinet] so if I want to keep something safe it goes in there. I think my things are safe here though."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Prior to our inspection we had received some concerns relating to how long people had to wait when they needed assistance, such as when they used their call bells. We reviewed call bell times and found people were having to wait for their call bells to be answered, sometimes 30 to 40 minutes. One person commented, "I can wait twenty minutes if I press the bell." The registered manager told us call bell responses were discussed at each daily briefing with staff, staff received coaching/clinical supervision sessions and messages were sent to staff on the computerised care planning system. The registered manager told us following our inspection visits they were taking action to improve how waiting times were analysed, but this was not yet embedded in practice to improve people's experiences.
- Some people told us how they felt the staff were not always responsive. One person told us, "I like to get up at 6am and have a cup of tea. They know that's what I like but sometimes I don't get one until nearly 10am. I think they either forget or they're too busy, I'm not sure which." Another person told us, "I always have my meals in my room and some days I have to ring to remind them because I think they've forgotten. One day one of them asked me what I wanted for pudding and went and got it, then about ten minutes later another carer brought me a second pudding. I'm not sure they talk to each other."
- Despite the delay in people receiving timely care, we saw examples of how people received personalised care. One person told us the several pillows on their bed had been provided because this supported them to sleep comfortably and help their breathing. Staff treated people as individuals and offered choices about what they wanted. Staff had good knowledge of people's preferences and could tell us everyone's likes and dislikes. Staff were aware of what person centred care involved and one described it as, "All about the person, what their needs are what they like, [their] certain ways of doing things."
- People's relatives told us how their family members had improved since living in the service. One relative said, "Now [family member] is always clean and well dressed and definitely more alert. [Family member] wasn't talking at all but I think [they have] improved." Another relative commented, "The staff are first class, they're always kind. When [family member] came here [they] couldn't walk but now [they] can if [family member] uses [their] frame."
- The provider had purchased an electronic care planning tool, which included people's care plans and risk assessments. People's care plans identified their specific needs and preferences and guided staff how they were to be met. A staff member told us how they could quickly update records in line with people's changing needs.
- There were some improvements being made in the computerised system, to alert the management team when people's care needs had not been met. When the system had been updated, this would allow members of the management team to monitor the meeting of people's needs. However, there were some areas that were already doing this, relating to nursing needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care records included how they communicated and guided staff how to communicate effectively. The registered manager gave us examples of how staff ensured effective communication, including the use of interpreters and picture boards. We observed staff using the alphabet to spell out what person trying to day.
● Some people's records guided staff to offer large print books.
● Important information about the service was available in other formats to be accessible to people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People's care plans documented how they maintained relationships with important people in their lives. Where there were restrictions on individuals visiting, this was documented, including arrangements to support visits elsewhere. Relatives told us that they were able to visit at any time and always felt welcome. One had contact with their relative by telephone, "I go to the office and they call [relative] so I can talk to [relative]. They leave and shut the door, so I can talk in private."
● To reduce people's isolation, there was a full time activities staff in each of the three units. All people spoken with, except for one, said there were a range of activities they could do if they chose to. Some people preferred their own company and did not wish to participate in activities. One person said, "I like to stay in my room, I don't like going out and there's no need, I've got everything I need right here." People told us they were encouraged to join in. One relative said, "[Family member] tends to want to stay in [their] room and I think they respect that. They bring the activity sheet each week and do ask [family member] to join in but [family member is] not interested."
● People who preferred their own company were offered one to one time. One person told us they were knitting poppies for Remembrance Day. We saw many staff wearing these, and one relative from another unit going to buy one. The activities staff member was taking the knitted petals and leaves home and stitching these up in their own time. One person's relative told us how the activities staff, "Always takes activities to [family member] if [family member] doesn't want to leave [their] room. [Activities staff] brought [family member] a mocktail to create the other day when [they] didn't want to go and join the others, cutting up fruit and stuff."
● Relatives were positive about the activities taking place. One relative said, "There's always something going on, always something to do. Staff are able to distract people if they become upset or bored… the staff are inclusive and provide activities for everyone to get involved in." Another relative said, "The activities are great, [family member] loves afternoon tea. [Activities staff] came and did a wheelchair dance with [family member] the other day. They do lots of trips out as well." Another relative commented, "There's quite a lot really. They decorated some ceramic things, they did some pressed flowers and I think they're doing toffee apples today. They do trips too, they took some of them, including [family member] to Bury to the Abbey Gardens. They took photos and had a walk through the grounds and then they had an ice cream I think. There's going to be a Halloween party and fireworks, I think they do quite a lot."
● During our inspection visits people participated in activities, including word games, playing dominoes, making toffee apples, having manicures, and some people did their own thing, including doing puzzles in a book, jigsaws and reading the newspaper. There was lots of impromptu singing taking place to the music which played in the background. For people living with dementia there was sensory items people could use.

● The first day of our inspection visit, there were visiting entertainers, who played and sang music, joined in

by people using the service. This was stopped for a while when a person started singing a song they remembered, when they had finished everyone clapped.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place which explained to people how they could raise concerns and what happened when they did.

● Records of complaints and concerns demonstrated they were investigated, responded to and addressed in a timely manner. These were used to drive improvement, for example a complaint relating to a person's weight loss and lack of supervision with food and drink had resulted in staff receiving clinical supervision, coaching to all staff alongside an example as to how records should be completed and were discussed in clinical risk meetings.

● People knew how to raise a complaint but had not done so. They told us when they had raised a concern or request, this was usually addressed. For example, one relative said, "We have asked if they can change the flooring, there's carpet at the moment and [family member has] had a few accidents. They've agreed and I think it's due to be changed quite soon." Another relative commented, "Things do go missing; I think that's to be expected. If it's [family member's] glasses which seems to happen, I ask the carers if they can look for them. They do and they're always found in the end, sometimes it takes a few days but the staff will keep looking."

● However, two people told us they felt the responses to their requests was inconsistent, with some staff doing what was asked and others not. This included asking to go to bed at earlier times.

End of life care and support

● Some care plans documented people's preferences for their end of life and some documented that the person had not wished to have this discussion at that time.

● One relative said, "What I really liked was that at the first assessment, we got to discuss [family member's] end of life plans so that I didn't have to be asked at a very emotional time when it's actually happening… They are very compassionate and consider my feelings."

● It was clear who had made decisions regarding not to be resuscitated and this information was passed onto new staff and agency workers through the handover.

● The home had recently been accredited in end of life by a local hospice, which included staff attending training in end of life care. Because of this accreditation, many people were admitted to the service at the end of their lives.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service had gone through many changes recently, including a change of name and changes of ownership twice over the last two years. The service had a consistent registered manager, management team and staff who had worked to try to make sure people received consistent care.
- We had received some concerns prior to our inspection regarding people's views of the care falling below required standards. Where this had happened the service had investigated, addressed them and learned from them to drive improvement.
- Staff spoken with were proud of their achievements in managing the changes they had faced. One staff member told us, "I feel supported by the company… if we need any help, they are always there. [Registered manager] is really good if we have any problems she's always there for us."
- Since the new provider had taken over, there had been changes including the introduction of the computerised care planning system. This had been managed well, despite some challenges the registered manager understood where improvements were needed and how this was to be addressed.
- There had been some issues with maintaining a consistent staff team and the provider and registered manager were working to reduce the risks of not having enough staff to meet people's needs. Discussions with the registered manager demonstrated they took action when staff were not working to the required standards.
- One relative said, "The highest compliment that I can give is that [family member] always said [they] would rather die than go into a care home. Within a few hours of being here, [family member] didn't want to go home."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Procedures relating to the duty of candour were in place and the management team understood their role and responsibility in this area.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager understood their roles and responsibilities of their role. They ensured we were kept updated with any incidents that happened in the service and actions they were taking to address them.

- Audits were in place to monitor the service people received. These included infection control, pressure

ulcer prevention, falls analysis, Parkinson's Disease reviews, meal time observations and night time visits. The registered manager was required to send information relating to their audits and any issues in the service to the provider's management team, including hospital admissions, Deprivation of Liberty Safeguards (DoLS) referrals and complaints.

● The service completed checks on call bell times but more work was needed to ensure that these were analysed, responded to and appropriately actioned. The registered manager told us following our inspection visit they had developed a system for analysing call bell response times and the daily briefing forms had been amended to include discussions at each meeting.

● Daily walk arounds took place by senior staff this identified housekeeping issues, catering, maintenance, activities, colleague issues, care/nursing issues, clinical care issue and admissions or discharges.

● The provider had undertaken a visit to the service to check on their care provision, actions had been planned to make improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We did not see evidence of formal reviews with family members, the management team said they had a resident of the day system which families were invited to. The resident of the day included the person having their needs reviewed and specific actions taken, such as deep cleaning their bedrooms. The management team said relatives tended to raise issues straight away rather than waiting for reviews and involvement of family members varied.

● People and relatives were asked for their views of the service in satisfaction questionnaires. Where people had raised areas of improvement these were addressed. A summary of the completed questionnaires was displayed in each unit.

● There were surgeries held, where the registered manager was available to meet with people and relatives, where required. The registered manager and management teams also held afternoon teas in units where people could raise any issues they had.

● Resident and relative meetings were planned every month in each unit, the dates were displayed in units. We reviewed records of these meetings and found people and relatives only turned up for these meetings in the Harlech unit, the minutes for their meetings were displayed in the unit. One relative told us, "They have regular resident and relative meetings, about once a month. I go because I can find out what's going on with the home and we can ask anything and they try to give us an answer. They tell us about events and trips out too."

● A notice board with information you said we did, this included information about people's comments about activities, as a result more outings had been done as well as visits from a local play group and Beavers club.

Continuous learning and improving care

● The management team said that they were currently supporting senior carers to train as clinical care associates. This role was introduced to support the registered nurses. As well as the introduction of this role, the service was planning to include mentoring roles for staff to support their colleagues, such as through their induction.

● When staff were not meeting the requirements of the service, they were performance managed. This included providing more training and support. This was to reduce the risks of people not being supported appropriately.

● Where concerns had been raised by staff about the performance of other staff, sometimes known as whistleblowing, appropriate action was taken to reduce the risks to people. This included, for example, not having an agency staff member to work in the service.

● To demonstrate to staff they were valued, there were employee awards with nominations from people

using the service, relatives and colleagues. The provider held an annual awards ceremony.

Working in partnership with others

- The registered manager told us they shared positive relationships with other professionals involved in people's care. This was confirmed by the feedback we received from a commissioner of the service who told us the registered manager and regional manager worked well with them.
- The service were working with the Clinical Commissioning Group (CCG) and the Friday following our inspection they were going to be providing care and support to people to be discharged from hospital and work to return home. This system helps to free up hospital beds in the community.