Avery Homes RH Limited

Scholars Mews

Inspection report

23-34 Scholars Lane
Stratford upon Avon
Warwickshire
CV37 6HE

Date of inspection visit:
28 September 2016
30 September 2016

Date of publication:
26 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 28 September 2016 and was unannounced. We told the registered manager we would return on 30 September 2016 to complete the inspection visit.

Scholars Mews is a nursing home which provides care to older people including some people who are living with dementia. Scholars Mews is registered to provide care for up to 64 people. At the time of our inspection there were 33 people living at the home, however two people were in hospital.

This home was previously called Avon Court Care Home. When we inspected this home in November 2015, we rated the home as 'requires improvement'. This was because staff and people lacked confidence in the management of the service and people were not always supported in line with their care plan, and to to pursue their hobbies and interests. At this inspection we looked to see if the provider had responded to make the required improvements.

The home is required to have a 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post.

People enjoyed living at Scholars Mews and they considered it their home. People received care that enabled them to live their lives as they wished and people were supported to remain as independent as possible. People were supported to make their own decisions and care was given in partnership with their wishes.

Care plans contained relevant information for staff to help them provide the individual care people required. However the clinical lead, registered manager and regional managers acknowledged some care plans required improvements and this was being addressed. People's care and support was provided by a consistent staff team, although the provider's staff team was supported by agency staff. Efforts were made to keep existing agency staff to support continuity of care. The staff team were knowledgeable and knew people well.

People were encouraged and supported by a caring staff team. People told us they felt safe living at Scholars Mews and staff knew how to keep people safe from the risk of abuse. Staff and the registered manager understood what actions to take if they had any concerns for people's wellbeing or safety.

Staff received training to meet people's needs, and effectively used their skills and knowledge to support people and develop trusting relationships.

People were supported to pursue various hobbies and leisure activities which enabled them to strengthen

and build relationships. Potential risks were considered positively so that people did things they enjoyed and kept in touch with those people who were important to them. Relatives told us they were able to visit whenever they wanted to, without restriction.

People had meals and drinks that met their individual requirements and people said they enjoyed the food choices provided.

People told us they could raise concerns or complaints if they needed to because the registered manager and staff were available and approachable.

The registered manager had quality monitoring processes which included audits and checks on medicines management, care records and accidents and incidents. The provider completed additional audits and checks to satisfy themselves improvements were being made.

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 felt safe living at the home. They were supported by enough staff who were available to provide their care and support. Staff understood their responsibilities to report any concerns about people's safety or if they believed people were at risk of abuse. People were supported with their prescribed medicines from trained staff. Regular medicine reviews ensured people received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff were trained and knew people well so they could effectively meet their individual needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and gained consent from people before supporting them with personal tasks. The registered manager understood and worked within the principles of the Deprivation of Liberty Safeguards. Staff referred people to healthcare professionals when needed and worked closely with other professionals involved in supporting people's healthcare needs.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, respect and dignity. Staff were patient, understanding and attentive to people's needs. Staff had a good understanding of people's preferences, how they wanted their care delivered and how they wanted to spend their time whilst promoting independence.

Is the service responsive?

Good

The service was responsive.

Staff had a good knowledge of the needs of the people they were caring for. People felt able to speak with the registered manager

and raise any issues or concerns knowing their concerns would be listened to. People were supported to maintain important relationships and were involved in care planning decisions, and how they wanted to spend their time pursing their hobbies and interests.

Is the service well-led?

Good

The service was well led.

People and their relatives were encouraged to share their views and felt the provider and management listened to and acted upon their concerns. The staff team felt supported by the provider and registered manager and had opportunity to shares concerns or feedback when necessary. The provider had systems to monitor the quality of the service provided to people and took action where improvement was needed.

Scholars Mews

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 inspection took place on 28 September 2016, was unannounced and consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor was an experienced nurse who specialised in dementia and end of life care. The expert by experience had experience of caring for a person who used this type of service.

We told the registered manager we would return on 30 September 2016 so we could speak with more staff, people and look at examples of records, checks and audits.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We spoke with the local authority, who did not provide us with any information that we were not already aware of. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people in the communal areas and in their own rooms. This was to see how people spent their time, how staff involved them, and how staff provided care and support to people when required. Some people living in the dementia unit were unable to communicate with us due to their health condition. We 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.

During our inspection visit we spoke with 14 people who lived at Scholars Mews to get their experiences of what it was like living there, as well as five visiting relatives. We spoke with the registered manager, two regional managers, a director of care and quality and a hotel services manager. We spoke with nine care and senior care staff and one nurse (referred in the report as staff), a clinical lead nurse, two activity co-

ordinators, two housekeepers and one maintenance staff.

We displayed a poster in the communal area of the home inviting feedback from people and relatives. Following this inspection visit, one relative contacted us to share their experiences of the service.

We looked at five people's care records and other records including quality assurance checks, medicines and incident and accident records.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe living at Scholars Mews. People felt secure and protected in the home and felt safe when they received care and support from staff. A typical comment was, "I always feel safe here because the doors are locked" and "I feel I have everything I need, always in the right place and the staff know how to look after me properly."

People were safe because they were protected from the risks of abuse. People were supported by staff who had completed training and understood what constituted abuse, and the actions to take if they had concerns about people's safety. A typical comment was, "I would report it to managers or go higher and contact the safeguarding team." One staff member said, "People are vulnerable and we need to protect them." A member of agency staff told us, compared to other providers they worked with, they judged this home as 'good and safe' because staff made sure people were safe and protected.

Staff understood their responsibilities to share any concerns that people might be at risk of harm. All staff, whether employed by the provider or agency, said they would share any concerns about staff's practice with the nurse, clinical lead or registered manager. One staff member told us they had shared concerns about some agency staff's skills and behaviours with the registered manager. They told us the registered manager had listened to their concerns and had taken appropriate action to ensure those staff did not work at the home again. The member of staff said they would not hesitate to share any further concerns about poor practice with the registered manager, because they were confident they would be treated seriously. The registered manager knew what action to take and when concerns were raised to them, they notified the safeguarding team.

Risks associated with people's health and wellbeing had been assessed, and care files informed staff how to manage them. These included risks associated with people's mobility and, if they required equipment to help them move, what equipment was needed and how many staff were required to transfer them safely. People who spent most of their time in bed were encouraged to reposition regularly to relieve pressure. At the time of our visit, no one had any skin breakdown.
One person told us they had an alarm mat by their bed to alert staff when they got out of bed in the night, so they could be supported when walking. Relatives felt their family members were protected from risks. A visiting relative told us their family member was prone to falls from bed and said, "We discussed bed rails, but agreed it was safer not to have them as [Name] might try to climb out over them."

Where risks were identified, people's care plans described the actions care staff should take to minimise them. Risks to people's mobility, nutrition and communication were assessed and staff were given guidance on managing the risks to ensure the best outcome for the person. For example, one person had been identified as needing two staff to assist them to move around, when they first moved to the home. Any changes in risk were communicated to staff during the handover between shifts. A member of staff told us if they missed the handover, the senior in charge of the shift updated them on any changes in people's needs, and they could read the daily records. They told us the daily records were detailed enough to give them confidence in understanding how to care for and support people on each shift to minimise potential risks.

There were enough staff on duty to meet people's needs. Prior to this inspection visit, we received information that staffing levels were not meeting people's needs. We arrived before 07:30am to speak with night staff who told us there were enough staff on duty to meet people's needs and keep them safe at night. Day staff confirmed there were enough staff to meet people's physical and social needs. People we spoke with confirmed there were enough staff to support them, however there were occasions when they had to wait for assistance, for example, some evenings and weekends. Relatives said staffing levels and continuity of care had and was, continuing to improve and staff were available and attentive when supporting people. One relative said, "[Person] doesn't ring their bell and staff are always popping in."

Staff told us there were sufficient staff to provide one to one support for those people who had been assessed as requiring a high level of supervision to maintain their safety. Comments included, "I would say there is enough" and "There is enough, we also have agency staff helping." Staff told us they worked flexibly to provide care that was responsive to people's individual needs. For example, if people wanted to get up earlier than usual, staff from the nursing unit came in earlier than usual to assist them. Some people liked to get up early every day, so night staff got people up, washed and dressed which eased the pressure on day staff to support people's preferred routines. We saw staff had time to sit and talk with people about subjects that interested them, such as where they used to work and their favourite films.

The registered manager told us they did not regularly use a dependency tool because, "We know what people need." The registered manager completed pre-assessments so knew whether people could be supported safely before moving to the service, or whether staffing levels needed to be increased. The registered manager was satisfied there were enough staff to meet people's needs but recognised the high use of agency staff to maintain staffing levels was not ideal. At the time of our visit, the home used 450 agency staff hours per week but used the same agency staff for continuity of care. People confirmed they saw 'the same regular faces'. High agency use was because employed care staff and nurses had left the service in recent months which is why the provider was reliant on supporting exisiting staff with agency staff. Recent recruitment campaigns had been successful which would decrease the reliance on agency staff and support people with consistent staff.

People told us they received their medicines as prescribed. Staff told us only trained staff administered medicines. People's medicines were delivered in blister packs and were colour coded for the time of day they should be administered which helped reduce or identify errors easier. Pharmacists supplied individual medicines administration records (MAR), which listed the name of each medicine and the frequency and time of day it should be taken. The MAR records had been revised from the standard format to include an additional administration time of 'early', that is, before breakfast. This meant medicines that were time critical or needed to be taken before breakfast, were given in line with the prescription. Staff signed the MARs to show when people's medicines were administered, or recorded the reason why not, for example, if a person declined their medicines. The clinical lead told us if a person declined a prescribed medicine on more than two consecutive days, they rang the person's GP to ask their advice.

For medicines that were prescribed once or twice a week, instead of daily, the clinical lead had marked up the MAR in advance, to minimise the risk of staff administering them more frequently than needed. For medicines prescribed in patches, staff used a body map to show where the patch had been applied. This ensured it was applied to a different area each time, to minimise the risks of making the person's skin sore. Thorough checks were in place to order, store and administer medicines and regular stock checks helped ensure medicines were administered safely.

Systems were in place to keep people safe in an emergency. These included regular fire alarm testing and fire drills so staff knew what to do to evacuate the building. Each person had a personal evacuation plan

that provided the emergency services with important information about their mobility and any equipment needed to evacuate them safely.

Good

Is the service effective?

Our findings

People told us they liked the staff and found staff knew what to do, and how to support them on a daily basis. People said staff were always available and when they did anything for them, it was to their satisfaction. Comments people made were, "[Member of care staff] is marvellous, she cares, takes time to talk and treats me like a human being" and "Staff are competent hoisting me, I always feel safe in the hoist, there are always two people (staff)."

People received care from staff who had the skills and knowledge to meet their needs effectively. Two staff told us they attended training in subjects that were relevant to people's needs, such as moving and handling and how to care for people living with dementia. A member of agency staff told us they had training in moving and handling so could support people to mobilise safely. Two staff were qualified moving and handling trainers. This meant they were able to train other staff in supporting people to mobilise safely and to observe staff's practice on an on-going basis. One qualified moving and handling trainer explained that if they saw staff move people in an unsafe way, they would 'tell and show' how to transfer in line with current safe practice.

Staff told us they had regular opportunities to discuss their practice, training needs and any concerns at one-to-one meetings with their manager. Staff felt supported by the provider to learn and complete training relevant to their job roles. One staff member told us they were currently studying for a nationally recognised qualification in health and social care (level 3). The provider monitored staff training to ensure staff received regular updates and training that helped them effectively meet people's needs.

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 to comply with the Deprivation of Liberty Safeguards (DoLS). The registered manager understood the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure people's freedoms were effectively supported and protected.

The registered manager understood their responsibilities under the Act. They had identified five people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the supervisory body. For example, they could not go out independently, because they did not recognise risks to their safety outside of the home. People's liberty, rights and choices were not restricted unnecessarily. For example, we saw one person who had the capacity to understand the risks, went out alone.

In the care plans we looked at, risk assessments for people's understanding and memory, confirmed whether people could make their own decisions or whether decisions needed to be made in their best interests. Some people had lasting powers of attorney to allow other people to make decisions on their behalf. The clinical lead told us the registered manager kept a copy of the documents issued by the courts

so they could be confident that people's relatives and representatives had the legal right to make decisions on their behalf. Relatives, whose family members lacked capacity to make decisions, told us they were involved in making decisions in the person's best interests.

We saw staff understood their responsibilities under the Act. Staff asked people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff maintained eye contact and watched the person's facial expression and body language, to understand whether they consented to support. The registered manager and clinical lead told us that new staff who completed the Care Certificate would receive training in the MCA and DoLS as this was part of the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff working in a care environment.

People had a choice of meals and chose where they wanted to eat. A member of staff told us that everyone was shown a menu the night before and asked what they wanted for lunch. People were supported to eat and drink throughout the day. At lunchtime, we saw there was a choice of soup, two different hot meals, salad or sandwiches. Some people chose to eat in the dining room and some people ate in their own rooms.

People with complex needs were supported by staff to ensure they received the food and drink they needed to maintain their health. Staff knew who needed their meals prepared to different consistencies, for example, soft or pureed. They told us meals and drinks were presented in different textures if people were at risk of choking. The information staff shared with us, matched the information we read in their care plans.

A member of staff told us staff recorded whether people had eaten well to monitor their appetites, as an indicator of their wellbeing. If people were assessed as at risk of poor nutrition staff recorded the actual amount people ate and drank on 'food and fluid charts'. If people lost weight and were at risk of poor nutrition, they were prescribed supplementary drinks to maintain their weight.

Records showed staff monitored the impact of supplementary drinks. For example, one person's care plan showed that staff regularly weighed the person and shared this information with the dietician. Once the person had regained weight, the supplementary drinks were stopped and they returned to a normal diet. Their care plan included advice from the dietician, including a minimum weight, to make sure staff knew when they should refer to the dietician in the future.

People told us they had access to, and used the services of other healthcare professionals. Senior care staff and the clinical lead nurse arranged healthcare appointments if people's health conditions or behaviours caused them concern. Records confirmed people received care and treatment from other health care professionals such as their GP, district nurses and chiropodists. Staff understood how to manage people's specific healthcare needs and knew when to seek professional advice and support so people's health and welfare was maintained. Senior care staff told us any advice was recorded and followed. A relative told us the chiropodist came to the home to make sure their relative received the care they needed for their feet.

Good

Is the service caring?

Our findings

People and staff were comfortable and respectful in each other's presence. People told us they were supported by a caring staff team and were complimentary about the staff and how they supported them. Comments were, "They are very good, hardworking" and "They can't do enough for you."

People said they were not rushed and staff worked around their routines. On the second day of our visit we spoke with one person who was going out for the morning and was waiting for their medicines. The team leader gave the person their medicines first. This meant the person was not delayed so they could get on with the day they had planned.

People told us they felt confident asking for help and said staff were kind, considerate and that they listened. One person said when they asked for help, "They (staff) smile, put a hand on you and look you in the eye…. I like that." Staff understood people's individual needs for reassurance and knew how to maintain their sense of self and wellbeing. When one person appeared to be confused, a member of staff held out their hand to them said, "So, [Name], would you like a cup of tea, piece of cake?" We saw the person responded with a smile, accepted the invitation and went with staff member to the lounge.

People were supported to maintain their dignity and were treated with respect. Everyone we saw wore clean clothes, and their nails were clean and manicured. We saw staff invited one person to attend a 'pampering session' with the hairdresser. The person smiled at the complimentary remarks staff made when they returned from the pampering session. The person told us they felt 'much better'. Relatives said staff knew how to improve people's wellbeing and knew what made them feel special. One relative said, "Staff put things into effect." They explained, "My [relative] likes having their nails done and they do it without being asked." They said although their relative had limited communication, they knew this made them feel happy because they always took pride in their appearance.

Relatives told us how important it was to them that their relations were well cared for. Every relative we spoke with was very complimentary about the caring attitudes of staff and recognised improvements had been made. Relatives said staff were caring and supportive, to them as well as their family member. A relative told us, "The care is really, really good" and "[Name] appears well cared for …..The staff are lovely. They do try really hard." In the 'comments book' on the coffee table in reception, we saw a letter addressed to the home, which read, "Thanks for the care and kindness shown to [Name]. They always received the finest attention." One relative said they had been on holiday and anxious they would not see their relative for a period of time. They told us they sent daily emails to the home and staff read them to their relative. They said, "I could tell they read them to [person] by their response." They explained knowing their relative was cared for and involved, meant they did not worry.

A relative gave us their experiences of how the staff were caring. They said, "I am humbled by the level of care, it's incredible." They explained why they felt like this, saying, "They make you (the person and the family) feel like you are the only one...it's personal." They said what staff did and how they supported their relation showed they cared. They said, "They know [name's] birthday, they are asking us what we would like

do…. they are ahead." This relative told us they had recommended Scholars Mews to others because people and families were valued. They told us they visited the home in the evenings and were supported to maintain a caring role in their family member's life. For example, this relative said, "I like to tuck her in (bed) at night, it's precious for me and I can do it." This relative explained that they could continue to do things they had always done which meant the important relationship between them and their family member was maintained.

Special events such as birthdays were celebrated and staff supported families to make special arrangements. A relative said staff arranged the 'private dining area' for their family so they could all celebrate a special occasion together. They said, "It's not a job to these people."

We saw throughout the inspection visit staff knew people well, and they used people's preferred names to give them a sense of identity. Staff recognised caring for people was an important part of their role, one care staff member said, "I love it here, we are a caring team, we have to make it their home." Another staff member told us, "It's not just a job title – carer, I care, I want to do my best. We work here to improve their spirits." Staff said friendly positive engagement with people showed they cared about them and how they were feeling. Staff told us they knew people well enough to understand how they liked to be supported.

Care plans were written from the person's perspective, so staff understood their needs and abilities from the individual's point of view. Each aspect of care and support included details specific to the person, under the headings of, 'I like, I dislike, I can' and 'I need support with'. Relatives we spoke with were involved in care decisions and said whenever there was a change, they were contacted and updated without delay. Relatives said communication had improved in the last 12 months since the provider had taken over the service.

People were given choices about how they lived their lives and received support in line with their preferred routines. For example, people we spoke with said they could get up when they wanted to, and go to bed at a time that suited them. People were encouraged to go out and maintain their own independence. Some people had the use of the internet so they could be responsible for managing their own lives and interests. One person told us they communicated over the internet with family members who lived in other countries. They said they used an internet based communication application with their relatives to discuss any care decisions when their care needed to be reviewed.

Some people had 'memory boxes outside of their rooms to help them remember which room was theirs. People and relatives had put photos and mementos in the boxes that reminded them of their previous life history, interests and things they were proud of.

Good

Is the service responsive?

Our findings

Overall, people felt their needs were responded to and care was personalised to them. People told us they were happy living at the home. Relatives were complimentary about the staff team and said recent improvements had improved the care people received.

Prior to the inspection visit we had received some concerns that the service people received was not to the standard they expected. During our inspection visit two people we spoke with told us of their concerns that staff and the management were not always responsive to their needs and on occasions they had to wait for support. We discussed this with the registered manager. They acknowledged there had been changes within the staff team that meant the service had not always been consistent and to people's satisfaction. They assured us that after the changes the staff team was now more settled. Relatives confirmed that staffing was now consistent and provided better stability which improved how staff responded.

The registered manager and both regional managers told us the provider was committed to delivering a responsive service. All of the relatives said they were pleased with the service and the way staff responded to meet people's needs. One relative said, "Staff are not reliant upon me, they do things for [person] and check with me rather than the other way around." They said they are always checked they were okay and if there were any concerns, "They always call me and let me know."

We found staff were responsive to people's needs. Call bells rang but staff attended to people with minimal delay. We saw one example when a staff member supported someone with personal care, then waited a few minutes for second care staff member to support them to help transfer. Staff told us the staff team was more consistent which made it easier to respond because staff knew people's care needs and preferred routines.

One relative told us their relation was 'Over the dementia bridge' meaning they no longer communicated coherently. They said staff were respectful and always asked and involved their relative when care tasks or choices were required. They said the provider had recently implemented a key worker system which worked well, meaning a designated care staff member was the 'go to' staff member to discuss care needs. This relative said this improved communication link meant the service was able to respond proactively. Another relative said staff knew how people were actually feeling. They said when, "[Person] says 'they are fine when they are not' staff know this is not right and encourage [person]." They told us this approach improved their relative's wellbeing and involvement.

People and relatives were involved in care plan decisions and felt staff used this information to meet people's needs, especially when their needs changed. A relative told us they were involved in planning their relation's care, because the person could not express themselves verbally, due to their complex needs. This relative told us, "We have a long questionnaire at the outset. We were asked about [Name's] likes, dislikes, history and work. Staff remember all the little details, for example, [person] hates draughts." People's preferences for support from male or female staff were recorded in their care plan. Staff told us people always received support from staff in accordance with their preferences.

Staff knew the people they supported although some permanent and agency staff said they did not always have time to read all of the persons' care records. Speaking with staff on the nursing unit, showed us some inconsistencies in staff knowledge and records. For example, one person's records said they could be moved to the lounge area. However, an agency staff member said the person should remain in bed, and a permanent staff member said they stayed in bed and were turned regularly. This conflicted with the care records. The regional manager, clinical lead and registered manager acknowledged improvements were needed to ensure consistent care was provided.

Monthly care plan reviews included a review of risks to people's health and wellbeing and care plans were updated when people's needs changed. For example, one person's daily records showed their abilities had improved once they became familiar with and settled at the home. At the most recent review of their care, staff had noted the person was now able to move around the home independently, where they had previously needed assistance from two staff when they first moved into the home. Their care plan was marked as 'needs updating'. The clinical lead told us the person had improved in confidence and ability, and their medicines had also been reviewed and changed as a result of their GP's advice.

People were supported to maintain their interests and preferred pastimes. A relative told us they had brought in the CD that was playing in the lounge, because it was music from their relative's era. We heard staff say 'of course' it was alright to play it. We saw the person was tapping their fingers in time to the music, which showed they appreciated it.

People's care plans included information about their preferred social activities, such as the kind of music they enjoyed, whether they liked reading and the type of films they enjoyed watching. Care plans included information about people's employment, pets and holidays, so staff knew the topics of conversation people might enjoy. A member of care staff told us they knew people well enough to know their preferred routines and the subjects they liked to talk about. For example, in the dementia unit, the person they supported on the day of our inspection liked to walk up and down talking about their grandchildren, or to watch and talk about old black and white movies. We saw this was recorded in the person's care plan, so all staff were able to find out how best to respond to the person's needs.

People had opportunities for purposeful activity and socialising. Some people chose to go out on their own, while others enjoyed their own company. We saw people were engaged in activities in the lounge. For example, one person was choosing some jewellery from a box of fashion accessories and another person was supported by staff to do some painting. One relative said their relation enjoyed fashion and make up and when staff got into 'fancy dress for a 40's night', staff asked the person to judge which was the best outfit. The relative said their family member valued this.

We saw staff understood and respected people's preferences to spend time in their own rooms, rather than in the communal areas. We saw staff went along to their rooms and spent time talking with them and planning how they might like to spend their day. For example, we heard a member of staff inviting one person to show them their photographs, or to watch a film with them. We heard the person become more animated when the member of staff mentioned football, which showed staff understood the person's interests. On the second day of our inspection visit, people took part in a Macmillan coffee morning. Activities staff had prepared the cakes for people to enjoy and people, relatives and staff chatted and socialised together. It was clear from people's expressions, they enjoyed this.

People were asked whether they had any specific spiritual, cultural or religious needs during their initial needs assessment, and there was a dedicated page in the care plans to record these. In the care plans we looked at, people had not requested support for any specific cultural practices.

Good

Is the service well-led?

Our findings

Before this inspection visit, we received some concerns from people living at Scholars Mews and their relatives regarding staffing levels and leadership within the home. We last inspected this service in November 2015 when it was called Avon Court Care Home. The registered manager and some of the staff were new to the service and the home was in the process of a large refurbishment programme. At that inspection we found staff responsiveness and management required improvement, although they had not breached the regulations. Since that visit, the name of the home had been changed to Scholars Mews.

At this inspection we checked whether improvements had been made. A requirement of the Regulations is for the ratings of our last report to be displayed. The report was not displayed and the registered manager assured us it had been, but someone had moved it. Later in the day, the ratings information was found and displayed in the communal reception. The registered manager knew it had to be displayed and assured us they would make sure it continued to be displayed.

We asked people and relatives what they thought about their home and the quality of the support they received. It was clear from what people and relatives told us there had been previous issues and concerns that had not always been addressed. Most of their concerns were around staffing levels, lack of familiar staff and how this had impacted on their daily routines. When we asked people about the service now, and recent managerial changes, people were optimistic in their responses. Relatives said the service was much better, communication had improved and there was structure in place. Relatives said the registered manager held fortnightly meetings so they were available to discuss any issues, concerns or to provide feedback. A relative told us they had recently attended a 'relatives meeting' and had been able to hear from each head of department about their role and responsibilities and the registered manager's plans for the future.

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One relative said the home was managed more effectively under the current provider. They said, "It's a different atmosphere, a lot better." They said staffing was better, even though there continued to be high agency use. They said, "Before I had to explain everything to them, now I don't." They said continuity of agency staff, and the right agency staff had improved. They also said closer management of staff and better organisation had brought about positive changes. They said the registered manager took action if staff or the service people received fell short of expectations. This was supported by a relative who contacted us post inspection. They said improvements were visible, such as staffing, communication, management of the home and improvements in the performance of agency staff which they said had been necessary. This relative and others praised the new management, the caring nature and commitment of staff and the clinical care provided by nurses.

We spoke with two regional directors that visited the home during our visit. They explained that when the provider took over the service 18 months ago, they quickly identified that the systems, environment and how people were cared for needed to be improved. The director of care and quality explained the provider's vision for the service was as a 'hotel with care services'. They told us people living at the home expected high standards of service and the role of the provider was to deliver this. They and both regional managers said

the home had 'come on in leaps and bounds', although recognised some areas were a 'work in progress'. For example, care planning and reviews were identified as requiring improvement to ensure they provided consistent information to staff. This supported our findings and the clinical lead told us this was one of their priorities and they had plans to update all care records.

Discussions with the registered manager showed they had identified where improvements were required. The registered manager had finalised their senior and management structure. They told us the new structure would provide increased leadership within the home and of shifts by increasing senior care team staff and putting a deputy manager in place. The registered manager said they were proud of their current team and recognised it had been a challenge over the last 12 months, putting the right staff team in place. Recent successful recruitment would increase staffing numbers so agency use was planned to reduce over the coming weeks and months. The registered manager said once they had a stable staff team, management and consistency would be easier to maintain.

Staff said recent changes had improved staff morale. Staff said the provider was listening to them and felt able to discuss concerns or opportunities. One staff member told us they were being supported with further personal development which made them feel valued. Some staff felt changes in the staff team took time to get used to and had improved over time. Staff said they worked well together as a team and supported each other.

Staff were confident to raise any issues or concerns they had. Staff told us if they saw anything of concern, they would raise it, or where necessary, felt confident to whistle blow and were confident their concerns would be listened to and acted upon. One staff member told us they had previously whistleblowed about staff and management concerns, but felt disappointed in the response from the provider which was to 'give the service time to settle'. Despite this, they told us if they saw or witnessed poor practice in the future they would not hesitate to report it.

During our inspection visit we found some improvements were required in the management and oversight of housekeeping and maintenance. On the first day of our visit a dining room floor in the dementia unit had been mopped, but not dried. The floor was extremely wet and slippery and had potential to place people at risk. We brought this to the attention of the hotel services manager who took action to limit the risk by dry mopping the floor. We found an electrical socket in a person's room on the ground floor was broken and hanging off the wall. We were told this socket was live and immediately informed the maintenance person to make it safe. When we returned on our second visit, this had been repaired. We spoke with the registered manager about this. They gave us assurances additional checks and measures would be taken to ensure such issues were not repeated.

A variety of audits were carried out on areas which included health and safety, infection control, care plans and medication. We found there were actions plans in place to address any areas for improvement which the registered manager updated once actions were completed. The provider had systems in place to monitor the quality of the care provided and undertook their own internal compliance monitoring audits. One regional manager said, "They are in line with yours (CQC) around each area." We saw findings from these visits were reported against and areas identified for improvement were recorded and action plans put in place with realistic timescales for completion. One regional manager said further visits were completed to ensure actions were taken. They also told us the provider looked at trends and patterns across the organisation in a variety of areas, such as pressure areas, tissue viability or incidents and accidents. If concerns were found, additional audits would be completed to minimise impact on people or the service people received.

The registered manager completed an audit of accidents and incidents but we found this was not always detailed, or provided a historical picture that would identify a trend. We were told action had been taken for people at risk, but it was not always evident what action and if, as a result, risks had been minimised. In one case, we found care records, falls logs and accident forms did not match for one person so we could not be certain how many times they had fallen, and the analysis was not clear. The registered manager assured us they would improve their analysis to make sure people were safe and protected.

People's personal and sensitive information was managed appropriately and kept confidential. Records were updated and kept securely in the staff office so only those staff who needed to, could access those records.

The registered manager understood their legal responsibility for submitting statutory notifications to the CQC, such as incidents that affected the service or people who used the service. During our inspection we found one safeguarding incident had not been notified to us, however the registered manager had referred it to the safeguarding team. The registered manager knew they had to notify us, however a third party agreed to notify us on their behalf, which is not the correct practice. The registered manager knew they should have told us and assured us they would send us notifications in future.