Bupa Care Homes (GL) Limited

Mount Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 23 February 2016.

This service was last inspected on 2 October 2014 where it was found to be compliant in all the areas we looked at.

Mount Hall provides accommodation and nursing or personal care for up to 32 older people. Accommodation is provided over two floors. There are 32 single bedrooms. All but three of the home's 32 bedrooms have en-suite facilities including wash basin and WC. Two communal lounges and a dining room are located on the ground floor. Access between floors is by stairs or a passenger lift.

The home is set in its own gardens in a semi-rural location near Macclesfield town.

The home had 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 2008 and associated Regulations about how the service is run. At the time of our inspection there were 30 people living in the home.

We found that people were provided with care that was safe, person centred, sensitive and compassionate. The home was managed and staffed by a consistent team of nurses and care assistants who were well trained and well supported.

We saw that the service had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. All the staff we spoke to confirmed that they were aware of the need to report any safeguarding concerns.

We looked at recruitment files for the most recently appointed staff members to check that effective recruitment procedures had been completed. We found that appropriate checks had been made to ensure that they were suitable to work with vulnerable adults.

The provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. This resulted in staff having the skills and knowledge to carry out their jobs well and provide safe and effective care.

We asked staff members about training and they all confirmed that they received regular training throughout the year and that this was up to date and provided them with knowledge and skills to do their jobs effectively. Staff informed us that they had access to external training in addition to the corporate providers training and also the manager held group supervision that reflected on areas of practice where staff could learn from one another.

People had care plans which were personalised to their needs and wishes. Each care plan contained detailed information to assist support workers to provide care in a manner that respected the relevant person's individual needs, promoting their characters and personal preferences'. The care plans were holistic as they considered in detail people's physical as well as mental health needs to maintain a good standard of well-being.

People living in the home told us that the standard of care they received was good. Comments included, "the home is excellent", "I feel I can talk to all the care and nursing staff on an equal footing". Relatives spoken with praised the staff team for the quality of care provided. They told us that they had every confidence that their relatives were safe and protected from harm and enjoyed a very good quality of life. One person told us, "the care is wonderful, just wonderful".

The service had a range of policies and procedures which helped staff refer to good practice and included guidance on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This meant that staff were able to help and support people who had difficulty in making decisions and ensured that plans were put in place in the persons best interests. The manager was part of a group linked to the local authority considering best practice in this area.

There was a flexible menu in place which provided a good variety of food to people using the service. People living there told us that the food was excellent and they had a wide variety of food choices. The home promoted themed days where the food and menus were matched to the activities of the day, for instance French day where the menu would be in French and people may reminisce about places they had been on holiday and carry out activities that matched the place.

Staff members we spoke with were really positive about how the home was being managed and the registered manager spoke positively about how passionate her staff team were in providing a high standard of care to everyone living in the home.

The registered manager looked for opportunities for the service to be involved in recognised areas of good practice and new ideas, such as the 'Hear to Care' project as well as working in conjunction with the local authority and the local community. She consistently looked for different ways in which to gain feedback about the service to ensure that people living in the home were involved in their care as well as the running of the home.

There was an internal quality assurance system in place to review systems and help to ensure compliance with the regulations and to promote the welfare of the people who lived at the home. This included audits on care plans, medication, accidents and complaints.

The home was well-maintained and clean and provided a calm, relaxing atmosphere. There were a number of maintenance checks being carried out weekly and monthly. These included the proper operation of window restrictors, water temperature as well as safety checks on the fire alarm system and emergency lighting. These were audited and then an additional check was done by the corporate provider every six months. Individual fire safety risk assessments were also completed for each person and these were kept in the care files and a summary was included in the fire safety book located by the front door of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff know how to recognise and respond to abuse. We found that safeguarding procedures were in place and staff understood how to safeguard the people they supported. People staying at the service felt safe and had no complaints.

The provider had effective systems in place to manage risks without restricting people's activities. Risk assessments were detailed and kept up to date to ensure people were protected from the risk of harm.

The arrangements for managing medicines were safe. Medicines were kept safely and were stored securely. The administration and recording of when people had their medicine was safe.

Recruitment records demonstrated there were systems in place to help ensure staff employed at the home were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff members had received regular training and they confirmed that this gave them the skills and knowledge to do their jobs effectively. Staff had access to external training and group supervision where they could reflect on specific areas of practice.

People's nutritional needs were assessed and monitored and the service sought to present food in different, interesting ways through the use of themes days that were linked to activity days.

The service had a range of policies and procedures which helped staff refer to good practice and included guidance on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People were supported to live their lives in the way that they chose. They were placed at the centre of decision making and the legal requirements regarding consent to care were met.

Is the service caring?

Good

The service was caring.

People living at Mount Hall confirmed that they were well cared for and were treated with kindness and compassion and maintained good relationships with the staff.

Visiting relatives were positive about the standard of care, the staff and the atmosphere in the home.

The staff members we spoke to showed us that they had a good understanding of the people they supported and they were able to meet their various needs. We saw that they interacted well with people in order to ensure that they received the care and support they needed.

Is the service responsive?

Good

The service was responsive.

People's care and support was planned proactively in partnership with them and where appropriate their family and other professionals. We could see that people had been consulted and felt listened to in terms of the care that they received.

The arrangements for social activities were good and focused on providing stimulating activities for both mind and body. Feedback was continuously sought on activities and staff provided evidence in care plans after each activity as to whether the person had engaged and enjoy each activity. This enabled staff to observe as well as gain verbal feedback on people's enjoyment of the various activities.

The provider had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. We looked at the most recent complaints and could see that these had been dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

The registered manager had robust and effective systems in place to assess and monitor the quality of the service, the quality assurance system worked to help to develop and drive improvement.

The manager operated an open and accessible approach to both

staff and people living in the service and actively sought feedback from everyone on a continuous basis in order to improve the service. The staff all said that they could raise any issues and discuss them openly within the staff team and with the registered manager.

There was an emphasis on continually striving to improve. The manager had carried out a number of surveys to gather opinions. Mount Hall also had a residents' involvement group where people could feedback their views and they operated a 'resident of the day' system whereby that person was visited by all departments in order to gain their views on all aspects of the home.

Mount Hall Nursing Home

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 23 February and was unannounced. The inspection was carried out by two adult social care inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit. We invited the local authority to provide us with any information they held about Mount Hall Nursing Home. The local authority confirmed they had no concerns.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We spoke with a total of seven people living there, five visiting relatives, a visiting hairdresser, the corporate trainer for the home and seven staff members including the clinical services manager and the manager.

Throughout the inspection, we observed how staff supported people with their care during the day.

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 to us.

We looked around the service as well as checking records. We looked at a total of four care plans. We looked at other documents including policies and procedures. Records reviewed included: staffing rotas; risk assessments; complaints; staff files covering recruitment; training; maintenance records; health and safety

checks; minutes of meetings and medication records.

Good

Is the service safe?

Our findings

Although we did not receive any specific comments regarding whether people felt safe the people we spoke with told us that they liked living in the home and we did observe relaxed and friendly relationships between the people living in Mount Hall and the staff members working there. Comments included, "the home is very good", "the home is excellent", "I'm happy with the home", "I'm very pleased with the place", "it's a lovely place". One relative told us, "we feel very at ease that she's been well looked after and cared for".

We saw that staff were aware of individual needs and people we spoke with felt that they were well cared for. Comments included, "staff are always very helpful, very cheerful", "the staff look after me very well". All the relatives we spoke with stated that their relative was well cared for, comments included, "The home is wonderful, absolutely wonderful", "the home is just unbelievably brilliant".

We saw that the provider had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. The home manager was aware of the relevant process to follow and the requirement to report any concerns to the local authority and to the Care Quality Commission (CQC). We checked our records and saw that any safeguarding or incidents requiring notification at the home since the previous inspection took place had been submitted to the CQC.

Staff members confirmed that they had received training in protecting vulnerable adults and that this was updated on a regular basis. The staff members we spoke with told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. One member of staff told us, "I'd go and see the manager straight away if I was concerned about anyone". Staff were aware of the need to report safeguarding incidents both within and outside of their organisation. We saw that the provider had a whistleblowing policy in place called "Speak up". Staff were familiar with the term whistleblowing and each said they would report any concerns regarding poor practice they had to senior staff. We saw that there was a poster clearly displayed in the staff room with an external number and email to contact if a member of staff had concerns. All staff confirmed that they were aware of the need to escalate concerns internally and report externally where they had concerns. This indicated that they were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to accurately record and report potential incidents of concern.

Risk assessments were carried out and kept under review so the people living in the home were safeguarded from unnecessary hazards. We could see that the home's staff were working closely with people and where appropriate their representatives and other health professionals to keep people safe. For instance we saw that a risk assessment and care plan for one person had been completed in consultation with a physiotherapist. We could see that the home's staff members were working closely with people to keep them safe without unnecessary restriction. For instance we saw risk assessments in all the care plans that we viewed to assess whether people could self-medicate. We saw one care plan, where this was appropriate and this enabled the person to retain a level of independence, which was recorded as being very important to this person throughout their care plan. Relevant risk assessments, regarding for instance falls, nutrition,

pain assessments were kept within the care plan folder.

Staff members were kept up to date with any changes during verbal handovers that took place at every staff change. This helped to ensure they were aware of any issues and could provide safe care. The provider also had 10 minute meetings called "Take 10", an 11am meeting with the heads of department at 11am and a 4pm where information was passed to the care team and we were able to view the notes from that day's meeting. This provided information on any actions that were carried forward from the previous meeting, who was visiting the home that day, resident of the day and anyone that was considered at high risk and what needed to be observed for that person. 'Resident of the day' was a system whereby all the head of department such as catering, maintenance, housekeeping, care and nursing staff would visit that person and request feedback on their specific area to ensure that the person was happy with all elements of their care and they could feedback directly to the people providing that service. All people attending the meeting signed the notes to verify that they attended and knew what had been discussed.

We looked at the files for three most recently appointed staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks has been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held a photograph of the employee, suitable proof of identity, an application form as well as evidence of references and notes from the interview showing that people had the relevant experience to carry out their roles.

We saw the provider had a policy for the administration of medicines, which included controlled drugs, the disposal and storage of medicines and for PRN medicines (these are medicines which are administered as needed). Medicines were administered by staff who had received the appropriate training. We saw both the medicines trolley and the treatment rooms were securely locked. We checked the medicine arrangements and observed medicines being dispensed. We saw that the practices for administering medicines were safe. We observed the nurse watching that pills were taken and then fully completing the Medicine Administration Record (MAR) sheet. We checked five MAR sheets and could see that the records showed people were getting their medicines when they needed them and at the times they were prescribed. This meant that people were being given their medicine safely. We saw clear records were kept of all medicines received into the home, administered and if necessary disposed of. Controlled drugs were stored securely and in the records that we looked at these were being administered and accounted for correctly.

On the day of our visit, there were 30 people living in the home. There were two nurses and 5 carers on duty between the hours of 8.00am and 2.00pm, two nurses and four carers on duty between 2.00pm and 8.00pm and one nurse and three carers on duty between 8.00pm and 8.00am. The registered manager and clinical services managers were in addition to these numbers. We looked at the rota and could see that this was the consistent level. The home manager advised that they used the dependency assessments that were completed during the pre-admission assessment to complete a staffing dependency assessment in order that the staffing levels were sufficient to meet the needs of the people living in the home at the time and this was reviewed regularly.

In addition to the above there were separate ancillary staff including a catering manager or assistant chef, cook and kitchen assistant and hostess. There was a hotel services manager and three domestic assistants cleaning the home and dealing with the laundry. There was also a maintenance staff member and an administrator and two part time activity co-ordinators.

On the days of our inspection, our observations indicated that there were enough staff on duty as call bells

were being answered promptly and staff were going about their duties in a timely manner. People living in the home told us, "nursing staff - occasionally they are short during the day but they are very reliable. Sometimes if the care staff are sick, the nurses will step in and take on the job", "calls are responded to quickly, except on one or two occasions when staff were busy", "staff respond quickly to calls usually", "the call bell is answered very promptly". One relative told us, "there are always enough staff on duty".

From our observations we found that the staff members knew the people they were supporting well. They could speak knowledgably about the people living in the home, about their likes and dislikes as well as the care that they needed. There was an on call system in place in case of emergencies outside of office hours and at weekends. This meant that any issues that arose could be dealt with appropriately.

The provider had received a five star rating in food hygiene from Environmental Health on 17 April 2014. The registered manager informed us that they had just received the same rating but had yet to receive the updated report.

We conducted a tour of the home and our observations were of a clean, fresh smelling environment which was safe without restricting people's ability to move around freely. The atmosphere in the home was calm and staff members were going about their roles in a professional and timely manner. We observed staff maintaining hygiene by the use of specific aprons when entering and leaving the kitchen area. The domestic staff wrote in the daily notes for each person what they had cleaned within the room and when towels and bedding had been changed. One person told us, "my room is cleaned out properly, I'm happy with the cleanliness". A relative commented that "the home is so clean".

We checked some of the equipment in the home, including bath hoists and saw that they had been subject to recent safety checks.

We found that the provider kept a nominal roll by the front door which included a quick guide of the level of assistance needed by each person if the home had to be evacuated in an emergency such as a fire. This provided details of any special circumstances affecting the person, for example if they were a wheelchair user. This was updated weekly to ensure that it was an accurate record of who was living in the home.

Good

Is the service effective?

Our findings

All the people living at the home that we spoke to and their family members felt that their needs were well met by the staff who were caring and knew what they were doing. Comments included, "they treat me extremely well", "the food is excellent, we get a nice balanced diet and it's well-cooked. If I don't fancy something, they'll give me an alternative", "they treat me extremely well and see to what I need". Comments from family members included, "staff by and large seem very good and responsible", "he is happy here", "we can't fault the staff at all, they are good with my mum and lovely with us. The lunch looked absolutely delicious and I tried some and it was lovely".

The provider had their own induction training programme that was designed to ensure that any new members of staff had the skills they needed to do their jobs effectively and competently. We looked at the induction records for three newly appointed staff members and could see that it was based on the Care Certificate Framework, a nationally recognised and accredited system for inducting new staff. The person would complete a maximum of five days induction in a classroom which included one day visiting the home to observe. The induction covered areas such as moving and handling, safeguarding, dementia awareness, fire safety, challenging behaviour and person centred care. Once this was completed and prior to starting work on shift, they would shadow existing staff members and would not be allowed to work unsupervised for a period. Shadowing is where a new staff member works alongside either a senior or experienced member of staff until they feel confident enough to work on their own. We could see from the staff rota that two members of staff were shadowing on the day of our inspection and they were in addition to the seven staff members delivering care. One staff member we spoke to said "I shadowed three days last week and I'm doing three this week before starting work". We spoke to the trainer for the provider and they confirmed that dependent on the role, staff may be provided with additional training as part of their induction for instance medication if they would be administering medicines and all staff had to complete a food hygiene workbook within three months of commencing in role.

We asked the trainer and staff about training and they all confirmed that they received regular training throughout the year, they also said that their training was up to date. The trainer advised that the training was monitored via a computer system, which flagged immediately to the manager is someone's training was about to go out of date in order that plans could be put in place to refresh that particular training need. We subsequently checked the staff training records and saw that staff had undertaken a range of training relevant to their role. This included safeguarding, moving and handling, nutrition and hydration, mental capacity and DoLS and behaviour that challenges. One staff member told us, "there is plenty of training". We saw notices in the care office for staff to access additional training outside of the organisation for instance that month, there were training courses available on 'practical skills to support breathless patients' and 'syringe driver training'. Staff confirmed that they were encouraged to access this training.

Staff members we spoke with told us that they received on-going support, supervision and appraisals approximately every six weeks. We checked records which confirmed that supervision sessions for each member of staff had been held regularly. The registered manager and staff also told us about group supervision sessions that focused on a particular issue. We saw a notice advertising the session for this

month focusing on thickened fluids. This allowed staff to talk about a particular issue together and learn from one another.

During our visit we saw that staff took their time to ensure that they were fully engaged with each person and checked that they had understood before carrying out any tasks with them. Staff explained what they needed or intended to do and asked if it was alright rather than assuming consent. One person told us, "they always ask me before they do anything". We observed a staff member helping someone to mobilise who was using a walking aid. We noted that they took their time, they did not rush the person and spoke to them during the whole time they were assisting the person. This was carried out in a dignified and respectful way.

The information we looked at in the care plans was detailed which meant staff members were able to respect people's wishes regarding their chosen lifestyle. We asked the people living at the home about their care plans and comments included, "I have a care plan, which is kept on the wall in my room. I have looked at it and am satisfied with the information and there are no gaps from my point of view", "my care plan is reviewed monthly and I have a say for instance on the choice of entertainer". A relative told us, "I'm invited to a review meeting monthly and they make me aware of any incidents". We also viewed correspondence in people's care files informing relatives of the date of the monthly review in order that they could contribute if they wished.

Visits from other health care professionals such as GPs, physiotherapists, chiropodists and opticians were recorded so staff members would know when these visits had taken place and why. We spoke to people living in the service about whether they had access to health services. They told us, "the doctor calls once a week and I can request to see him in one day's notice. He understands my conditions and I understand and discuss my medication with the nurse", "I wasn't sleeping well, but got to see a female doctor who reviewed my medication and I slept for seven hours".

The provider had policies and procedures to provide guidance for staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the home tried to obtain consent to care from the person themselves; if this was not possible because they had been assessed as not having capacity then their family or representative would be consulted to make sure their known preferences and previous likes and dislikes were taken into account when looking to make decisions and provide care that was in the person's best interests.

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the manager had applied to the supervising authority for ten people to be subject to DoLS and they had received authorisation for six of these people. We were able to view the paperwork in relation to both standard and urgent DoLS applications and saw that where they had not received an authorisation, the manager had been in contact with the supervising authority to follow up. We checked two care files and found mental capacity assessments and best interests decisions relating to each specific area had been completed. There was a clear flow diagram on each care plan to clearly prompt staff on the process to follow when looking at

someone's capacity and where if necessary a best interest decision was needed.

We spoke with staff. They all confirmed that they had received training on MCA and DoLS and they were all able to tell us who was subject to DoLS within the home.

The provider prepared their own food and had a catering manager, two assistant chefs, a cook and two catering assistants and one hostess that were employed by the service. The menu provided a good variety of food to the people using the service. The home followed a four week flexible menu that was called the principle menu that was set by the corporate provider. We saw that the dining room had a menu which exhibited a number of choices for lunch and evening. People were asked what they wanted at every meal time. Special diets such as gluten free and diabetic meals were provided for if needed. Staff members we spoke to confirmed that people could request an alternative option such as an omelette if they did not like the meal of the day and this was recorded on the menu choices form. The people using the service told us, "As I have difficulty swallowing, I need all my food well mashed or in liquid form and they meet my needs well and there is a choice of main course", "the food is good, the kitchen staff call every day to take an order from the menu", "I can get a packed lunch if I have an outside appointment at lunch time", "meal times suit me personally". Whilst we did receive two negative comments about the timing of mealtimes and food choices that remained on the menu that people didn't like, we could see that in the evening the provider had a 'nite bite menu' which was pictorial; these were light snacks that staff could prepare outside of the designated meals time or later at night if people wished and the choices on the menu were varied.

The registered manager told us that they also host themed days where the food is linked to the activities of that day, for instance if they have a French day, the menu will be in French and people can reminisce about holidays spent in that country. We saw photograph displayed on the wall in the downstairs corridor of activity days where everyone appeared to be enjoying themselves.

We observed lunchtime in the home and saw that the food looked tasty and appetising and was well prepared. The tables were set with cloth napkins, table cloths, cutlery and flowers so the meal times were distinguished from other times of the day when the room was used for different activities. Staff were wearing protective aprons when handling and serving the food or entering the kitchen area. We saw that staff offered people drinks and they knew people's preferences and choices. Staff were attentive and there were a number of staff on hand observing lunch, for instance the hostess was available generally to help and assist in the capacity of a waitress, whereas care staff were available to people needing support with eating. These people were assisted by staff members in a patient and unhurried manner. Staff were chatting to people eating as they were moving through the dining area and prompting people and checking that people were ok throughout the mealtime. Staff took the time to explain to people what the food was and asking permission before helping someone.

We saw that staff used the Malnutrition Universal Screening Tool to identify whether people were at nutritional risk. This was done to ensure that people weren't losing or gaining weight inappropriately. On the care files that we looked at, this was being reviewed on a regular basis. This was also monitored through the home's on-going auditing systems.

We saw staff offer drinks and that they were alert to individual people's preferences and choices in this respect. We saw in care plans that where someone was identified at being at high risk additional monitoring of fluid and food intake was undertaken. We viewed these records and they were up to date and detailed as they included very clear pictorial guidance to staff as to how much fluid an average glass or jug would contain and the optimum amount that the person needed. People living in the home told us, "they know my likes and dislikes and keep me topped up with water", "I can request a hot drink any time".

The home was very clean and maintained to a high standard and provided an calm, relaxing environment that met the needs of the people living there. There were two lounge areas; one which was quieter which provided communal spaces for people undertaking different activities.

The provider provided adaptations for use by people who needed additional assistance. This included bath and toilet aids, grab rails and walking frames and sticks to help maintain independence.

The laundry within the service was well equipped and it was neat, tidy and well organised.

Good

Is the service caring?

Our findings

We asked people living in and visiting Mount Hall about the home and the staff who worked there. They all commented on how kind and caring all the staff were. Comments included, "the carers are pleasant and cheerful in their duties, they positively enjoy it", "I feel I can talk to all the care and nursing staff on an equal footing", "staff are kind and patient". Visiting relatives told us, "My mum did not give them an easy ride to begin with and they have been so kind and patient and good with her. We have nothing but praise for this place. This place is just wonderful and has a happy atmosphere", "people are so kind and the home's atmosphere is so nice and the staff are all so good and easy to talk to", "my relative was initially in a small room with a limited view, but the home instigated a move for them to go into a larger, airy room with much improved views".

It was evident that family members were encouraged to visit the home when they wished. People living in the home told us, "My daughter can visit at any time, and she talks to me on my mobile", "I can have visits at any time", "my wife comes and visits regularly, but when my family come, I go home and seem them during the day", "I don't have a mobile but my daughter can ring the staff on the home's mobile to let me know when she is coming". Comments from relatives included, "We can visit at any time. We can have lunch with her and the activities are very good and we can stay and join in. We were here until 10pm last week, there are no restrictions", "they always make me feels welcome and I cannot make any suggestions for improvement".

We viewed cards and compliments that had been sent into the service. One person's relatives wrote, "Dear friends at Mount Hall, thank you all so much for the care and kindness you showed [name] whilst he was with you. Also the welcome I was always given made such a difference to a hard time". Another relative wrote, "To all the wonderful staff at Mount Hall. Thank you so much for the fantastic, dedicated care you have given [name] over the past years and that you continue to give to [name]. We really appreciate all you do".

The staff members we spoke to showed that they had a good understanding of the people they were supporting and they were able to meet their various needs. They told us that they enjoyed working at Mount Hall and had very positive relationships with the people living there. Comments included, "I like working here", "I love it here, Mount Hall is a nice home". The registered manager told us that staff members would often come in on their days off to visit people and one staff member had taken and paid for a day out with someone where they shared a common interest. The manager said of the staff that "they go above and beyond their role".

We saw that the relationships between people living in the home and the staff supporting them were warm, respectful and dignified. Everyone in the service looked relaxed and comfortable with the staff and vice versa. During our inspection, we saw there was good communication and understanding between members of staff and the people who were receiving care and support from them. We saw that staff members were interacting well with people in order to ensure that they received the appropriate care and support from them. Staff took their time with people and ensured that they understood what the person

needed or wanted without rushing them and always seeking their permission before undertaking a task. We observed that staff used a dignified approach to people, for example knocking on people's door before entering and there were signs on each room that people could use stating "do not disturb" for instance when someone was receiving personal care. We observed a staff member stopping to chat with people who had just had their hair done and was complimenting them on how nice they looked.

We undertook a SOFI observation in the dining room over lunch on the first day of the inspection. We saw that staff members were moving around the dining room attending to people's needs and speaking to people with respect and encouraging them to eat their lunch and seeking out whether they needed support.

We saw on the day of our inspection that the people living in the home looked clean and well cared for. For example most of the female residents had had their hair styled as the hairdresser was present on the day of our visit. Those people being nursed in bed also looked clean and well cared for.

The quality of the décor, furnishing and fittings provide people with a homely comfortable environment to live in. They were all personalised, comfortable, well-furnished and contained items of furniture and individual items belonging to the person. People living in the home and their residents commented that they were happy that they were able to personalise their rooms. Comments included, "I'm pleased to be able to put my paintings on the wall", "we can bring in pictures for her and they are put on the wall". There were two lounges, offering people a choice. The one downstairs was the larger of the two with a large television and noisier activities would take place in this room. The quieter lounge housed the home's cat 'Pumpkin' and there was a fish tank in this room and often quieter activities such as bridge club would take place in here. There were books and games available in both rooms for people to use.

The provider had a range of information available for people living in the home available in the reception area. There were leaflets inviting complaints as well as compliments. There was information leaflets about other service the provider had, information about paying for care, East Cheshire Advocacy Service. Forms were also available inviting comments on carehome.co.uk. There were leaflets about hospital services as well as a copy of the latest residents survey, CQC outcomes and a certificate stating that all staff had completed and signed up to Six Steps to Success end of life programme dated 30 September 2015. The provider also had a welcome book for any new person coming to live in the home.

The manager advised that they also had a holistic therapist attending the home each week who had training in palliative care and she would contribute to the good practice that they were following alongside the Six Steps to Success end of life programme. The manager told us that the therapist was able to provide anything from a general massage to reflexology. She was from the local area and would also speak with people living in the home about what was happening in the local community in order that they continued to feel involved in the community outside.

We saw that personal information about people was stored securely in their rooms so they knew who was writing in the plans and they could access this whenever they wanted to. Everyone commented that they felt involved in their plan and people we spoke to knew what was in their care plan and were aware that they could access this at any time.

We found that appropriate 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) records were in place on four of the care files we reviewed. We saw that either, the person, or where appropriate, their relative or health professional had been involved in the decision making process. We found that the records were dated and had been reviewed and were signed by a General Practitioner.

A 'Do Not Attempt Cardio Pulmonary Resuscitation' form (DNACPR) is used if cardiac or respiratory arrest is an expected part of the dying process and where cardio pulmonary resuscitation (CPR) would not be successful. Making and recording an advance decision not to attempt CPR may help to ensure that the person dies in a dignified and peaceful manner.

Good

Is the service responsive?

Our findings

Those people who commented confirmed that they had choices with regard daily living activities and that they could choose what to do, where to spend their time and who with. Comments included, "I please myself in getting up and what to do. I can ask a carer to help with a shower and rubbing my back", "I can go out onto the grounds around the home with a carer", "staff know me well and what I need to stay well. I usually go for a walk each day and they always offer to come with me, but I like to go out by myself".

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. As part of the assessment process the home asked the person's family, social worker or other professionals who may be involved to add to the assessment if it was necessary at the time. We looked at the pre-admission paperwork on the four care plans that we viewed and could see that assessments had been completed. One family member commented on this process, "They came out to visit before Mum came in and involved us and really put my Mum at ease. Mum felt very at ease and very well informed before she moved in". The registered manager told us that they have a welcome book for anyone coming to live in the home and some of the people already living in the home will go and meet and greet people during the settling in period in order to make people feel at home.

We looked at the care plans to see what support people needed and how this was recorded. We saw that each plan was personalised and captured the needs of the individual. We also saw that the plans were written in a style that would enable a staff member reading it to have a good idea of what help and assistance someone needed at a particular time. The plans included a summary sheet 'what does a normal day look like?' at the front which gave a quick overview of key risks for that person and the main likes and dislikes and what care they needed and much more detail was provided in the relevant section of the care plan. The care plans included an assessment of people's physical health as well as their mental health as people were assessed against a geriatric depression scale and plans put in place to try to alleviate social isolation whilst respecting people's wishes in relation to privacy. All the plans we looked at were well maintained and were being reviewed monthly so staff would know what changes if any had been made.

We spoke to a visiting relative who told us, "I feel informed, the nurse rings me after the doctor's visit with my Mum if any medication has been prescribed".

The four care plans we looked at contained detailed information regarding background history to ensure the staff had the information they needed to respect the person's preferred wishes, likes and dislikes. For example the food the person enjoyed, where they had lived, holidays they had enjoyed, what they preferred to be called, preferred social activities, people who mattered to them and it was recorded on each care plan whether the person had any preferences for male or female carers. We asked staff members about several people's choices and the staff we spoke with were knowledgeable about them.

The provider employed two part-time activity co-ordinators who worked 28 hours a week in total. Their job was to help plan and organise social or other events for people. The people using the service were asked what kinds of activities they liked to do during the assessment and care planning processes. Two people we

spoke to commented that they had been involved in giving their views on the activities. The manager advised that she had recently undertaken a specific survey on activities in February and we were able to view some of the comments. Comments included, "I enjoyed everything and am happy with the entertainer", "the harpist was great", "I feel most activities are covered". We saw on the care files that each activity that the person attended was recorded and whether the person had enjoyed this activity. Staff then had to provide evidence as to how they had reached this conclusion, for instance "X really enjoyed the varied music, he was singing along and tapping his feet and feedback from him afterwards was 'excellent'". All the comments were then reviewed each month and an assessment as to how much involvement the person had in the activities in the last month was recorded. Residents also were able to comment via the residents involvement group where issues such as food and activities were discussed. All the residents that we spoke to were aware of the committee and a number of them were active in this committee.

We saw newspapers available in the reception area as well as books and puzzles and games in the lounge areas for quieter activities. There was a poster in the reception area advertising activities each week ranging from news review –what's in the papers, card making, flower arranging, horticultural therapy, cinema club as well as posters advertising the out and about club which consisted of impromptu outings each day at any time, a book, literature and poem group and bridge group. On the day of our inspection we observed a flower arranging session taking place in the large lounge and everyone participating appeared to be enjoying this. The bridge group was facilitated by a local volunteer who came into the home and also was able to talk to people about the local area. The book group was supported via the activity co-ordinators as well as a volunteer from the local WRVS (now known as the Royal Voluntary Service). The manager told us that she felt it was important to have links to the local community in order that people living in the home did not feel isolated. A horticultural therapist and pet therapist also visited the home every two months in order to provide activities that were stimulating and targeted at older people.

We saw a copy of the resident involvement charter displayed encouraging people living in the home, their relatives and advocates to be involved in a number of areas including planning for their care, joining residents groups and activities, being consulted on changes to the home environment, completing internal surveys and participating in staff recruitment interviews.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. Copies of leaflets were available in the reception area and there was a poster explaining how to feedback any comments. We looked at the five complaints that had been received in 2016 and could see that these had been dealt with appropriately. One person we spoke to commented that they had raised a complaint but "nothing ever gets done", however their relative told us that "after all he has said he is happy here. This person was encouraged to raise their concern with the registered manager and we spoke with the manager regarding this. Everyone else was clear that they could speak to the registered manager should they have any complaints or issues.

Good

Is the service well-led?

Our findings

There was a registered manager in place and they had been in post since September 2013. The manager told us that information about safety and quality of the service provided was gathered on a continuous and on-going basis via feedback from the people who used the service and their representatives, including their relatives and friends, where appropriate. They 'walked the floor' regularly in order to check that the home was running smoothly and that people were being cared for properly. The manager also told us that she got involved in delivering care and assisting people with eating on some occasions as she was a trained nurse. The manager conducted regular night spot checks and walked through the entire home each morning. Call bell response times were reviewed daily and the clinical services manager had a morning checklist that they completed each day which included looking at the resident of the day, staffing and checking short term plans. We asked the people living in the home how it was managed and run. Comments included, "I don't think it could be better", "I don't know what could be improved in the home", "it's good here, I can't really complain", "The quality of life is very good. There is no place like home, but this is the next best thing". We spoke to relatives and they told us, "it generally clean and well-run", "I cannot make any suggestions for improvement".

People living in the home and families told us residents and relatives meetings were held by the registered manager. We were able to view the minutes from the last meeting held on 26 January 2016. Issues discussed included, staffing, improving the Wi-Fi service in the home, when care plan reviews were taking place, maintenance and food issues. There was a note on the minutes in larger font encouraging people who needed this in large print to request this.

The provider also had a residents' involvement group. Everyone we spoke to was aware of the residents' committee and the people that commented on their involvement told us, "I'm a member of the staff and residents' committee where issues are discussed. I raised an issue about activities and I was listened to and some improvement resulted", "I'm on the committee and was involved in giving views on the activity programme". The manager informed us that previously there had been two groups for feedback on food and activities; however she wanted the people living in the home to be more involved in all aspects of the home so she combined the meetings into one involvement group that meets every month. She informed us that the group have contributed to choosing the new furniture and decoration in the lounges and she wanted them to be involved in recruitment of staff to the home. She advised that whilst people had been involved in the recruitment of new staff previously that there is no-one at present who felt that they wanted to get involved in this area.

The manager produced a newsletter for the home, which included the latest news about the home and upcoming events as well as projects that would be happening in the home, photos from recent events and a crossword and a 'dates for your diary' section.

In order to gather feedback about the service being provided, the provider completed a residents' survey annually. We looked at the resident report for 2015 and could see that it contained a number of questions such as 'thinking about your care home overall, how satisfied as you with it?', people were asked to rate the

following, whether they received privacy, quality of care they received, staff are available when I need them'. They were also asked to comment on the food, activities, general environment, their involvement in the home, whether they knew the home manager and senior staff and could approach them. The survey found there was 100% overall satisfaction and comments included 'excellent care, quite happy with everything', 'staff are very nice', 'staff very kind and helpful'.

The manager also told us that she produced an additional survey specifically on activities as this was an area identified for improvement in the overall residents' survey. We were able to view the survey and further detail regarding this is contained in the responsive section of the report.

The manager informed us that Mount Hall applied and has been chosen to take part in the "Hear to Care" project and they have received funding for the one year project. The project is in conjunction with the NHS and looks at pinpointing hearing loss at an earlier stage. They have had two meetings already where people living in the home and their relatives can come along and use the equipment to see if they have any hearing loss or if there are any early warning signs of hearing loss. They can also be referred to the audiology unit if necessary.

The manager informed us that she volunteers and sits on a committee in conjunction with Cheshire East Council in relation to DoLs and MCA. The aim of the group is to share good practice and at the last meeting, they reviewed information that is produced to give to relatives and friends explaining DoLS and MCA to improve awareness.

The manager told us that the service has been assessed to provide placements to student nurses from Staffordshire University. At present they do not have anyone in place as the person who trained to be the mentor to the students left the service after completing the training, therefore they are looking to train another member of staff. The manager felt that this would be beneficial for nurses starting out on their training to gain valuable insight into looking after older people as well as benefiting the home as they could share current best practice and experience from the University.

Mount Hall had its own internal quality assurance system in place. The clinical services manager conducted a weekly clinical risk review where all the medication was audited, all new and re-admissions were reviewed as well as the care plans relating to nutrition, GP referrals, tissue viability, falls, incidents, DoLS, and DNACPR. We looked at a sample of these and could see that they were being carried out by the clinical services manager and any issues were being acted upon.

The provider also had a corporate monitoring system where they received a visit each month from the quality assurance manager and area manager and they produced a monthly report identifying any areas for improvement. We were able to view the last available report which looked at areas such as first impressions of the home, DBS checks and personnel files, duty of candour files, complaints, care plans, staffing, kitchen, laundry, medication, infection control, resident involvement, maintenance, training, observations of the standard of the environment and staff knowledge of issues such as speak up, fire, complaints and safeguarding. They then produced a report about what corrective action was needed and by what date.

In addition to the above, there were also a number of maintenance checks being carried out weekly and monthly. These include the water temperature, equipment such as wheelchairs and bedrails, the proper operation of window restrictors as well as safety checks on the fire alarm system and emergency lighting. We saw that there were up to date certificates covering the gas and electrical installations, portable electrical appliances, any lifting equipment such as hoists and the lift. The home had a continuity plan in case of an incident where everyone would need to be moved out of the home. The maintenance manager told us that

all the paperwork is then subject to a bi-annual review by the corporate monitoring team which provides a further audit trail.

Staff members we spoke with had a good understanding of their roles and responsibilities and were positive about how the home was being managed and the quality of care being provided and throughout the inspection we observed them interacting with each other in a professional manner. We asked staff how they would report any issues they were concerned about and they told us that they understood their responsibilities and would have no hesitation in reporting any concerns that they had. They said that they could raise any issues and discuss them openly with the registered manager. Comments from the staff members included, "Jane is very approachable", "the home is well-managed, we have a good staff team and look out for one another and help care staff is it's needed", "the home is well managed, we try and work around what people want and I get on with Jane".

The staff members told us that regular staff meetings were being held and that these enabled managers and staff to share information and/or raise concerns. During our inspection we viewed minutes from past staff meetings and saw that these were being held on a regular basis. Staff had opportunity to discuss a variety of topics including staffing and issues around the home.

Periodic monitoring of the standard of care provided to people funded via the local authority was also undertaken by Cheshire East's Council contract monitoring team. This was an external monitoring process to ensure the service meets its contractual obligations to the council. We contacted the contract monitoring team prior to our inspection and there were no concerns highlighted.

As part of the inspection, all the folders and documentation that were requested were produced quickly and contained the information that we expected. This meant that the provider was keeping and storing records effectively.