The Boyne Care Home Limited

The Boyne Residential Care 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 Boyne Residential Care Home provides personal care to 25 people with dementia care needs. The service has 19 single bedrooms and three twin bedrooms. Those in the twin rooms have made a positive choice to share a bedroom.

At the last inspection on 23 and 24 November 2015, the service was rated Good.

At this inspection we found the service was Good.

People felt safe living at the service. People were safeguarded from the risk of abuse and staff knew the action to take if they had any concerns. There were enough staff available to meet people's needs and staff recruitment procedures were followed to ensure only suitable staff were employed. Risks were assessed and plans put in place to minimise them. Infection control procedures were being followed and the service was clean and fresh throughout. Systems and equipment were serviced at the required intervals and were maintained to keep them in good working order. People knew about their medicines and these were being managed safely. The provider was open to learning from incidents to improve practice.

People's needs and wishes were ascertained before they came to the service and the provider used up to date technology and followed good practice guidance and relevant legislation to drive up standards and practice in the service. Staff training needs were identified, they undertook recognised qualifications in health and social care and received ongoing training to provide them with the skills and knowledge to care for people to a good standard. People's dietary needs and preferences were identified and met and there was a good variety of meals available, including those to meet people's religious and cultural needs. People's healthcare needs were identified and they received the input from healthcare professionals as required.

The provider had followed dementia care good practice guidance to redecorate the service and provide a homely, dementia-friendly environment for people to live in. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People, relatives, and professionals were very happy with the care and support staff provided to people.

Choices were offered and met and staff were respectful and maintained people's privacy and dignity. Staff had a good knowledge of people's individual care and support needs which they met in a friendly, kind way and there was a happy, homely atmosphere throughout the service. People's religious and cultural needs were known and respected.

Care records were comprehensive, person centred and reviewed regularly to keep the information up to date. Activities were based on people's wishes and abilities and people enjoyed taking part. There was a complaints procedure in place and people felt confident to express any concerns, however minor, so they could be addressed. End of life care wishes were discussed and recorded so these were known and could be followed.

The registered manager was approachable and responsive and provided good leadership. They continuously strived to make improvements to the care and support people received and to the environment they lived in. The registered manager followed up to date good practice guidance and legislation as well as obtaining the views of people, relatives, staff and stakeholders about the service provision, which they listened to. The provider empowered people by being proactive and educating them about safeguarding, complaints, medicines management and mental capacity.

The service provided good quality care and met all relevant fundamental standards.

Further information is in the detailed findings in the main body of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Boyne Residential Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This was a comprehensive inspection. This inspection took place on 13 and 14 November 2017 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of one inspector 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.

During the inspection we viewed a variety of records including care records and individual risk assessments for three people, the medicine supplies and medicine administration record charts for 11 people and three staff recruitment files. We also viewed risk assessments for equipment, premises and safe working practices, servicing and maintenance records for equipment and premises, complaints and safeguarding records, audit and monitoring reports and policies and procedures. We observed the mealtime experience for people and interaction between people using the service and staff throughout the inspection.

We spoke with ten people using the service, the registered manager, one senior care worker, three care

workers, the activities lead who was also a senior care worker, the chef, the laundry assistant and two visiting healthcare professionals. Following the inspection we requested feedback from five healthcare professionals and received feedback from three of them. We also got feedback from the visiting hairdresser.

Good

Our findings

People confirmed they felt safe at the service. One person said, "I feel safe all the time. My things are safe here too and they look after everything." Another told us, "Everything is fine. I'm safe and so is everything we have here." Processes were in place and being followed to protect people from abuse. Safeguarding policies were available and an 'easy read' large print format was displayed in the service. Safeguarding was discussed at the monthly residents meetings so people were kept informed about recognising and reporting any concerns about abuse. Staff received training in safeguarding and people, visitors and staff were encouraged to speak out about any concerns so they could be addressed. Whistle blowing procedures were in place and staff felt confident to report any concerns and knew to contact the local authority or the Care Quality Commission should the provider not respond to concerns. Monies held on behalf of people were stored securely and records of income and expenditure were maintained.

Staff understood the risks to people and the action to take to mitigate them. One care worker told us, "I make sure people can move safely around their home by looking out for hazards and reporting them straight away and staying up to date with training. Residents are free to go where they want to so we have to make sure it's all safe. I read risks (assessments) so I know how each person is different and what they need to stay safe like having their walking frame in reach, rails in place or to walk slower and supporting them."

Risks were assessed and action plans put in place to mitigate risks. We saw that people had individual risk assessments for any risks associated with the way they lived their lives. For example, for people who went out of the service unaccompanied, this had been assessed and an action plan put in place. We observed staff ensured people carried with them equipment and information such as a mobile phone, contact details for the service and details of any significant health conditions, so the information could be used in the event they needed support to return to the service. Assessments for risks including nutrition, skin breakdown, falls and mobility were carried out and all personal risk assessments were reviewed monthly to keep the information up to date.

Risk assessments for systems, equipment and safe working practices were in place and updated annually, along with the fire risk assessment for the premises. One care worker told us, "I am a Fire Marshall and we do have regular drills, weekly tests and talk in team meetings about the procedure to evacuate the building safely if we had an emergency. We all know our jobs and the staff support each other by training and doing good drills." Safety checks including for fire safety equipment, water temperatures, window restrictors and fridge and freezer temperatures were carried out and recorded and there was a system of daily, weekly, monthly and three monthly checks for different items of equipment in use, to ensure they were being

maintained in good working order. Staff confirmed that repairs were reported and carried out promptly. A care worker told us, "We know to report everything that is broken or not working as it should. It gets repaired quickly and we don't have to work with a shortage of equipment."

There were sufficient numbers of staff with the right skill mix to meet people's needs. One person said, "There seems to be lots of very nice staff around. I haven't had to wait for anything" and "[Staff] are very kind and there are plenty of them, day or night." A relative told us, "They [staff] seem lovely and there are always plenty of them. You see a lot of one to one going on." There was a team leader with four other care workers in the morning and three care workers in the afternoon on duty to meet people's care and support needs. There were also two activities coordinators and catering and domestic staff on duty during the day. The registered manager worked five days a week and was also on call at the weekend. The activities lead explained that although they usually worked Monday to Friday they would attend at the weekend for specific events and they were happy to be flexible with their time.

Recruitment processes were in place and being followed to ensure only suitable staff worked at the service. Staff completed application forms and curriculum vitae were available, listing the applicants work history, with any gaps in employment being explained. Health questionnaires had been completed. Pre-employment checks included a minimum of two references, one being from the previous employer, a Disclosure and Barring Service (DBS) check, proof of identity including copies of passports and evidence of people's right to work in the UK.

People we asked knew about their medicines. Their comments included, "They bring it at meal times and I know what they are for. I have them on time every time and they are nice when they give them to me" and "My wife and our children know what tablets I have because we all talked about it together with the [care worker]." Relatives were happy with the way medicines were being managed. One said, "This seems very well managed and it is done very discreetly." Another told us, "They bring them and [relative] has them at mealtimes. They explain each time what they are for and they have chatted with me about them and asked if I am happy with it too."

Policies and procedures were in place and covered each aspect of medicines management. Staff only administered medicines if they had received medicines training and the senior care worker on duty demonstrated a good knowledge of medicines management. The dispensing chemist supplied the majority of people's medicines in a 28 day 'pod' blister pack. A description for each tablet was written both on the 'pod' and on the information sheet supplied by the dispensing chemist, so staff could identify each tablet in the pod. Medicines supplied in original boxes and bottles were dated when opened and a tally of the number of tablets in stock was also recorded on medicine administration records (MARs). All medicines were being securely stored and appropriately recorded and signed for.

Information leaflets were available for each medicine a person was prescribed so staff could read them for additional information. We carried out stock checks for six boxed medicines and these tallied with the numbers administered. All the MARs we viewed were completed and there were no gaps in signing. Patient information charts for each person included a recent photograph, allergy information, and a list of each medicine with any specific administration instructions. Charts for identifying where creams were to be applied were in place so care workers had this information when applying them.

Protocols for 'as required' (PRN) medicines were done and these stated when and why each PRN medicine should be given, the dose and frequency. Pain assessments were carried out for people prescribed pain relieving medicines so their pain level was assessed and the efficacy of the medicine could be monitored. One person said, "They have written down the pain killers I have if I need them and they told me to ask right

away if I am in pain."

Where medicines were administered covertly (where a person was non-compliant with their medicine) this had been discussed and written agreements between the GP, pharmacist and provider were in place. The GP reviewed people's medicines every six months and more frequently if changes were indicated. For example, if someone no longer needed regular pain relief this was reviewed and changed to PRN and then, if still not required, was reviewed and discontinued. The pharmacist had recently reviewed people's medicines for potential interactions and the results had been shared with the GP for their input.

Infection control was being well managed to protect people from the risk of infection. One person said, "I like [the service] yes. It feels nice and is clean all the time." Policies and procedures for infection control reflected current legislation and good practice guidance and were being followed. The service was clean and fresh throughout and we saw that cleaning procedures were being followed. Staff completed training in infection control and food hygiene and practiced good infection control, with personal protective equipment including gloves and aprons being available for use when required.

The kitchen was clean and tidy. One of the kitchen staff told us, "I plan everything and keep records for everything. No one is allowed in the kitchen apart from kitchen staff and we wipe down everything in the morning and before we leave with antibacterial spray for infection control. The first thing I do is check fridge and freezer temperatures and record it. I do daily, weekly and monthly checks/audits." A care worker said, "We use gloves, aprons and hand gels and wash our hands after personal care, before lunches and when changing beds. It stops us spreading the infections."

The provider was open to learning from incidents to improve practice. One care worker told us, "Everything is reported and recorded and emergency services, GP's are called immediately. We talk about how we could prevent things happening in meetings and discuss incidents and how we can prevent it or what we can do better when there is an incident." There had been an incident where a change in a medicine dose had not been implemented. This had been highlighted and action taken immediately by the provider to review the supply and management of medicines, and to put a robust procedure in place for staff to follow in order to mitigate the risk of recurrence. Two staff had attended 'falls champion' training provided by the local authority and accident records were monitored and audited by the provider to identify any trends so action could be taken to minimise recurrences.

Good

Our findings

People's needs were assessed prior to admission to the service to ascertain if their needs could be met. One person told us, "We chatted about what I would like and need before I came in and then when I did arrive we updated that together. They have been very respectful so far and ask my permission to assist me each time." Another person said, "I had phone calls and I visited the home with my brother and we had a chat about how I like things." We saw pre-admission assessments had been carried out that covered each aspect of a person's care needs and reflected people's wishes.

The staff followed good practice guidance including that from the National Institute of Clinical Excellence, the Alzheimer's Society, the National Activity Providers Association and the Registered Care Homes Association in the service. They also used recognised assessment tools to assess different areas of a person's care needs, including those for nutrition, pain control and skin integrity. There were four homes that were linked and good practice information was shared between them, for example, when care planning training was given by one local authority this had been shared with the other services and the care plan layout reviewed to better capture people's needs and how to meet them.

The service had access to the internet and people could use this and were able to communicate electronically as well as by telephone. The service had an electronic tablet as well as a laptop computer and staff used these to access information, for example about a specific health diagnosis or activities for people to participate in. Call bells were in place and people were happy these were answered promptly. One person said, "I use the bell if I am in my room and they always come very quickly. I have the bell on my bed or next to it and I can always reach it. They come very quickly day and night."

People and relatives felt the staff were well trained. One person said, "Yes they seem very well trained and professional. They are very kind too." A relative told us, "Yes they are well trained, I feel happy with [relative] being here with them. They are lovely." Staff received training to provide them with the knowledge and skills to care for people effectively. The service had a trainer who attended the service regularly to provide training and updates. They confirmed that the provider ensured staff training was kept up to date. They told us they encouraged staff to discuss the specific behaviours of individuals, so they could explore together and identify the most effective way to help each person.

All new staff had an induction to the service and training in the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Staff had received training in a variety of topics including health and safety, food

hygiene, first aid, dementia care, sign language, dealing with behaviour that challenges and equality, diversity and human rights. Staff received supervisions, both one to one and also in group settings, which were used to provide updates on training and to discuss any areas that had come up, for example, changes in medicines management.

People and relatives were happy with the food. Comments about food included, "Yes I like it. They help me to choose what I would like and tell me what it is. They help me to cut it", "There is a lot to choose from. It is very good quality and well cooked" and "No complaints there. [Relative] gets choice and it always looks and smells good. They cater for special diets with no question." Drinks were available at all times. One person said, "I have a water jug by the bed and they have come to ask about all different drinks throughout the day and evening." Another said, "They are always asking if you would like a drink and the jug is always refreshed." A care worker told us, "We weigh people weekly and monthly. We monitor their food and fluid intake and record so we can see a healthy diet and effective intake of fluids to prevent UTI's (urinary tract infections). We record and monitor if a resident is refusing food and get advice from senior staff and chat with the resident and are encouraging."

People's dietary needs were being identified and met. People's food preferences were discussed and recorded, and included any religious or cultural needs, so these could be met. Nutritional assessments were carried out and care plans were in place where needs had been identified for people. People were weighed monthly and if concerns were identified this was increased to weekly and reported to the GP, so action could be taken to address the situation. The meals were provided by a food company and then heated at the service. A variety of meals were available including 'high density' meals and fortifying meals with butter and cream, both of which were used to provide additional calories for people identified as being at risk of malnutrition. Individual meals to meet people's religious and cultural needs were available.

Pictorial menus were displayed in the dining room so people knew the meals that were available. Additional choices were also available if people did not want the meals on offer. If people had swallowing difficulties they were referred via the GP for assessment and instructions were followed, for example, providing a soft diet and using a thickening agent so drinks were at correct consistency. Staff were available to provide the support and assistance people needed with their meals. The service operated a 'protected mealtime' policy, discouraging visits at mealtimes and ensuring the television was switched off so that people could concentrate on their meal without distractions. The food and drink people consumed was recorded and people's intake was being monitored, so action could be taken if changes were noted, for example, by referring someone to the community dietitian for input.

The provider communicated effectively with other services. For example, we saw where people had been referred for healthcare input, such as arranging GP appointments and communication with the dispensing pharmacist for any changes in medicines management. Changes were recorded and implemented so people received the care they required.

People had access to healthcare professionals including GP, chiropodist, optician and community matron. One person said, "It's all arranged, you don't really have to ask but if you do, it is done very quickly. I see everyone here or in the community like the hairdresser, dentist, podiatrist." Healthcare professionals confirmed that staff knew about people's healthcare needs and that people were referred for care and treatment in a timely way. Their comments included, "The staff are extremely proactive with healthcare management of people using the service", "The home always notify me of new residents or existing ones that need my services" and "The manager or senior team leaders notify the GP surgery or myself they have any concerns with patients and act in a timely manner."

The provider had recently carried out redecoration and refurbishment work on the ground floor and there were plans for the first floor also. The registered manager was a dementia care champion and the work had been planned using good practice guidance for people with dementia care needs. The aim was to provide a familiar environment that people using the service could relate to. Bedroom doors had been painted in contrasting colours and door furniture used so they became the person's 'front door'. Memory boxes were next to some bedroom doors and we saw where pictures of one person in their younger days and other items of memorabilia had been used, to help the person to identify their room. Handrails were painted in contrasting colours to the walls so they stood out and people could see them easily. Bedrooms were personalised and people could bring in possessions to make them homely. One person said, "They have lovely rooms and you can decorate it how you like with all your things around you."

There were wall displays with reminiscence themes, for example, a sweets cabinet, a china cabinet, a post office cabinet, a film wall with posters of classic films that people had chosen and the hairdressing room with a red and white barbers revolving pole outside, all of which were from days gone by and provided orientation and talking points for people. The activities lead had contacted companies and also gone to the Museum of Brands to get historical packaging images to use. The communal dining and lounge areas were uncluttered and the flooring was wood effect non-slip that was easy for people to move over and also to use walking aids on. There was a room where people could receive visitors in private if they did not wish to go to their rooms and visitors could also sit with people in the communal rooms. We saw people could move around easily and enjoyed looking at the wall displays. There was an accessible, secure garden that was well maintained and provided a pleasant area for people to walk around and sit out in.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and DoLS. One told us, "I know the MCA is here to protect everyone and to ensure they get the best care and have their rights met at all times." The staff had carried out 'mini mental' assessments as well as a mental capacity assessment for each person. Where people were identified as possibly not having capacity and could not leave the home independently they had been referred for DoLS assessment. There were 10 people for whom DoLS authorisations were in place. These had been checked for any conditions, such as specific medicines being reviewed monthly, so that the information was included in the care records and action taken to meet the conditions. People were able to move freely around the service and where able, people could go out of the service unaccompanied, or with visitors and staff. If people were not able to sign to agree to their care plans then either their representative with the legal right to do so or two staff signed the care records, to evidence they had involved the person as much as they were able.

Good

Our findings

People were treated with care and kindness by staff and were happy living at the service. Their comments included, "Yes [staff] very attentive so far. They have welcomed me, introduced themselves and made me feel at home. I feel settled and part of the furniture", "Yes they are very chatty and ask how you are and what you have been doing today" and "They are very nice. They do things to make you more comfortable like new cushions if you ask or activities you would like to do." A relative told us, "They are lovely. They do extra things like arrange personal visits to church, bring new activities into the home and make it a happy place." We saw staff spoke with people in a gentle way, getting down to their eye level, listening to them and ensuring they had understood the information they had been given. People were dressed to reflect individuality and there was a very homely feel.

People confirmed that staff had got to know them well and understood how to provide the care and support each person wanted. People were able to make choices about the care and support they received. One person said, "I still choose how I live and make my own decisions and they write things for others in my care plan so we all know how I want things." A relative said, "They are welcoming of everyone. It is so very nice that the home is part of the community. They asked me to advise them on different things like how she manages with her walker, on stairs and personal care. I'm happy they involve me." A healthcare professional said, "I find all the staff to be very caring and efficient. They do their best to keep residents occupied and entertained and I feel they meet the needs of the people that live there." A care worker told us, "Everyone's choices of how they live and spend their time is listened to and we try to make this easy for them by offering activities to suit their interests and make the home inviting, easy to live in safely and stimulating."

Any preferences were recorded, for example, waking and retiring times, the gender of staff providing personal care and food likes and dislikes. Two care workers told us, "Choices and personal requests are listened to like requesting bed times and choosing to eat what they would like and where. Residents are able to go out if they can unsupported and are monitored with use of mobiles" and "Residents choose what they do and where. They are listened to and we treat them as equal people." There was a breakfast bar and people could choose what they wanted to eat, with a range of cereals and cooked breakfast items to choose from. People could choose what they wanted at each meal and staff were available to provide any support and assistance they needed.

Staff received training in dignity, respect and person centred care. They respected people's privacy and dignity and ensured personal care was carried out discreetly so that people felt comfortable receiving their care. Comments from people included, "They knock and they have given me time to find my feet and settle

without pressure or rush. They showed me how to lock my door and windows which makes you feel secure and safe and I feel it is all very dignified", "They knock and they ask if they need to touch me to help me. They explain what they are doing", "They ask me if they can come in and if they need to sit down they ask. Yes we can lock our door" and "They treat you very well. They asked me if I would like a female carer when the male member of staff is on but I said it was fine." A relative said, "They are very respectful and as a family they give you lots of privacy if you would like it during visiting. They are very good at that." Information about people was stored securely and treated confidentially.

People's religions were recorded in the care records. The service had input from representatives of the Baptist Church, Jewish faith, Church of England and Catholic Church. They also had a quarterly visit from the Christian Fellowship and groups came to sing carols at Christmas. The service had an extensive equality, diversity and human rights policy, with information about many different religions and cultures, with specific details of observances and practices for each one. This provided staff with information about the way people's religious and cultural needs were to be respected. Birthday parties took place at the service and people enjoyed celebrating together.

A relative told us, "They visit the church regularly and they do fantastic trips. They do church services here sometimes too at Christmas it is lovely and festive here and they sing, bake and really celebrate birthdays too." The meal provision included individual meals for people with specific religious of cultural dietary needs. The registered manager explained that even when people said they did not have to eat special meals, they would make sure these were available should they want it. The registered manager said that there had been a positive outcome for a person who had been reluctant to eat, but since they had provided a culturally appropriate diet for the person, their appetite had improved and they were enjoying their meals.

Good

Our findings

The provider had done a review of the care plan documentation and there were now five care plan documents that covered all aspects of the person's care and support needs. These were person centred and provided a good picture of each individual, their needs and how these were to be met. The care plans and assessments were reviewed by the key workers monthly and we saw examples where people and, where appropriate, their representatives had been involved in an annual care plan review. This meant that the views of people and their families were sought and included in the care plans and people could change their wishes if they wanted to, which would be recorded. Contact information for Age Concern advocacy services was displayed and people were encouraged to have people to represent them, especially for those with dementia care needs.

Activities took place every day and there were two activities coordinators who led the week day activities, with one of the care workers being identified to lead activities on Saturday and Sunday. The activities lead had undertaken training in activities through the National Activity Providers Association (NAPA) and also read published research and guidance for providing meaningful activities for people with dementia. They had used the materials to assess the ability of each person to identify the style of activities appropriate for each individual. The activities programme was planned to provide a variety of activities that reflected the areas that people would respond to according to their needs. The activities lead was using an online application to develop additional reminiscence activities and life history books for people.

Staff understood the importance of involving people in their care and in providing meaningful activities for people to participate in. One care worker told us, "Everyone's choices of how they live and spend their time is listened to and we try to make this easy for them by offering activities to suit their interests and make the home inviting, easy to live in safely and stimulating." Another said, "The activities are good and we work together and at meetings we can offer suggestions and we do them." The activities lead told us she was given time and money to plan activities felt well supported by the team in their role. The service had also been visited by children from a local nursery school and the registered manager said this had been very successful. Plans were underway to repeat this as both the people at the service and the children had benefitted from their interactions.

Birthdays, significant days and festival days were marked and celebrated at the service. The weekend prior to our inspection Remembrance Day had been marked with displays of poppies, which people had been involved with making, and watching the television coverage of the Remembrance Day events. People confirmed that they enjoyed the activities and their comments included, "I like drawing and making things

and I like to bake. We go on trips and visits. We go to parks a lot and to the shops", "There are lots of things going on all the time. I like to potter and there is always something. I like the movies, going to the shops, parks and places" and "I like to garden and do crafts and there are always things like that going on. I like music too. I like going to the garden centre." A relative said, "There is always something going on and sometimes more than one thing at a time." Outings were arranged including a visit to a local theatre to see the pantomime and entertainers also came to the service regularly.

There was an easy-read version of the complaints procedure and this was on display and was also discussed at the residents meetings. We asked people who they would speak to if they needed to make a complaint. One person said, "The management and actually I feel any member of staff would take a complaint very seriously and act appropriately." Another told us, "The management team and they deal with concerns very quickly and they are very reassuring. The manager is such a lovely lady." People and relatives were confident to raise any issues and we saw these were recorded and action was taken to address them promptly.

People and, where appropriate, their representatives were included in discussions about their end of life care wishes. One person said, "I have spoken about my end of life wishes and it was handled discreetly and recorded." A relative told us, "They chatted with me about the importance of dignity and respect during [my family member's] last weeks and his wishes will be met. It's all written down and I am happy with it." 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were seen in people's care records. They had been completed by the GP following consultation with the person or, where appropriate, their representative and were reviewed every six months. A recognised process for end of life care was followed to assess people so their end of life care needs were identified and could be met. Advanced care plans had been completed for some people and we saw that people's wishes had been discussed and recorded. In the borough of Hillingdon 'Coordinate my care' system was in place. Details about the person including their resuscitation status were recorded centrally so the information could be accessed by their GP, paramedics and other healthcare professionals. The registered manager confirmed that the service was part of this scheme.

Good

Our findings

The service 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 2008 and associated regulations about how the service is run. The registered manager and her husband had owned the service for several years and the registered manager took over this role in April 2017 and also had previous experience as the registered manager. They were experienced and knowledgeable about managing a care home.

The registered manager was focussed and receptive throughout our inspection and provided any information we requested promptly. It was clear from our observations and comments received that she communicated well with people, relatives and staff and provided good leadership.

People knew who the registered manager was and were complimentary about her. One person said, "[Manager] is very nice and is always saying hello and asking me how I am. She comes around to us all." A relative said of the registered manager, "Yes she is good. She has an open door approach and has helped me arrange everything with solicitors." People said the registered manager listened to them and responded to any issues raised. One person said, "I feel I can ask her any questions and she asked for feedback during the whole booking in time. She was relaxed but very professional and informative." Another person told us, "They listen to your feedback and [registered manager] tells you what they have done afterwards. She always comes back and gives us news." A relative said, "You can chat with them any time, day or night and they always have time to chat on the phone too. I've never needed to complain but I would if I had to. They do ask for any feedback. She is amazing at helping [relative] and me."

Staff were very positive about the registered manager. One of them said, "[Manager] is fantastic, supportive and discreet, she is a great manager. She helps out all the time and is a good problem solver." Another told us, "[Manager] is brilliant, proactive and supportive. She loves this home as we do. She gets things resolved quickly." Staff also commented about the registered manager's approach to them. Their comments included, "A lovely caring lady and gets things done quickly and fairly" and "She is very nice and flexible. She always has time for you." Staff felt the service was being well run by the provider. One told us, "They work as part of the team and you feel they can be approached at any time. They are always assisting on the floor and everyone knows [registered manager]. The residents and relatives love her." Another said, "It is well run from the top and the team are all supported in everything. It is very good how we are treated with respect. My culture and beliefs are respected too. I feel included and respected."

The registered manager had a recognised qualification in management and had undertaken training in dementia care and was a dementia care champion, providing training to staff in all the homes the provider owned. They attended the local authority meetings for care home providers and said they participated in the meetings and found it valuable to learn about any changes in Hillingdon for health and social care, for example, the 'Red Bag' project being introduced in February 2018 to help people living in care homes to receive quick and effective treatment should they need to go to hospital in an emergency. They also attended some of the Skills for Care registered manager network meetings held at the local authority and found these were good for sharing experiences and receiving training information and updates. The registered manager was knowledgeable about the service and they worked well with the staff team to provide quality care and support to the people living there.

The provider had a system of monthly audits that covered all areas of the service and these were carried out and action taken to address any shortfalls identified. The registered manager had put together a document entitled 'Quality Assurance Assessment Summary' and this included everything they had done to improve the service and the care provision in 2017. The document evidenced why work had been identified and what had been done. For example, the refurbishment in line with dementia care guidance, review of the care records paperwork and bringing in new care plans and a daily activity report, to better capture and record information that was person-centred and easy for staff to read and get up to date with when they had been off duty. The service had been inspected by the local authority quality assurance monitoring team (QAM) in February 2017 and at the follow up visit in May 2017 the service had addressed all the shortfalls identified at the QAM first visit. We saw that these improvements had been maintained during our inspection.

The provider offered two week work experience placements for European students to come and learn about aspects of the service. They also took school students over 16 years with an interest in studying medicine to do voluntary work at the service once a week over a period of a year and then provided them with a statement of the work they had completed. These students were also able to apply to work at the provider's nursing home to gain further experience. The registered manager said all relevant recruitment checks and training were completed prior to the student working at the service, so they were safe to do so. The registered manager said she always suggested the students do some research prior to their placement, for example, reading on the Alzheimer's Society website to have some understanding of dementia care.

We asked people how they were kept informed about what was happening in the service. One person said, "They tell you and remind you and they have a big noticeboard. We have meetings and they listen to our views and suggestions." A relative told us, "They have meetings and teas and events for relatives and residents and they send you the dates and minutes of meetings and we discuss things like outings, events, food and they do listen and write everything down and then they tell you how they are acting upon this."

A residents meeting was held every month. At each meeting the activities lead would go through a series of easy-read booklets that provided people with information about aspects of their care and support, and also about how to raise concerns. The areas covered included 'how to express my choice', a booklet explaining each aspect of being able to make choices for themselves, 'safety of medicines in care homes', 'deprivation of liberties safeguards', 'complaints' and 'safeguarding'. People were able to tell us about the different aspects of their care covered at these meetings and it was apparent that the information had been imparted in a way that they understood and retained. People were also asked their opinion about the service and for input on any changes taking place, for example, with the recent redecoration and the 'film wall'. Relatives meetings were held every six months and minutes were taken and shared. Relatives were informed about current projects, both in-house and information from the local authority provider meetings, to keep them up to date.

Satisfaction surveys had been carried out for people, relatives and stakeholders and the results were all positive. Any areas where an issue had been identified had action plans in place, for example, ensuring people were introduced to the registered manager at each meeting so they remembered who they were. People we asked were clear who the registered manager was and this showed they had retained the information. We asked people and relatives for examples of the good things the home does. Comments included, "They are very good at organising and the move in was stress free and straight forward", It is homely and there is always a lot going on", "They are very caring and it is always like that with a lovely atmosphere", "Everyone seems so happy and approachable" and "They keep relatives informed and a part of people's lives and you can pop in whenever you like." We asked what the service could do better and comments included, "Nothing as yet", "It is all very good" and "I'm finding it hard to think of anything."

The registered manager carried out night spot checks and recorded the findings, actions taken at time of the visit and any areas for discussion at the next team leaders meeting. There had been three spot checks in 2017. Monthly staff meetings took place and part of the meetings was to reflect on any events that took place and learn from them. The registered manager incorporated current good practice guidance and relevant legislation in staff meetings and training so staff were kept informed. One care worker said, "We have recently discussed the new KLOEs in staff meetings and how we use them. We do need to be aware and we always are of any changes. This comes from the good management." The KLOEs are the key lines of enquiry as part of the Care Quality Commission's assessment framework that are used to answer the five key questions we ask of providers.

Policies and procedures had been reviewed in 2017 and evidenced the legislation and good practice guidance relevant to each document. Notifications were submitted by the service for any notifiable incidents and the provider was signed up to receive Care Quality Commission newsletters to keep up to date with any changes or other relevant information.