Bupa Care Homes (CFHCare) Limited

Meadow Bank Care Home

Inspection report

Meadow Lane
Bamber Bridge
Preston
Lancashire
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Tel: 01772626363

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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

This inspection took place on the 8, 9, & 10 November 2016 and was unannounced. Meadow Bank Care Home is registered to provide care for up to 110 older people including people living with dementia and people who require nursing care in four single storey units. Accommodation is in single fully furnished bedrooms and each unit has assisted bathing facilities, dining and lounge areas. The laundry services and kitchen facilities are centrally located within the administration block and main reception area.

There was a manager in post who had submitted an application to the Care Quality Commission to be registered as the manager for the service. The registration requirements for the provider stated the home should have a registered manager in place. 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 last inspection on 15 & 16 July 2014, we found the service was meeting the regulations that were applicable at the time.

During this inspection we found the service was meeting the current regulations.

People using the service told us they felt safe and well cared for. People had mixed views about the staffing levels but considered there were enough staff to support them when they needed any help.

The manager followed a robust recruitment procedure to ensure new staff were suitable to work with vulnerable people.

The staff we spoke with were knowledgeable about the individual needs of the people and knew how to recognise signs of abuse. Arrangements were in place to make sure staff were trained and supervised at all times.

Medicines were managed safely and people had their medicines when they needed them. Regular checks on the management of medicines were carried out and action taken where shortfalls were identified. Staff administering medicines had been trained to do this safely.

Risks to people's health and safety were identified and measures had been put into place to mitigate these risks. We asked the manager to carry out a risk assessment on the use of specialist high dependency easy chairs designed for people's comfort as a safety precaution. These were being used by staff and relatives to the same effect as a wheelchair.

We found the premises to be clean and hygienic and appropriately maintained. Regular health and safety checks were carried out and equipment used was appropriately maintained.

Staff followed the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions for themselves. Staff understood the importance of gaining consent from people and the principles of best interest decisions. Routine choices such as preferred daily routines and level of support from staff for personal care was acknowledged and respected.

People using the service had an individual care plan that was sufficiently detailed to ensure people were at the centre of their care. Care files included 'My day, My life' profile of people's needs that set out what was important to each person.

People's care and support was kept under review, and people were given additional support when they required this. Relevant health and social care professionals provided advice and support when people's needs had changed.

We found staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Care plans were written with sensitivity to reflect and to ensure basic rights such as dignity, privacy, choice, and rights were considered at all times.

Activities were varied, interesting and appropriate to individual needs. Links with the local community were good and being further developed.

People were provided with a nutritionally balanced diet that provided them with sufficient food and drink that catered for their dietary needs.

People using the service and relatives told us they were confident to raise any issue of concern with the registered manager and that it would be taken seriously and the right action taken.

People using the service, relatives and staff considered the management of the service was very good and they had confidence in the manager.

There were systems in place to monitor the quality of the service to ensure people received a good service that supported their health, welfare and well-being. Audits were completed regularly and the outcomes were monitored and reviewed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by sufficient numbers of staff who had been carefully recruited and were found to be of good character.

People's medicines were managed in accordance with safe procedures and staff who administered medicines had received appropriate training.

Staff were aware of their duty and responsibility to protect people from abuse and were aware of the procedure to follow if they suspected any abusive or neglectful practice.

Risks to the health, safety and wellbeing of people who used the service were assessed and appropriately managed.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were trained and supervised and were given enough information to care for the people they supported.

Where people lacked the capacity to consent to care and treatment, the principles and guidance around best interest decisions were followed under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and kept under review.

People were supported to have sufficient to eat and drink and to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care.

People's views and values were central in how their care was

provided.

People could be confident their end of life wishes would be respected by staff that had been trained to ensure they were given dignity, comfort and respect.

Is the service responsive?

Good

The service was responsive.

People's care and support plans were person centred and sufficient in detail to ensure they received consistent support from care staff who knew them.

People were provided with a range of appropriate social activities.

People had access to information about how to complain and were confident the manager would address their concerns appropriately.

Is the service well-led?

Good

The service was well led.

People made positive comments about the management and leadership arrangements at the service.

Systems were in place to assess and monitor the quality of the service and to seek people's views and opinions about the running of the home.

Staff had access to a range of policies and procedures, job descriptions, staff handbook and contracts of employment to support them with their work and to help them understand their roles and responsibilities.

Meadow Bank 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 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 8, 9, & 10 November 2016 and the first day was unannounced.

The inspection team consisted of three adult social care inspectors.

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.

We looked at intelligence held on our own systems about the service. This included statutory notifications. A notification is information about important events which the service is required to send us by law. We reviewed safeguarding information and any comments or concerns received. We contacted health and social care professionals and asked for their views on the service provided.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 14 people using the service, six relatives, two senior staff, four unit managers, six care staff, a housekeeper, one agency nurse, one maintenance person, the manager and the area manager. We visited eight people in their rooms to review their welfare monitoring observations completed by staff. We used the Short Observational Framework for Inspection (SOFI).

We looked at a sample of records including ten people's care plans and other associated documentation, four staff recruitment, induction and supervision records, minutes from meetings, medication records, policies and procedures and health and safety audits, staff rotas and training records. We also looked around the premises.

Good

Is the service safe?

Our findings

We asked people using the service about their life at the home, what they did, the staff who supported them, their accommodation and what being safe meant for them. Comments included, "Living here is a great deal better than I expected. I was greatly reassured when I arrived by the pleasantness of the staff and their understanding nature." "Absolutely safe here. I suppose the staff help me feel this as they are very approachable." And, "I use my call bell in the night. They always respond quickly, I have never been ignored."

Some people could not effectively express their views. To help us understand their experiences of living in the home, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Throughout our inspection we did not observe anything that gave us cause for concern around how people were treated. We observed positive staff interaction and people were seen to be comfortable, content and happy in staff presence.

Visitors/relatives also expressed their satisfaction with how their relatives were looked after and supported. One visitor said, "She's much better in here. It gives me piece of mind to know she is safe." Another visitor told us, "I feel that [my relative] is very safe when I leave here. I have no complaints." And another told us "I feel so lucky to have found somewhere my husband is settled and safe."

People we spoke with had mixed views as to the staffing levels. Comments included, "Sometimes there is not enough staff around. I feel they are too stretched" "I do have concerns about staffing. It seems they do not replace people if they call in sick. Sometimes I come in and can't see there are not as many staff working as there normally is." Relatives told us, "On occasions there have been problems with staffing but I feel this is always dealt with effectively and staff are brought in to cover." "The staff are lovely. There is always somebody around. I think they have the amount of staff right." And, "There is always someone present in the lounge at all times. In fact I overheard a staff member this morning say to another, 'I can't leave yet as there is nobody to cover me'."

We looked at how the provider managed staffing levels and the deployment of its staff. We requested three consecutive staffing rotas including the week of inspection. We noted sickness absence was covered by existing staff and agency staff when required. We discussed staffing issues with the manager and area manager. They told us they used a staffing tool that calculated the dependency needs of people using the service. Whilst this was good, it had not taken into account increased activity during the day at specific times, such as early morning and meal times. We had observed people on the Ribble unit were in bed at lunch time and people who had been helped to get up during the morning were served lunch in their lounge chairs. When we asked staff about this we were told there were so many people requiring the assistance of two staff, it was an impossible task to get everybody up and dressed earlier. In order to ensure people were not rushed and their needs were attended to appropriately, some people were assisted to get out of bed after lunch. Staff reassured us every person had their personal care needs met whilst in bed. Following our

inspection we received notification from the manager that extra staff were now deployed at the busier times such as when people needed to get up and during meals.

The provider had robust recruitment procedures designed to protect all people who used the service and ensured staff had the necessary skills and experience to meet people's needs. We looked at the recruitment records of four staff members, two of which had been recently employed at the service. We found checks had been completed before staff began working for the service. These included the receipt of a full employment history, an identification check, written references from previous employers, a physical and mental health declaration and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Regular checks on the registration status and fitness to practice of all nursing staff had been completed. We noted when agency nursing and care staff were being used to cover shifts the home had received confirmation from the agency that they were fit and safe to work in the home.

We noted contractual arrangements were in place for staff, which included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures.

We checked how the provider made sure people were protected from unsafe care by identifying and managing risk to people's health and welfare. Risk assessments were in place and recorded in people's care plans. These were personalised and identified risks involved in delivering people's care safely. We found the standard of risk management plans to be good. They provided staff with guidance on how to manage risks in a consistent manner and included for example moving and handling, use of bed rails, tissue viability, nutrition and falls. A recognised risk assessment tool for the monitoring of malnutrition and skin integrity was in use and where an increase in risk was identified, we saw that appropriate action had been taken. This included for example the provision of specialist equipment such as an air mattress to minimise the risk of developing a pressure ulcer, or referral to an external agency for advice.

Staff had been trained in the safe use of bed rails and moving and handling people. We observed two people being moved around in special lounge chairs designed for their comfort. There was a risk of injury to people's legs and we recommended the use of these chairs to move people be risk managed. The manager told us she would deal with this straight away.

Before the inspection we had received a high volume of safeguarding referrals relating to minor altercations between people who resided on Sabrina unit. We looked at risk assessments for managing behaviours that challenged. We found the attention to detail in managing risk to people becoming distressed in any given situation was relatively good. It was clear from reading risk assessments how people might communicate distress and what trigger signs to look for. One example we saw was the impact of being unable to communicate with others. Risk assessments were kept under review and updated on a regular basis. People funded for one to one support received this level of supervision. We noted information in the PIR however, indicated no staff had received positive behaviour support training. The manager and area manager told us training in this topic was planned for.

We looked at how medicines were managed. There had been five safeguarding alerts in the past twelve months in relation to medicines not being administered appropriately. A monitored dosage system (MDS) of medicines was in use. This was a storage device designed to simplify the administration of medicines by placing the tablets in separate pods according to the time of day. Nursing and care staff who were

responsible for the safe management of people's medicines had received regular training and checks on their practice had been recorded. Detailed policies and procedures were available for them to refer to.

The Medication Administration Records (MAR) charts we looked at were accurate and up to date. The MAR provided information on prescribed items, including a description of the medicines, dosage instructions and a photograph of the person. Staff had instructions on administering prescribed medicines "as necessary" and "variable dose" medicines. There was also information recorded about how people preferred their medicines to be given to them. This would help make sure these medicines were offered consistently.

Medicines were clearly labelled and codes had been used for non-administration of regular medicines. There were records to support 'carried forward' amounts from the previous month which helped monitor whether medicines were being given properly. Medicines that should be dated on opening to help make sure they were appropriate to use had not always had this recorded. The unit managers told us they had recently devised an audit system to support them to identify issues like this more readily. Auditing of medicines had increased to daily, weekly and monthly checks.

Medication was stored securely in designated rooms with appropriate storage for refrigerated items. Appropriate arrangements were in place for the management of controlled drugs which were medicines which may be at risk of misuse. Controlled drugs were administered, stored and disposed of appropriately and recorded in a separate register.

People had consented to their medicines being managed by the service on admission. We observed people's medicines were given at the correct time and in the correct manner with encouragement given to take them as needed. People told us they were given their medicines when they needed them. People said, "I get my medicines on time" and "The staff make sure I have what I'm supposed to have."

Records were kept in relation to any accidents and incidents that had taken place at the service, including falls. The records were reviewed by the manager and follow up action, such as referral to a GP or other health care agency was clearly recorded. Learning from incidents had included for example medicine management. This resulted in a review of the accountability of agency staff undertaking this duty, and further safe handling of medicines training provided for staff to ensure people were kept as safe as possible.

Staff had also been trained to deal with emergencies such as fire evacuation and to support the safe movement of people. There was a key pad access to leave the home and visitors were asked to sign in and out of the home. This helped to keep people safe. One relative we spoke with said, "Security is good here. Very controlled access to premises. You have to buzz to be let in and out."

We looked at the arrangements for keeping the service clean and hygienic. People raised no issues about the cleanliness of the home. People said, "The staff work very hard to keep this place clean" and "The home is very clean." We found most areas that we looked were clean, however we noted two bed rail protectors was visibly dirty. We raised this with the unit manager who told us staff were instructed to wipe up any spillage as they occurred and addressed our concerns immediately.

We noted staff had access to personal protective equipment (PPE) such as hand gels, paper towels, disposable gloves and aprons throughout the home. This ensured staff were able to wash their hands before and after delivering care to help prevent the spread of infection and we noted staff had been trained in infection control. One person was being barrier nursed in their room.

There was sufficient equipment to launder and maintain people's clothes and different coloured bags were

used to separate contaminated waste and laundry. Domestic and laundry staff worked each day and cleaning schedules and sufficient cleaning products were available. The environmental health officer had given the service a five star (maximum score) rating for food safety and hygiene. Most of the staff had completed Food hygiene/handling training.

Environmental risk assessments and health and safety checks were completed and kept under review. These included for example, regular checks in relation to fire, health and safety and infection control. Emergency evacuation plans were also in place including a personal emergency evacuation plan (PEEP) for each person living in the home. Heating, lighting and equipment had been serviced and certified as safe. Equipment used at the service such as hoists, wheelchairs and bath chairs had been regularly tested to ensure their safety. The service had contingency plans in place to deal with emergencies such as a fire, flood, gas leak and loss of power to the home.

Good

Is the service effective?

Our findings

People using the service told us they felt staff were knowledgeable about their needs and requirements and carried out their caring role in a professional and understanding way. Comments included, "The carers look after all of us very well. You couldn't get care better anywhere else, it's just great," "I am very fortunate to be here." "I can't praise them enough. They do not belittle me if I cannot do something. I would say that the staff have the correct training and they care for me very well." Relatives/ visitors expressed their satisfaction with the care and support the service offered their relatives. One visitor said, "Staff are brilliant. They treat my mum as an individual. They have a very good understanding of her needs." Another relative said, "All the staff are very good. I can only speak from my experience."

We looked at how the service trained and supported their staff. From our discussions with staff and from looking at records, we found staff received a wide range of appropriate training to give them the necessary skills and knowledge to help them look after people properly. Information in the PIR showed all staff had completed the Skills for Care Common Induction standards or Care Certificate. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Approximately 50% staff employed had completed a nationally recognised qualification in care.

Staff we spoke with told us they were up to date with their mandatory training and felt they had the training they needed. They said, "We get quite a lot of training, and they make sure we are kept up to date with it", and "I definitely get the support and training I need to do my job." Nursing staff confirmed they were given the time, support and opportunity to attend training required to ensure they could keep their registration up to date and had access to clinical supervision to enable them to reflect on their practice, their knowledge and skills. Staff told us they could ask for additional training if they felt they needed it. One member of staff said, "I have been supported to develop my skills and knowledge; the company has supported me from when I first started."

We looked at how the service managed 'Do Not Attempt Resuscitation' (DNAR). We saw that consent forms in place and clear evidence discussion had taken place with the person the DNAR related to and or their relatives and the persons GP. The persons' wishes were documented clearly within their care plan and reviewed.

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). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.
The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS and to ensure that

where someone may be deprived of their liberty, the least restrictive option is taken.

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. Before this inspection we had received notification from the service of DoLs applications being made. According to the PIR ten people were subject to authorisation under the Deprivation of Liberty Safeguards. We looked at records relating to this and found these were being managed well with best interest decisions in place. Mental capacity assessments had been conducted to establish if people lacked the capacity to make decisions about the care and support they wished to receive. Records demonstrated that people's choices had been respected and the principles of the Mental Capacity Act had been followed, where this had been felt necessary.

Staff understood the importance of gaining consent from people and the principles of best interest decisions. Care records showed people's capacity to make decisions for themselves had been assessed on admission and in line with legal requirements. Useful information about their preferences and choices was recorded. We also saw evidence in care records that people's capacity to make decisions was being continually assessed on a monthly basis which meant staff knew the level of support they required while making decisions for themselves. Where people had some difficulty expressing their wishes they were supported by family members.

We looked at how people were supported to maintain good health. People's health care needs had been assessed and people received additional support when needed. People were registered with a GP and people's healthcare needs were considered within the care planning process. We noted assessments had been completed on physical and mental health needs. This helped staff to understand the extent of people's limitations regarding their health and to recognise signs of deteriorating health. One relative told us, "The unit [Sabrina] deal with medical issues well. My husband has recently had issues with his catheter and they have worked with the hospital to get it changed to a Suprapubic one. They are even going to train the nurses up on how to change it to stop him having to go into hospital for the procedure." Another relative told us, "My mums medical appointments are always kept on top of."

From our discussions and review of records we found the staff had developed good links with health care professionals and specialists such as GP and community nurses, tissue viability/falls team, continence specialist, community mental health services, chiropody and opticians. People's healthcare needs were kept under review and routine health screening arranged to ensure they received co-ordinated and effective care.

We were shown around the whole building as part of the inspection. We saw that the interior decoration was clean and bright and well maintained. The home was equipped to support people's diverse needs such as physical disability, nursing and dementia care needs and provided a pleasant environment. People told us the home was "very nice" and "suits me" and "I like my room, it's cleaned every day" and they had arranged their rooms as they wished with personal possessions that they had brought with them.

The PIR submitted to the Commission and records we looked at demonstrated the services commitment to ensure people received meals of their choice and met their individual needs. The organisation (BUPA) had introduced the 'principal menu' in the summer of 2014. The menu catered for people with different nutritional requirements and ensured their nutritional needs were met, whilst also providing choice.

We found people were supported to have sufficient amounts to eat and drink and to maintain a balanced diet. Menu's were displayed and picture charts with meals were also used to support people make their

choice of meal. People told us they enjoyed the food and were given plenty of choices. One person said, "The food is good. I always like whatever is on offer. I like everything." Another person said, "The meals are nice and I can have what I want." Whilst people told us the food was good we were told the temperature of the food served could be improved. People said, "The food is excellent although at times could be a little hotter. The staff know my likes and dislikes." And, "Meals are nice but sometimes are cold. There is always enough and I get a good choice." Relatives we spoke with told us, "The food seems to be quite good from what I've seen." And "I feel the food is a good standard. I am often around when meals are being served and they always look plentiful and appetising."

We saw that people were regularly asked for their views on the food provided and the menu was a regular feature on the 'resident meeting' agenda and in quality monitoring audits. Special diets were catered for such as diabetic, soft and pureed diets.

We observed the arrangements over lunchtime in three of the units. We noted on one unit people were given their lunch served on over knee tables. People were offered a choice of meal. We were told people had a cooked breakfast, lunch was a snack meal and the main meal was served in the evening. The lunch time meal served looked nutritious in content and portions served were generous. People could have as much as they wanted and were regularly asked if they wanted any more. People requiring support to eat their food were generally given this but we had observed two separate occasions when a member of staff [agency] stood over a person whilst supporting them to eat. We discussed this with the manager who told us that was unacceptable and assured us any staff observed conducting themselves in such a manner would be called to account for their actions. All staff had completed malnutrition, care and assistance with eating and dignity training to raise awareness.

We noted risk assessments had been carried out to assess and identify people at risk of malnutrition, weight gain and dehydration. People's weight and nutritional intake was monitored in line with their assessed level of risk and referrals had been made to the GP, Speech And Language Team (SALT) and dietician as needed. Charts were maintained to support staff keep a record of nutritional intake for people at risk and those we viewed were being completed appropriately. A relative told us, "There has been a time where mum had stopped eating. Staff were responsive with this." We observed staff offering people hot and cold drinks throughout the day.

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring towards them. Comments included, "I like it here. I can't say there isn't anything I dislike. I usually get up after lunch but this is my choice." "The staff are really kind", "They do their best and they are all very friendly, I do feel cared for."

Relatives we spoke with told us, "Staff are brilliant. They treat my mum as an individual. They have a very good understanding of her needs." And, "I know all staff by name and am always made to feel welcome." Compliments received at the service regarding the standard of care afforded to people included, "I never worried about the standard of care and support given to him. He felt he was loved." And, "God bless you for the wonderful work you do, you are very special people. Your work goes on day to day. It is a job that could not be done unless you have a love for people in very sad circumstances."

Relatives told us they felt involved and had been asked about their family member's likes and dislikes, and personal history. The 'My Day, My Life' care documentation supported staff to better understand people's individual needs, choices and preferences and focused on the development of person centered care plans. This provided staff with some insight into people's preferences, lifestyles and how they communicated their needs particularly for people living with dementia.

From our observations over the three days we were at the home, we found staff overall were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Calls for assistance were responded to promptly and staff communicated very well with people. We saw that where people had difficulty using words, they were supported by staff who showed patience and understanding. We visited ten people who were in their bedrooms. They looked comfortable and staff were seen to pop in and out carrying out welfare checks. People told us staff were respectful as they knocked on their door and waited to be invited in.

The service also had robust policies and procedures to support the delivery of care. Staff induction covered the principles of care such as independence, privacy, dignity, choice and rights and staff received training on equality and diversity.

Staff we spoke with displayed a clear knowledge and understanding of the needs and vulnerabilities of the people they cared for and were well informed about people's individual needs, backgrounds and personalities. They were also familiar with the content of people's support plans. and they understood their role in providing people with person centred care and support. It was evident throughout the course of the inspection that staff knew people well. One staff member said, "I always ask people what they would like me to do. I never just do things. I know what people like and what they don't like. It's important to know especially when some people can't tell you in words what it is they want. Communication is important."

We considered how 'dignity in care' was managed. People using the service had a key worker or named nurse. Key workers/named nurses role was to have an oversight of people's care and support and to build positive relationships with them, their family and friends. We observed people were appropriately dressed

and assistance with personal care was given behind closed doors. Signage was used to support people living with dementia to identify toilets and bathrooms. We noted toilet doors did not have locks on. We raised this issue with the manager. The home had recently been refurbished. The manager immediately arranged for locks to be fitted during our inspection.

People were encouraged to take pride in their appearance to help promote independence and boost self-esteem. People told us staff would assist them with any tasks relating to this should they require it. Hairdressing services were on site and visitors/relatives we spoke with confirmed that people always appeared well groomed. Comments included, "Whenever I visit, which is most days [my relative] is always clean and presentable. In fact everybody living on the unit is. Staff are responsive if someone spills something down them and will help them change into clean clothes." And, "[Relative] is always clean and presentable."

We checked people's care records. We were able to establish the level of support staff provided in meeting people's needs. For example bathing and showering. Where a bath or shower was not an option due to people's health, people were given bed baths. Daily records indicated full support with personal care was given. We discussed how the staff managed personal care with people who were resistive to any support. Staff told us they always recorded personal hygiene needs in daily records to make sure staff following on from their shift were aware of any problem and would offer the support later. One staff member told us, "Sometimes we have difficulty with [named person]. We never force the issue we just try different ways to encourage them. More often than not we are successful."

Staff spoke about people in a respectful, confidential and friendly way. Communication was seen to be very good. Daily records completed by staff were written with sensitivity and respect. We noted confidentiality was a key feature in staff contractual arrangements and all staff had been instructed on confidentiality of information. This ensured information shared about people was on a need to know basis and people's right to privacy was safeguarded.

According to the PIR the service had excellent links with the local hospice to access support for people, relatives and staff. The manager had been trained at the hospice in end of life care and was the designated end of life champion. People nearing the end of their lives were supported to make decisions about how and where they want to be cared for and who they wish to be involved. Care plans were put in place to ensure that dignity and privacy was maintained and the person's wishes clearly documented in agreement with their relatives and healthcare specialists to ensure these were understood and followed. This meant staff could approach a person's end of life care safe in the knowledge they were caring for the person according to their wishes, ensuring their dignity and their comfort, and treating them with respect

People using the service, and their relatives and friends were encouraged to provide feedback directly to staff and the management team about the home. This approach was supported by quarterly residents/relative meetings held on each unit and the use of satisfaction surveys. We noted the service had developed a resident/relative staff activity and fundraising committee.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. Everyone we spoke with who were able to comment were complementary about the staff regarding their willingness to help them. One person told us, "The carers will do anything for you" and another person commented, "They come when I call and help me all the time. I have a buzzer I can use." Relatives told us they were always informed and kept up to date if their relatives needs changed or they experienced difficulties. One relative said, "I am always informed about any meetings and kept informed of any changes." And another relative told us, "They always contact me quickly if [family member] has any problems or is feeling unwell."

We looked at the arrangements in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at ten people's support plans and other associated documentation. We noted an assessment of people's needs had been carried out before people were admitted to the home. We looked at completed assessments and although basic in information we found they covered all aspects of the person's needs. People had been involved in their assessment and information had been gathered from relatives and health and social care staff as appropriate. This process helped to ensure the person's needs could be met within the home.

Each person had a care plan that reflected their assessed needs. The care plans we looked at were detailed and included personalised information. This information helped staff have an understanding of people's background and interests and ensure the care and support met with their cultural and spiritual needs and lifestyle preferences. This included for example, interests and activities, family contact, identification and management of risks, personal needs such as faith or cultural preferences, physical and mental health needs, communication and social needs. The standard of care planning however was not consistent in all units as some plans were seen to lack detail. Other care plans were very well written and reflective of assessed needs. The manager told us they were fully aware of this issue and was supporting a relatively new unit manager bring all the care plans up to a good standard.

Care records also detailed people's routines, likes and preferences and provided some evidence to show people were at the centre of their care. The care plans and associated risk assessments had been regularly reviewed by staff. This helped to ensure people's care and support was maintained consistently and helped staff to monitor and respond to any changes in people's well-being. We noted however review of some care plans did not necessarily give an overview of the rationale why there were or were not any changes to people's care. Detailed daily records however were kept of the care and support delivered and this helped staff to monitor and respond to people's wellbeing. Staff we spoke understood good values in care and their understanding of equality and diversity was good and they referred to "caring for people as individuals".

Care plans for people living with dementia were supported by 'My life, My day'. This gave details of what was important in people's lives and how this can be achieved with staff support. The profile set out what was important to each person for example how they were dressed, personal care and how they could best be supported.

We were able to establish people and or their relatives had been involved in the reviews of their care. We spoke with relatives during this inspection and asked them how involved they were in planning their relatives care. Relatives confirmed they were consulted about their relatives care. Comments included, "I am aware of my mums care plan and have regular meetings. If I wanted to look at it at any time this would not be a problem." And, "I am involved and they always tell me if anything changes."

People's needs were recognised and addressed by the service and the level of support was adjusted to suit individual requirements. The provider had systems in place to ensure they could respond to people's changing needs. For example staff told us there was a handover meeting at the start and end of each shift. During the meeting staff discussed people's well-being and any concerns they had. This meant staff were kept well informed about the care of people living in the home. Daily reports provided evidence to show people had received care and support in line with their care plan. We noted the records were detailed and people's needs were described in respectful and sensitive terms. We also noted charts were completed as necessary for people who required any aspect of their care monitoring, for example, personal hygiene, falls and behaviour.

People were able to keep in contact with families and friends. Visiting arrangements were flexible. Visitors we spoke with told us they were able to visit their relatives and friends at any time and were made to feel welcome. People's friends and family had been invited to join in with activities and were informed of forthcoming events. Information about daily activities was displayed on notice boards around the home.

We noted there was a variety of activities on offer. These included for example quizzes, crosswords, weekly clergy visits, card games, getting to know you sessions, dancing, indoor exercise, entertainment, crafts, singing, music and films. We saw a new cinema room had been created and was a popular venue for people. We also noted a café was a feature for people to visit for a cup of tea and social gathering with friends and a new initiative to fundraise for an adopted charity was planned for. The manager told us they were hoping to create a sheltered pathway linking both ends of a unit for people living with dementia who needed to walk about. There were also plans to source community facilities such as a local 'dementia café' and 'singing for the brain'. During our visit people were entertained by 'The Land Girls' and we observed armchair activities and singing. Birthdays and seasonal celebrations took place. People had took part in remembrance day Sunday and children in need. It was clear the service took pride in helping others and this created an environment where people could be confident they had made a difference in society and their support was valued.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. We noted there was a complaints procedure displayed in the home and information about the procedure in the service user guide. According to the PIR there had been fifteen complaints at the service, eleven of which were handled under the service complaints procedure. We found a very professional approach had been taken to deal with the issues raised. The whole process from receiving the complaint to a resulting satisfactory conclusion had involved the complainant. All complaints were reviewed in order to identify any lessons learnt and enable strategies to be put into place to minimise the risk of a reoccurrence. As a result of the complaints, investigations and lessons learnt they had introduced champions in dignity, infection control, safeguarding and activities, staff training and supervision.

People told us they would feel confident talking to a member of staff or the manager if they had a concern or wished to raise a complaint. One person told us, "I would definitely say something if I was concerned about anything." Relatives we spoke with were complementary about the service and told us they would raise any concern with a member of staff or the registered manager if needed and be confident this would be taken

seriously. Relatives told us, "I know who to complain to and I feel it would be dealt with effectively." And, "I would go to the person in charge of the unit if I had any issues. I have never seen the manager but I know where her office is should I need to speak with her." Staff we spoke with confirmed they knew what action to take should someone in their care or a relative approach them with a complaint.

Good

Is the service well-led?

Our findings

We asked people using the service and relatives/visitors for their opinion of how the service was managed. People made some positive comments as to how the service was run and about the manager. They said, "I think she is very nice, we always see her about and we can talk to her. She gets involved and is interested in what we are doing." "I think the manager has everything sorted. Staff know what they are doing, it's nice here." Relatives we spoke with told us, "It's nice to see the home manager walking around. She is always present." "She most certainly has time to talk to us. I have raised issues I am not happy with and she has dealt with this very well. I have no problems at all."

The manager was qualified, competent and experienced to manage the service effectively and was currently processing an application to register with CQC. The manager had responsibility for the day to day operation of the service. She was supported in her role by a Clinical Service Manager (CSM) and unit managers. Furthermore an area manager visited the home on a regular basis to provide support and guidance and to review audits and action plans that had been developed to address any issues raised as a result of audits completed.

The manager told us she attended head of department meetings. She also regularly met with other managers within the company to discuss the service development and share best practice. She was also an Alzheimer's' dignity champion and was focusing on promoting people's involvement within the service.

We were able to verify the provider had effective governance audit systems in place. According to the PIR a programme of audits were in place to review practice in all areas of the home. We found auditing to be an integral part of the operation of the service These were carried out by unit managers and the CSM and they were RAG rated (Red, Amber, and Green) to determine risk. The results of the audits were monitored by the CSM and prompt action had been taken to improve the service. We could see from the ratings where shortfalls in category red or amber were identified, actions with timescales imposed for completion were recorded and reviewed. Audits included regular daily, weekly, monthly and annual checks for health and safety matters such as cleanliness, fire fighting and detection equipment, learning logs, staff training and medicines audits, all of which helped determine where the service could improve and develop. This supported the service in providing a quality care that considered people's health, welfare and safety at all times. We were also told a new 'Care and Quality Team' was in place and a new quality model and quality framework which supported the governance process from the home through the organisation to the Board.

The manager and CSM also completed the required quarterly reports for the local Clinical Commissioning Groups (CCG). (CCGs are clinically-led statutory National Health Service bodies responsible for the planning and commissioning of health care services for their local area). These included for example, falls, pressure ulcers, DoLS and infection rates in the home, policies, incident reporting, complaints and mandatory training

There were systems to seek people's views and opinions about the running of the home. People were asked to complete annual customer satisfaction surveys to help monitor their satisfaction with the service

provided. We noted resident/relative meetings took place. At their meeting in September people had discussed preparing for Christmas.

People using the service and relatives participated in an annual Customer Satisfaction Survey. The results were collated and analysed and shared with all staff, residents and relatives. There was an 'open door' policy which meant that people using the service, their relatives, professionals visiting the service and members of staff were welcome to speak with the manager at any time. The manager told us she promoted an open inclusive culture and learning from the people they cared for on how they can improve. Members of staff we spoke with considered the manager was very supportive and they were happy in their work. Comments included, "It is a nice place to work in. I think we work well as a team." "I really enjoy my work here. If I have any issue I know I can always speak with any of the managers at any time and I know I can leave it with them to sort out. I've never had a problem that way."

Staff members told us they had been provided with job descriptions, staff handbook, employment policies and procedures and contracts of employment which outlined their roles, responsibilities and duty of care. We saw evidence staff were being held accountable for their practice through audit systems and they were receiving training and supervision to support them in their role.

There was a clear management structure at the service and staff were aware of the lines of accountability and who to contact in the event of any emergency or concerns. Staff meetings were held regularly and viewed by staff as a good arena to discuss new ideas and receive updates from the manager.

The manager was seen throughout our inspection to interact professionally with people living in the home, with staff and with visitors. Throughout our discussions it was clear she had a good knowledge of people's needs and circumstances and were committed to the principles of person centred care.

The manager described her challenges as making sure the staff had the right skills to meet people's needs, ensuring all people's needs were met and managing the diversity of people's health and social care needs. The manager set out detailed planned improvements for the service in the PIR under safe, effective, caring, responsive and well led. This demonstrated the manager had a good understanding of the service and was focused on improvements.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local commissioners, local authority safeguarding and deprivation of liberty teams. Our records showed that the manager had appropriately submitted notifications to CQC about incidents that affected people who used services.