Kloriann Medicare Limited

Park House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26 July 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Park House Nursing Home on 3 January 2014, at which time the service was compliant with all regulatory standards inspected.

Park House Nursing Home is a residential nursing home in the Queensbury area of Bradford, providing accommodation and personal care and nursing care for up to 25 older people. There were 21 people using the service at the time of our inspection, 18 of whom were living with dementia.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

There were sufficient numbers of staff on duty in order to safely meet the needs of people who used the service and to maintain the premises. All areas of the building were clean and well maintained, including external areas.

Staff were trained in safeguarding and displayed a good knowledge of safeguarding principles and what they would do should they have any concerns.

People who used the service and their relatives expressed confidence in the ability of staff to protect people from harm.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service (DBS) checks, references and identity checks.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Care Excellence (NICE).

Risk assessments took into account people's individual needs and staff displayed a good knowledge of the risks people faced and how to reduce these risks.

People received the treatment they needed through prompt and regular liaison with GPs, nurses and specialists.

Mandatory staff training was regularly updated to ensure staff had a good working knowledge of people's needs, whilst the Care Certificate modules were used to help refresh staff knowledge. Staff had received

training in Fire training, Pressure Ulcer Prevention, Manual Handling, Mental Capacity Act, Continence Care, Equality and Diversity, Infection Control, Control of Substances Hazardous to Health (COSHH), Health and Safety, Dementia Care, Falls Awareness and Safeguarding

Staff received regular supervision and appraisal processes as well as regular team meetings.

We checked whether the service was working within the principles of the MCA. Staff displayed a good understanding of capacity and consent and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was calm and welcoming. People who used the service, relatives and external stakeholders told us staff were patient and dedicated and we observed staff interacting with people in this way. We received a range of unanimously positive feedback from relatives and external professionals about the caring attitudes of staff and how they delivered the culture and values of the service. The premise of treating people who used the service as staff would their own relatives was well evidenced and indicative of a caring service.

Person-centred care plans were in place and staff had ensured a comprehensive amount of information about each person was readily accessible. We saw regular reviews took place with the involvement of people and their family members.

Group activities took place regularly, such as trips away from the home and in-house entertainment. Likewise, one-to-one time was offered to people by the activities co-ordinator. There was an opportunity to improve the way group activities were planned – currently people's life history documents were not consulted to ensure the activities planned met people's preferences. Relatives and people who were able to communicate their preferences did however confirm they enjoyed the group activities.

People who used the service, relatives and an external professional we spoke with had confidence in the staff team, the registered manager and the owners. We found the culture to be person-centred and consistently focussed on ensuring people received a high quality of care in a calm and dignified fashion.

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.

Risks to people were assessed and individual plans were in place to help staff reduce these risks. Staff displayed a good knowledge of the risks people faced.

Staff knowledge of safeguarding responsibilities and procedures was good.

The administration of medicine was safe and in line with issued by the National Institute for Health and Care Excellence (NICE).

Is the service effective?

Good

The service was effective.

Staff had received a range of refresher training to keep their knowledge current, as well as specific training to meet the changing needs of people who used the service.

People's medical needs were well met through systematic monitoring and regular access to primary and secondary health care services.

Where people's needs changed external advice from healthcare professionals was incorporated into care planning.

Is the service caring?

Good

The service was caring.

People who used the service, their relatives and external professionals gave unanimously positive feedback regarding the caring and dedicated attitudes of all members of staff.

Staff were observed to interact with people in a calm and patient manner at all times and people had evidently developed trusting relationships with staff who cared for them.

Staff at all levels consistently demonstrated the caring values set out in the philosophy of care.

End of life care plans were detailed and people's relatives were consistent in their satisfaction with Park House as a place their relatives would want to choose as a place to spend their final days.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and a keyworker system successfully ensured staff had a good understanding of people's changing needs.

Surveys were conducted regularly and relatives were involved in reviews of people's needs to ensure staff were acting on the most up to date information.

There were a range of group and individual activities in place, with potential for improving the manner in which activities were planned to make them more person-centred.

Is the service well-led?

Good

The service was well-led.

The registered manager, owners and staff had successfully developed and maintained a positive caring culture that focussed on delivering high quality care in a calm and dignified fashion.

Quality assurance and auditing systems were comprehensive and ensured high standards of care were maintained.

People who used the service, their relatives, staff and external professionals we spoke with described management and staff as well organised, approachable and accountable.

Park House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 26 July 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking to people and observing interactions between staff and people who used the service. We spoke with two people who used the service and five relatives. We spoke with nine members of staff: the registered manager, the two owners, a nurse, two care staff, the activities co-ordinator, the cook and a domestic assistant. We spoke with a visiting social worker and a community health care professional. Following the inspection we spoke with a GP, a dietitian and a community matron.

During the inspection visit we looked at four people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, quality assurance systems, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning and safeguarding teams. No concerns were raised regarding the service by these professionals.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

Relatives of people who used the service and external professionals we spoke with all expressed confidence in the ability of staff to provide care safely. One person told us, "Oh yes, it's lovely here." One relative told us, "We've had no problems in terms of safety," whilst one healthcare professional told us, "In all the years I've been visiting there have never been safeguarding issues." We observed people who used the service behaving in a calm manner with staff who were caring for them, which indicated they had a degree of trust in them.

We reviewed risk assessments and found them to be clear, accurate and specific to individual need. When we spoke with staff they were aware of the specific risks faced by people and how they should reduce these risks by following the actions set out in the risk assessments. One person was at heightened risk of slips and falls and we saw there was a range of guidance in place for staff, for instance how to help the person bathe without risk of injury. We found the instructions to be clear and when we spoke with relevant staff they were able to describe how they supported people to minimise such risks. Risk assessments regarding mobility had regard to how people who used the service could be involved in their care, for example in one risk assessment we saw clear instructions to, "Be very careful to explain all steps to [person] when trying to transfer them to alleviate their anxiousness." We saw staff adhering to this guidance during our inspection, explaining a transfer from an armchair to a wheelchair to the person at each stage.

We saw the storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Care Excellence (NICE). We saw people's medical records contained their photograph, any allergy information and emergency contact details. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. Controlled drugs were securely stored and we found associated procedures to be safe, for instance two members of staff verifying when a controlled drug had been administered. Controlled drugs are drugs that are liable to misuse. We reviewed a sample of people's administration records of controlled drugs and found it was accurate and corresponded to the controlled drugs remaining. One external healthcare professional we spoke with stated, "Their medication management is very good."

With regard to 'when required' medicines such as paracetamol, we found there was detailed additional information in people's care files regarding when this might be required. We saw the registered manager had acted on advice from an external professional and was in the process of incorporating this information so that it was alongside people's MARs. Staff displayed a good understanding of people's 'when required' medicines and how people would communicate the need for such medicines to staff. Staff also displayed a good knowledge of the topical medicines (creams) people required. We saw the application of these creams could be made safer by the use of body maps to show exactly where about a person the cream should be applied, but we did see detailed written instructions in the topical medical administration records we saw.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a locked cabinet and a locked fridge was also in use. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits. This demonstrated people were not put at risk through the

unsafe management of medicines.

Staff displayed a clear understanding of safeguarding and were able to describe the risks of abuse people might face and how they would respond if they felt this was the case. We found these responses to be in line with the registered provider's safeguarding policy.

We found there were sufficient staff on duty to meet the needs of people who used the service, with four care staff, a nurse, the registered manager, two domestic assistants and a cook on duty at the time of our inspection. People who used the service, relatives and staff all told us they felt there were sufficient staff to meet people's needs. We observed call bells being responded to promptly throughout the inspection and saw the service kept a log of the times call bells were triggered and responded to. This meant people using the service were not put at risk due to understaffing.

We saw appropriate pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw the registered manager had asked for at least two references, proof of ID and had completed interviews with candidates. This meant the service had a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found all areas of the building, including people's bedrooms, bathrooms, kitchens and communal areas to be clean and free from odours. The local infection control team confirmed they had no ongoing concerns regarding the cleanliness of the service and people who used the service and their relatives raised no concerns. We saw regular environmental checks of the service were undertaken. One relative stated, "The cleanliness is excellent and there are no smells." Another told us, "It's always clean and I'm here regularly."

We saw where people used bed rails this had been appropriately risk assessed and considered in consultation with people's families. One external healthcare professional commended the rigour of the consideration the registered manager put into their bed rail assessments.

With regard to the premises we saw Portable Appliance Testing (PAT) and periodic electrical testing had been undertaken. The fire alarm and emergency lighting were tested regularly, whilst fire extinguishers had been serviced and window restrictors were in place. Fire doors were regularly checked. We saw all lifting and hoisting equipment had been regularly tested and service in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Water temperatures were regularly checked to ensure people were not at risk of scalding, whilst a periodic legionella inspection had been undertaken. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were clearly documented and recorded in such a way that made it easy to identify any trends that might develop. We saw there had been no major incidents or accidents since our last inspection. We saw an instance of a person cutting their finger and this had been analysed to establish the cause, with care plans then updated to help reduce the risk of reoccurrence.

We saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. These were easy to follow and easily accessible. This meant members of the emergency services would be better able to support people in the event of an emergency.

We saw contingency plans were in place for a range of circumstances such as a fire or electrical failure, but that a gas cut/failure had not been incorporated into this plan. The registered manager agreed to

incorporate this eventuality into the plan.

Good

Is the service effective?

Our findings

We found staff had a good awareness of people's needs and people who used the service were supported to healthy outcomes through the ongoing support of a knowledgeable and skilful staff.

One visiting social care professional said, "They are on the ball and always ask me for advice if they need to." A visiting healthcare professional said, "They're so good at anticipating needs. Even with continence issues they seem to get no UTIs [urinary tract infections] and their skin care is always sound." Another visiting healthcare professional was complimentary about staff knowledge, stating, "They always have an update about the person." We received similar comments from the GP who visited the service regularly, who stated, "Whoever is on shift is able to answer my questions, such as 'Have they eaten; Have they been drinking?' They know about their patients." Relatives consistently told us they felt staff were equipped to care for people who used the service. This demonstrated people's relatives and professionals alike had a high degree of confidence in the skills and knowledge of staff.

Staff training was well managed and we saw the registered manager used a matrix to track who was due to refresh certain training courses. We saw all staff had received a range of training that equipped them to help meet people's needs. Staff had received training in Fire Safety, Pressure Ulcer Prevention, Moving and Handling, Mental Capacity Act, Continence Care, Equality and Diversity, Infection Control, Control of Substances Hazardous to Health (COSHH), Health and Safety, Dementia Care, Falls Awareness and Safeguarding.

We saw the registered manager had delivered the Care Certificate to new members of staff and had also used modules of the Care Certificate to refresh individual areas of existing staff knowledge. During our inspection staff received refresher training on pressure ulcer prevention and awareness and both visiting professionals we spoke with commended staff knowledge in this area.

Where people's needs changed we saw staff had been trained so they could continue to provide good levels of care to people. For example, we saw some people had end of life care plans in place and wanted to choose to stay at the home rather than go into a hospital when they reached the end of their lives. We saw care staff had been trained in palliative care and nurses had been appropriately trained in the use of syringe drivers, which meant the service was better able to support people's wishes. A syringe driver is a small pump used to steadily administer small amounts of fluid to a person so they receive consistent pain relief.

All staff we spoke with confirmed they received support and supervision from their immediate line manager and from the registered manager. We saw evidence of staff supervisions occurring regularly, as well as annual appraisals and team meetings.

We saw staff sought and adhered to advice from external professionals. We saw advice from a dietitian had been added into people's dietary care plans and risk assessments. When we spoke with this professional they told us, "They absolutely take on board advice and put it in place." They went on to say, "They adapt to need and do a lot of food fortifications. Their food and fluid charts are always in order and they use the

MUST tool." The Malnutrition Universal Screening Tool (MUST) is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw evidence that people who had previously been at risk of malnutrition had successfully put on weight and maintained this.

With regard to nutrition we saw people were given a choice of meals. We saw snacks and refreshments were offered during our inspection. One relative told us, "The cook is good and has to cope with a lot of different needs." We spoke with the cook who demonstrated a good understanding of the varying specialised diets people required. We saw this information was clearly displayed in the kitchen, along with allergy information, to ensure people received meals that met their needs.

We saw tables were laid with a menu and flowers before each meal, in pleasant surroundings with music audible in the background. We observed staff interacting with people during lunch and found them to be patient, attentive and unhurried. Staff shared jokes with people where appropriate.

The owner of the service told us they had recently purchased dining chairs with sliding feet and we saw these proved effective in supporting people to transfer in and out of dining chairs.

We saw people were supported to access health care services such as GP visits, Speech and Language Therapy (SALT) appointments, dentist appointments, hospital reviews, optician appointments and chiropody services.

We saw evidence of other good health outcomes. For instance, one person who moved to the service with a poor prognosis from the hospital and was only able to mobilise with support. During the inspection we saw them moving from the conservatory to the dining room with the aid of a walking frame but without staff contact. We saw documentation from the person's social worker confirming their mobility had improved. Staff we spoke with did not attribute this to a specific aspect of the person's care regime but the, "Environment and atmosphere."

We saw staff were well placed to monitor and support people's health needs through monthly health checks such as weight, blood pressure, body mass index, pulse and temperature. These were compared against the 'baseline' results taken at the person's admission to the service. This meant staff had a current understanding of people's needs and whether they had changed since admission. This also meant visiting healthcare professionals had a good array of relevant information about people's health needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of the principles of the MCA and the importance of DoLS. We saw people's capacity was assessed on a decision-specific basis, rather than blanket decisions being made about people's capacity. We saw mental capacity

assessments were regularly reviewed. We also saw appropriate documentation had been submitted to the local authority regarding the DoLS.

We saw staff communicating with people well, using gentle physical contact and positioning themselves closely to people when supporting them, as per people's assessed communication needs. We saw a range of 'flash cards' in the office and one relative told us they had also brought in some of these cards from home. Flash cards are picture cards that people who are unable to verbally communicate can use to show people what they would like, or what they are feeling. The relative confirmed staff sometimes used these cards so the person who used the service could communicate more easily and stated, "It reduces some of the frustration for them." This demonstrated that staff communicated well with people who used the service by using a variety of methods.

With regard to the premises we saw it was a Grade II listed building and, as such, limited alterations could be made. We saw some bedrooms were en suite and there were ample bathing facilities throughout. Corridors were clear, with carpets contrasting with walls and any carpeted areas free from fraying. The building had a large conservatory area which we saw being used throughout the inspection, as well as a well maintained outdoor space. In their completed PIR the registered manager had told us about a 'Woodland Walk', a wheelchair accessible pathway through the wooded area of the grounds. We spoke with one relative who confirmed they regularly used this facility to walk with the person they visited, whilst relatives and two people we spoke with confirmed they found the building and the surroundings met their needs.

Good

Is the service caring?

Our findings

Feedback from people who used the service, relatives and external health and social care professionals was unanimously positive and was representative of a caring culture that was demonstrated by staff at all levels. One person said, "Marvellous, isn't it." One relative told us, "We visit as a family regularly and that is how the place feels, like an extended family. I was here visiting once and there were other relatives visiting in the conservatory. Two people didn't have visitors and I noticed that a staff member took their paperwork and sat in between these two people to keep them company. They didn't have to do that but they didn't want people to feel left out – it was a lovely touch."

Another relative told us, "The staff are wonderful, fantastic; more like friends. [Person] gives them hugs and kisses – more than me! It feels like a family and they treat [Person] like their own mother." This relative went on to explain how supportive staff had been in relation to ensuring their own anxieties about their relative and their needs were not neglected. They said, "Even though they're looking after my [relative], they support me too. They helped me to understand the impact of dementia and the reasons behind it, which really helped me cope at a difficult time – they are so wonderfully caring. I used to be the main carer and still being involved in this way is really important to me. I don't know how to thank them – they always make time despite everything they have to do and they always put [relative] first." Another relative told us, "I did the care plan with [Nurse's name] – I feel reassured I know I'm involved and I have peace of mind when I leave here." This demonstrated that staff fully involved relatives in the planning and delivery of care and took the time to know and support relatives.

One relative gave us an example of a trip they had attended recently to support their relative. They said, "One member of staff came along to help me with [Person's] transfers and getting around – it was their day off. They came along because they wanted to – it's what they do here, they're very committed."

This demonstrated staff displayed caring behaviours, in line with their mission statement and philosophy of care, which stated respectively, "House Nursing Home aims to provide its residents with a secure, relaxed, and homely environment in which their care, well-being and comfort is of prime importance" and, "Carers will strive to preserve and maintain the dignity, individuality and privacy of all residents within a warm and caring atmosphere."

We found staff had consistently delivered in this latter aspect, and all visitors consistently commented on the homely, calm and caring culture. One relative said, "The carers, nurses, management, they're all wonderful – it's so hard to explain, it's like coming home to a nice pair of slippers." One external healthcare professional stated, "Staff are really gentle and calm – they put people at ease," whilst another said, "The care is at the next level – really fantastic," and, "We were greeted warmly today as we always are."

We saw 5 visitor questionnaires had been filled in in late 2015 and all responded with the highest rating for questions regarding the standard of care. One response stated, "Would be happy to have my family live in Park House." When we spoke with an external healthcare professional they told us, "If one of my relatives had to or wanted to go into care I would be very happy with Park House." We found this was a consistent

theme from professionals we spoke with and we noted that one member of staff had a relative living at Park House whilst another staff member's relative had used the service for respite care; the premise of treating people who used the service as staff would their own relatives was a clear instruction from the registered manager and one that all staff embraced to ensure people received quality care.

A number of relatives pointed out the positive and reassuring impact of the continuity of care. We saw staff turnover was extremely low and that the service didn't use agency workers. One relative told us, "I think this really helps in terms of reducing [Person's] anxiety when they have enough worries." Another said, "It's very rare they have a change so [Person] gets to know the staff and trusts them." External professionals supported this view, with one stating, "Staff have been there a long time and know people's ins and outs." This demonstrated the registered manager had successfully achieved and maintained a culture that valued the importance and impact on people of maintaining a continuity of care.

We saw a range of thank you cards received by the service which contained similar sentiments, such as, "Thanks for the unlimited care, compassion and dedication," "You all helped by nursing and caring for [Person] as well as reassuring them so they became content in their surroundings. You became their second family who they trusted and felt comfortable with," and, "You are a fantastic group of staff who are very caring and [Relative] could not be in a better place."

Whilst we could not speak at length with people who used the service because of their communicative difficulties, we observed interactions between staff and people who used the service. We saw staff speaking gently and patiently to people, encouraging them through repeating their sentences and gentle physical contact when they were supporting people to move. We observed staff were not only compassionate but shared jokes with people who used the service and successfully maintained a relaxed, homely and caring atmosphere.

When we reviewed minutes of staff meetings we saw staff had been reminded about the importance of maintaining the dignity of people who used the service, for example being careful not to speak over them. We saw this instruction was observed and that when staff needed to speak to each other they did so discreetly and respected people who used the service. For example, at one point we observed one staff member discreetly ask another to adjust a person's glasses on their nose as they walked back across a room. This enhanced the person's dignity in a discreet manner and was indicative of care staff who were focussed on people's needs and rights.

We saw rooms were pleasantly decorated and personalised to people's tastes, for example with their own furniture and photographs. We saw care plans had regard to people's individual needs and preferences, for example one person had an 'Expressing sexuality' care plan in place, which specified how often they would like their hair setting and whether they wanted to wear lipstick. Another person had a religion care plan in place, ensuring they were regularly visited by a local priest.

We saw people had end of life care plans in place, where they had expressed where their preferred place to die was and what type of funeral service they wanted. The registered manager was aware of recent best practice guidance (Care of dying adults in the last days of life, December 2015, National Institute for Health and Care Excellence) and clearly described how they supported people at the end of their lives in a dignified and respectful way. We saw a cover sheet had been attached to the front of this file and the majority of nursing staff had confirmed they had read it. We spoke with a local GP who confirmed the service supported people well at the end of their lives. This demonstrated staff valued the importance of people's right to have a dignified and, as far as possible, comfortable end to their life if they chose to do so at Park House.

We found care plans to contain comprehensive levels of information regarding people's likes, dislikes and personal histories. When we spoke with staff they were able to tell us about people's needs and preferences in detail.

We saw people's personal sensitive information was securely stored in locked cabinets and on a password-protected computer system, in line with the confidentiality policy.

Good

Is the service responsive?

Our findings

We saw the provision of activities for people who used the service was varied and positively received. Feedback from recent service user questionnaires showed that three people had highlighted the range of activities as particularly enjoyable.

We saw people enjoying game of armchair hoopla in the living room, whilst there was evidence of people taking part in ball exercises, skittles, quizzes, baking and coffee mornings. We saw the activities coordinator had applied for people to have their bus passes renewed and kept on file so that they could go on group outings using the local authority Access Bus. Relatives confirmed people went on regular trips using this bus, for example to Halifax and Shibden Park, and were extremely complimentary about the passion, dedication and motivational skills of the activities co-ordinator. We also saw they spent one-to-one time with people who used the service, for example giving manicures and hand massages whilst chatting to people.

The registered manager and activities coordinator acknowledged they could improve the personalised nature of activities provision by reviewing each persons' individual likes, dislikes, preferences and life histories before planning activities. We saw that each person had a detailed document called 'My Personal Life History', which stated, 'By providing information in the following areas: school years, relationships with siblings, marriage, hobbies and interests, likes and dislikes and life as it currently is, this will enable us to have an understanding of these things and the people that are important to you." We saw, whilst this document had been consistently completed to a detailed degree, the person-specific information was not always used as well as it could have been to inform activities planning.

We saw this was sometimes the case in people's care planning. In one person's care file we saw the activities care plan was generic and stated, "To encourage [Person] to undertake activities that they enjoy to assist in giving [Person] a sense of wellbeing and purpose." We found some activities could have been better planned in line with people's personal histories, likes and preferences. The registered manager and activities co-ordinator agreed to review people's life history information when planning activities.

With regard to how the service met people's changing health needs, we encountered a range of positive feedback from relatives and external professionals, which was supported by discussions we had with staff and the documentary evidence we viewed. One visiting healthcare professional told us, "They are always pro-active about people's changing needs." Another healthcare professional we spoke with after the inspection confirmed, "They ring if there is ever a problem," whilst a relative told us, "There was a bit of an issue when we were sorting the admission but they were on it straight away – they were great."

When we reviewed people's care files we saw a range of evidence indicating they had received prompt and responsive care to meet their changing needs, for example through referrals to occupational therapy and the Speech and Language Therapy (SALT) Team. We saw people's care files and the health information therein were regularly reviewed by the nurses to establish whether the current care plans and support in place were sufficient. We saw regular health checks (for example, blood pressure, temperature) were

compared against recordings taken at admission to help this review process. This ensured care and nursing staff and visiting professionals had the right information about people's needs.

We saw care plans were detailed and written in a person-centred way, focussing on the needs of each individual. Each care plan started with an overview of the person's needs, in their voice, entitled, "My name is…and this is how to look after me." Each contained the person's photograph and explained who their keyworker was. When we spoke with people's keyworkers they displayed a good understanding of people's needs. We saw people's consent, or the consent of people acting in their best interests, was sought at all stages. We saw each person's care planning was made with the benefit of access to information from external health and social care professionals, and people's family or advocate.

People were protected against the risk of social isolation by being supported to take part in group activities, through regular contact with family members and advocates and through the visits of external visitors, such as a piano player, and people who attended coffee mornings and afternoon teas the service would put on and advertise locally.

We saw information regarding how to make a complaint was clearly displayed in communal areas. Relatives we spoke with knew how to make a complaint and who to approach, as per the registered provider's policy, although they told us they had no reason to complain.

We saw people's views were regularly sought through surveys and reviews of care needs. We saw results from recent questionnaires had been analysed by the registered manager and discussed with staff at a team meeting. Questionnaires completed by people who used the service, with the help of relatives of the activities co-ordinator, were uniformly positive. We also saw the registered manager held intermittent meetings with relatives, approximately every 6 months. We asked relatives if they felt this was enough and they all confirmed, whilst formal meetings were intermittent, they were positively encouraged to be involved with decisions regarding their relatives' care and all aspects of the service. One relative said, "The information they give us is very good and we are always consulted." This demonstrated the registered manager routinely found ways to seek feedback from people who used the service and their relatives.

Good

Is the service well-led?

Our findings

All relatives we spoke with confirmed the registered manager was approachable and accountable, stating that they had a, "Hands-on" approach to the service. External professionals we spoke with were similarly complimentary about both the registered manager's involvement in the service and the way they organised and supported staff. One said, "It's a well-led service. Everything is well organised." Another said, "[Registered manager's name] is great – really on top of everything." Staff also confirmed they received a good level of support from the registered manager, whether it be vocational (one person told us how the registered manager was supporting them to achieve an external qualification) or emotional, for instance if they were returning from work after being off work sick. We found the registered manager to have extensive relevant experience in care and nursing.

Staff were also complimentary about the level of support offered by the owners, who they stated were on site regularly and took a, "Real interest in ensuring people's needs are met – they are often on site and approachable." One member of staff said, "The owners are always here and we get all the equipment we need." We spoke with the owners, who demonstrated a good understanding of people's needs and the support staff required. We saw the relationship between the registered manager and the owners had been built over six years and ensured their skills complemented each other.

One external healthcare professional attributed the calm atmosphere to the leadership of the service, stating, "It's really calm because it so organised – everyone knows what they're doing and no one is in a panic."

We found staff morale to be high and turnover of staff low. One member of staff told us, "It's a great team," and we found staff we observed to work and communicate well together to meet the needs of people who used the service. This demonstrated a strong team spirit, which in turn ensured people who used the service were cared for by a consistent group of carers who displayed caring behaviours and values.

We saw the registered manager undertook regular 'walkarounds' of the service to ensure the environment was clean and free from hazards. One member of staff confirmed, "[Registered manager's name] does regular walkarounds to stay on top of things," and we saw documentary evidence indicating that the registered manager completed these checks regularly and ensured staff maintained the premises to a high standard.

The registered manager and other staff undertook a range of audits on a monthly basis, including medicines audits, bed rails, care plans, health and safety and infection control. We saw these checks were used to remind staff of best practice and ensured all aspects of the service underwent a good degree of scrutiny to ensure the service maintained a high level of care for people who used the service.

The registered manager described a good working relationship with the clinical commissioning team and other external stakeholders. We saw the registered manager met with external stakeholders regularly at Bradford Care Association meetings, as well as establishing a good working relationship with another

provider, through whom they were able to access additional training for staff. The registered manager had a good awareness of the 'Making a difference in dementia' campaign, a Department of Health strategy which focusses on the role of nurses in supporting people with dementia. The registered manager was aware of the resources available through Skills for Care and was pursuing the possibility of undertaking the Gold Standards Framework in end of life care. Gold Standards Framework is a nationally recognised programme providing a framework for improving end of life care. This meant the registered manager was exploring and acting on opportunities to improve their understanding of best practice in care. We also saw latest best practice guidance from the National Institute for Health and Care Excellence (NICE) on end of life care, falls management and medicines management was made available to staff in the office.

We found the registered manager had ensured the service did not become isolated (it is set in its own grounds away from the main road) through this continued liaison with external professionals but also through ensuring the home remained part of the wider community, for example through ensuring regular visitors. We saw coffee mornings and afternoon teas provided an opportunity for residents to engage with people from the community. This also provided an opportunity to raise money for the residents' fund. We saw people who used the service also had visits from a local school and from a local priest.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided, accurate and up to date. We also saw a good degree of organisation of key information in the office, such as guidance regarding the most up to date requirements in relation to DoLS and recent guidance and contact information regarding the risks of sepsis. We saw appropriate notifications had been made to CQC.

The registered manager and owners had a clear vision for how they would maintain high levels of care and look to make service improvements in the future. We found the culture to be focussed on providing calm and dignified care to people who could feel at home. We found the registered manager, owners and staff had successfully delivered the caring, person-centred care described in company literature, service user guide and the Provider Information Return, and that staff took pride in delivering this care.