N. Notaro Homes Limited

Immacolata House

Inspection report

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Date of inspection visit:
16 June 2016

Date of publication:
02 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16 June 2016 and was unannounced. The service was last inspected on 20 September 2014 and no concerns were identified.

Immacolata House provides accommodation for up to 49 people who need nursing and personal care. At the time of the inspection there were 49 people living at the home. The majority of people were living with a dementia and many had complex nursing or other support needs. Most of the people who lived in the home were unable to express themselves fully due to their dementia or other health conditions.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager told us their service philosophy was "For our residents to live as they want to live, safely".

Staff supported people in a very caring and considerate way and had a very good understanding of each person's needs and preferences. We observed there was a genuine affection between people and the staff.

People and their relatives told us the service was responsive to their needs and people had a lot of choice about how they spent their days. One person said "There's something on every day" and a relative told us "I've only got to say a concern and they are on to it". People benefitted from individual engagement with the care staff as well as a variety of organised social and recreational activities.

Most relatives thought the registered manager was open, accessible and responsive. One relative said "She runs the place very well. She's definitely focused on the people here. The whole team are dedicated to the residents and to looking after the relatives". Staff described the registered manager's style as "fair but firm". Most of the staff liked this approach as they said they knew where they stood. The provider's quarterly staff survey results showed a high staff satisfaction score at Immacolata House.

There were enough suitably qualified staff to keep people safe and to meet their needs, although there had been quite a high turnover of staff over the last 12 months. Over recent months staff turnover and the number of agency staff hours had significantly reduced.

People were kept safe because risks were well managed and people were protected from abuse and avoidable harm through appropriate policies, procedures and staff training. People received their medicines safely from registered nurses and people were protected from the risk of infection. There were always two qualified nurses on each day shift to ensure people's clinical needs were met.

A local GP visited the home on a weekly basis and a dentist, optician and chiropodist visited regularly. The service also worked in close partnership with other health and social care professionals to meet people's

health and wellbeing needs.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. Staff were knowledgeable about each person's dietary needs and preferences. A new two weekly menu was about to be introduced following consultation with people and their relatives. The new menu choices looked varied and appetising.

The home's environment had been purpose built to support people living with a dementia. It was spacious, clean and bright throughout with lots of natural light. Communal facilities were signposted with pictures to help people understand their use. There were spacious, well maintained, secure gardens and grounds for people and their visitors to enjoy.

The service had good links with the local community. Various events were organised at the home, including: open days, Alzheimer's days, Art in the Garden supported by the local Ladies Guild, reminiscence events, fetes and other national celebrations. The service also participated in the Archie Project to raise school children's awareness of dementia.

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.

There were sufficient numbers of suitably trained staff to keep people safe and meet their needs.

Risks were identified and managed to help people remain safe.

People were protected from abuse and avoidable harm.

People received their medicines safely from registered nurses and people were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care and support from staff who were trained to meet their individual needs.

People were supported to maintain good health and to access external professionals when specialist advice was needed.

People's nutritional needs were met, including any special dietary needs.

The service acted in line with current legislation and guidance when people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Good

The service was caring.

People were supported by very caring, friendly and considerate staff.

People were treated with dignity and respect and were supported to be as independent as they were able to be.

People were supported to maintain continuing relationships

with their family and friends.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their needs and took account of their wishes and preferences.

People and their relatives were consulted and involved in decisions about their care.

People, relatives, staff and other professionals were able to express their views and these were taken into account to improve the service.

Is the service well-led?

Good

The service was well led.

People were supported by a strong and accessible manager and a dedicated and motivated staff team.

The service had a caring and supportive culture focused on promoting the health and well-being of the people who lived in the home.

The provider's quality assurance systems ensured the quality and safety of the service provision was maintained and improved.

Immacolata House

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.

The inspection took place on 16 June 2016 and was unannounced. It was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's 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 the improvements they plan to make. The service was last inspected on 20 September 2014. At that time, the service was meeting essential standards of quality and safety and no concerns were identified.

Most of the people who lived in the home were unable to fully express themselves, due to dementia and other health conditions. We therefore spent time observing the care and support practices in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with two people who lived in the home, four visiting relatives and 14 members of staff. Staff included a registered nurse, a student nurse, two senior carers, two care supervisors, two care assistants, an activities co-ordinator, a domestic, the cook and assistant cook. We spoke with the registered manager and also the provider's operations manager who visited the home later in the day. Following the inspection we received telephone calls from two members of staff and two relatives.

During the inspection, we looked at records which related to people's individual care and to the running of the home. These included four care plans, food and fluid charts, medication records and some of the provider's quality assurance records, including staff training, complaints and incident files.

Good

Is the service safe?

Our findings

We spoke with two people who lived in the home who were able to express their opinion of the service. We observed staff interactions with the other people who were unable to fully express themselves due to their dementia and other health related conditions. We also spoke with visiting relatives to gain more information about people's experiences of the service.

People and their relatives told us they felt safe. One person who lived in the home said "All of the staff are nice, they never shout at me. I've never seen anything bad. They're not horrible with anyone". A visiting relative told us "The staff really know my wife and therefore it reassures me she is safe". Another person's relative said "All the staff are kind and of a high standard. I've never encountered anyone I've had worries about, and there are enough staff".

People were kept safe because risks were well managed. We observed staff cared for people in a safe manner, for example: supporting them when walking; ensuring footrests were used when using a wheel chair to prevent damage to their feet; and using appropriate manual handling techniques when using hoists or supporting people to stand. People were moved safely and their dignity was maintained. The service had a planned equipment maintenance programme and regular testing to ensure equipment was safe for people to use.

People's risks were assessed and information was provided to staff on how to reduce the identified risks. Staff demonstrated a good knowledge of people's risks. For example, one person's care plan said they had an allergy to a food item, all staff spoken with knew to avoid giving the person the food item. Another person's records described them as at risk of falling. Information was recorded on how to reduce the risk, including ensuring the person always used their walking stick and staff remained observant. During the inspection we observed staff reminding the person to use their stick and supporting them to get the walking stick and use it.

Risks of people becoming dehydrated or malnourished were reduced because the risks were assessed and action taken to minimise it. People's fluid and food intake was recorded and monitored by senior care staff. If the levels of food or fluid intake were not maintained to an agreed level, a nurse was informed and action was taken to address this. For example, a nurse told us they would contact the GP for advice and ensure staff were informed at each handover to encourage the person to eat or drink.

Risks associated with people's personal care were monitored. A folder was kept in each person's room recording the daily care provided, observations about people's skin where creams were applied, and the water temperature of people's shower. Air mattress pressures were checked and recorded to ensure they were correct for the person's needs, and records were made when people were repositioned. Records showed the home had a very low incidence of pressure sores. A senior care worker told us it was their job to ensure staff completed the records accurately and reported any issues to the nurses.

The service protected people from the risk of abuse through appropriate policies, procedures and staff

training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns within the organisation and to external authorities. Staff told us they had no concerns about any of their colleagues' practices but would not hesitate to report something, if they had any worries. Staff were confident the provider would deal with any concerns quickly to ensure people were protected.

The risks of abuse to people were also reduced because there were effective recruitment and selection processes for new staff. Staff described their recruitment which included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks a person's criminal history and their suitability to work with vulnerable people.

Records showed incidents and accidents were investigated and action plans put in place to minimise the risk of recurrence. As far as we could ascertain, the service met its statutory obligations to inform the local authority safeguarding team and the Care Quality Commission of all notifiable incidents.

Staff knew what to do in emergency situations. People's files contained personal emergency evacuation plans which described the measures staff had to take to support them to remain safe. For example, in the event of a fire, the information described the nearest exit route and/or safest place for the person to go to. It also stated whether or not the person needed support with a hoist and whether they used a wheel chair for mobility.

There were service continuity plans in the event of an emergency situation, such as a fire or utilities failures. In-house maintenance staff and external specialist contractors were employed to carry out fire, gas, and electrical safety checks to ensure the environment was safe. The registered manager and the provider's senior management team also carried out regular health and safety checks. The service had a comprehensive range of health and safety policies and procedures for staff to follow.

There were enough staff to keep people safe and to meet their needs. The day time staffing level was based on a ratio of four people to one member of care staff, excluding people receiving one to one staff support. On the day of inspection there were two trained nurses (or equivalent) and 11 care support staff. In addition, three people with complex needs received one to one staff support. At night, there were either two nurses and four care staff, or one nurse and five care staff. One person received one to one staff support at night. The service also had a team of domestic, laundry and kitchen staff. The registered manager and her deputy (on three days of the week) were additional to the staffing levels detailed above.

The registered manager said they never start a shift short-staffed. If sufficient notice was given they used their own bank or agency staff to cover absences. Very short notice absences were sometimes covered by domestic staff, who received the same training as the care assistants, except they were not allowed to move or reposition people. A relative said "Generally speaking there are enough staff and the number of agency staff has dwindled a lot". A member of staff said "Yes, there are enough staff most of the time". Staff and relatives commented on the high turnover of staff over the last 12 months but said this was now beginning to settle down. Please see the Well led section of this report for more details.

People received their medicines safely from staff who had been trained and assessed as competent to administer medicines. The nurses were responsible for administering people's medicines, although occasionally the care supervisors assisted if a person needed additional time and support with taking their medicine. The care supervisors received distance learning and training from a local pharmacy in medicine administration. Their competency was then checked by the home's deputy manager (a registered nurse) before they were allowed to support the nurses with their medicine rounds.

We observed people were given their medicines in a safe, considerate and respectful way. One of the care supervisors said "We are very vigilant and particular with medication. Care staff don't interrupt the nurses when they are doing the medicine rounds".

Medicine administration records (MAR) were accurate and up to date. Medicines were stored safely and there were suitable arrangements for medicines which needed additional security or required refrigeration. The provider had an appropriate medicines policy and procedures. A GP visited the home every week and reviewed people's prescriptions, including 'as required' medicines, to ensure they were up to date and appropriate.

People were protected from the risk of infection and there were effective infection control measures in place. There were sufficient supplies of personal protective equipment (PPE) for staff to use, located around the premises. We observed staff wearing protective aprons and gloves when providing personal care and when preparing or handling food. There were also notices around the home advising staff about how to maintain a safe level of hand hygiene.

On the day we inspected there were no reported infections in the home. We were told if a person had an infection, a discreet symbol would be placed on their door to alert staff and visitors of the increased risk. We observed the home was very well maintained and appeared clean and tidy throughout. There were clear housekeeping schedules and we observed regular cleaning of the premises during our inspection.

Good

Is the service effective?

Our findings

People and their relatives told us the service was effective in meeting people's health and personal care needs. One person who lived in the home said "We are always asked if we are alright. I can see the doctor if I want to, but I don't have to". A relative said "The impact of being here has been good for both of us. My wife's improved so much. The last few months she's been so much better and calmer. She now instigates conversations with me whereas before she was just reactive. The nurses said they haven't changed her meds so it must be the care she is getting".

However, a number of relatives commented on the high turnover of care staff over the last 12 months. One relative summed this up by saying "There has been quite a lot of change but overall I'm happy. The new staff are as good, if not better than before, and they are very professional and good at their jobs".

People's needs were fully assessed prior to moving to the home and then regularly thereafter. This ensured people's changing care needs were understood and met. Appropriate equipment was also in place as needed. For example, people at risk of pressure damage to their skin had specialist pressure relieving equipment and the home was equipped with assisted bathing facilities for people with mobility needs.

People were supported to maintain good health and wellbeing. A number of people had complex physical and/or mental health needs and some required one to one staff support. There were always at least two qualified nurses on each day shift to ensure people's clinical needs were met. The service employed a mix of general and mental health registered nurses. A local GP visited the home on a weekly basis, and also at other times as requested. A dentist, optician and chiropodist also visited regularly. People's care records described their health needs and any risks associated with them. Information was provided on the action needed to maintain their health, including regular access to external health care professionals when needed. We saw there were records of multi-professional assessments in people's care plans.

People were supported to access healthcare practitioners from the local GP practice, speech and language therapists, dieticians, tissue viability nurses and other specialist nurses. For example, a person who had shown signs of being at risk of choking had an assessment completed by the speech and language therapy team who provided information on how to reduce the risks. Relatives told us they were informed of changes in their relative's health needs and they were involved in discussions about their care.

People's records relating to wound care demonstrated their wounds were being monitored appropriately. For example, photographs were used to show if wounds were improving or deteriorating and appropriate action was taken. The nurses detailed how people were in their daily records and noted any changes in people's needs, risks or care. The information was discussed at shift hand-overs to ensure all staff were aware and up to date with people's current needs.

Staff received training to ensure they had the knowledge and skills to provide effective care in line with current best practices. This included generic mandatory training, such as: safeguarding (which also covered the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards), first aid, infection control, fire

safety, moving and handling, and living with dementia. Person specific training was also provided to meet people's individual needs, including communication strategies for people who were unable to speak or could not fully understand verbal communications. A fairly new member of care staff said "The training is helpful and interesting and it has helped me be better at what I do".

Newly appointed staff completed an induction programme and worked alongside more experienced staff. During their induction, staff completed a range of mandatory and service specific training. The Care Certificate had been introduced as part of the induction programme. The Care Certificate covers an identified set of standards which health and social care workers are expected to adhere to in their daily working life.

Training records showed staff were up to date with their mandatory training. The provider also supported staff with continuing training and development, including vocational qualifications in health and social care.

The majority of the staff we spoke with said they felt very well supported by colleagues, senior staff, the registered manager and the provider. Please see the Well led section of this report for further details. Staff told us they received individual staff supervision from their line manager every couple of months, as well as team supervision sessions, and an annual performance and development appraisal. This provided a regular opportunity for performance review and to discuss any staff training and development needs.

Staff said they all worked well together as a supportive and caring team and this helped them provide effective care and support. In addition, people's individual care and support needs were regularly discussed at shift hand-overs, staff supervision sessions and monthly team meetings. Staff told us they were able to rely on the senior care staff and the nurses for advice or assistance whenever needed.

Staff received training and had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found staff knew how to support people to make decisions and knew about the procedures to follow where a person lacked the capacity to consent. This ensured people's rights were protected. Care plans recorded discussions with people's relatives and any decisions made in their best interest. This included Do Not Attempt Resuscitation (DNAR) decisions.

DoLS applications had been submitted for the majority of people who lived in the home, as certain restrictive practices were necessary to keep people safe from harm. Six DoLS authorisations had already been granted and the remaining applications were awaiting decisions. The authorisations granted were all within the date of expiry and the service was complying with the stated conditions. This showed the service followed the requirements in the DoLS. We observed there were associated risk assessments and best interest decisions documented in people's care plans. We were told restrictive practices were regularly reviewed with a view to reducing the number and impact of any restrictions on people's freedom, rights and choices.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. People's nutritional needs were assessed and staff were knowledgeable about each person's dietary needs and preferences. Some people were prescribed food supplements and others required food and drink at a specific consistency to help them swallow and avoid choking. At lunch time we observed an experienced staff member providing clear instructions to a newer member of staff on how to assist a person who was at risk of choking.

We observed the lunchtime experience in two of the home's dining rooms. There were pictorial menus on each table, along with condiments and napkins. Menus provided a choice of two meals as well as alternatives, such as salads and jacket potatoes. People were offered a choice of drinks by being shown two jugs of juice. Staff sat down to be at eye level with people whenever they spoke with them or asked them a question. Staff were caring, patient and gentle in their approach and the way they encouraged people to eat and drink. There were sufficient numbers of staff to support people appropriately and in an unhurried way. We observed some people received one to one staff support, some were supported by their relatives and others were able to eat their meals unassisted. If people wanted, they could choose to have their meals in their own rooms.

One person said "The food is very good, but it does depend on who is in the kitchen. If I don't want something they ask me what I would like instead". A relative told us their husband needed to have a soft diet and so their food was mashed up. They said "The food is the same as others have and there is variety. When I asked for bigger portions they accommodated my request".

To help people living with dementia understand the meal choices, staff plated a small sample of each meal to show people what the choice was. People then either said or pointed to their choice. On the day of inspection the choice was either lasagne or a mushroom omelette served with mashed potatoes, broccoli and gravy. Both of the sample plates included mashed potato and broccoli, which meant the two plates looked very similar. This made it more difficult for people with limited understanding to decide on a preference. Also, the broccoli was overcooked and looked unappetising. The cook said they did not know what had gone wrong with the broccoli that day. They had also been told they had to serve the meal with mashed potatoes. Later, the registered manager told us this was decided at a relatives meeting as they wanted to limit the number of meals served with chips.

People who were able to communicate and people's relatives had been consulted about a new two weekly menu. The new menus were agreed at the June 2016 relatives meeting and were being introduced the week following our inspection. The new daily menu choices were varied and looked appetising. They included meat, fish, non-meat and pasta dishes. Meals included a range of potatoes, including creamed, croquette, roast, chips and new potatoes. A selection of seasonal vegetables was also available each day.

People also had a choice of desserts, breakfasts and suppers. Drinks and snacks were also available throughout the day. People could choose fruit juice, tea, coffee or milk drinks as they pleased. We observed the home used 'vintage style' cups and saucers and were told this was to enhance people's 'cuppa' experience and to help them reminisce.

The service ensured that any special dietary needs were met. For example, soft or pureed meals were prepared for people who had swallowing difficulties. Portion sizes and calorie intake was controlled for people who needed to lose or gain weight. People who were at risk of malnutrition or dehydration due to their health condition received fortified diets. They were weighed regularly and their daily food and fluid intake was recorded and monitored by the nurses. Appropriate action was taken if the level was different from their assessed needs. There were also special diets for people with diabetes or gluten free

requirements.

The buildings and environment had been purposely designed to support people living with a dementia. The modern building was organised into four care units, each with 12 or 13 bedrooms, and their own nursing station, lounge and dining area. The accommodation was spacious, clean and bright throughout with lots of natural light.

The door to each person's room was designed to resemble a house front door, with a knocker and door number. People were able to choose their own preferred door colour. Each room had a 'memory box' on the wall next to the front door containing some personal items to help people remember their room. We observed all of the communal facilities were identified by large signs with pictures to help people understand their use. For example, the dining areas were sign posted with pictures of knives and forks.

We observed there were handrails throughout the home to help people with mobility needs. There were also lots of cuddly toys placed along the handrails to provide sensory interaction for people who wanted to grab them. Similarly there were 'rummage boxes' in a number of the communal areas.

A striking feature was the large communal conservatory in the centre of the ground floor. This had doors leading out onto the homes lovely, well maintained and secure gardens and grounds. We observed some people sitting in the gardens. One person who lived in the home was enjoying sitting on their own and having a smoke, other people were sitting and chatting with their relatives. Visitors told us their relatives enjoyed going for long strolls around the large grounds and also spending time in the home's well stocked pet farm.

Good

Is the service caring?

Our findings

We observed people were cared for by gentle, caring and patient staff. Staff went to people's eye level whenever they communicated with them and spoke in a clear and kind manner. One person who lived in the home said "All the staff are nice. They are always asking us if we are alright". A relative said the staff were always kind and made sure their relative looked nice. We observed all of the people looked well cared for and were appropriately dressed in clean clothing. A member of staff said "All the care staff are so kind. For example, if they notice someone's top is up they will pull it down".

Relatives told us they were always made to feel welcome when they visited. One relative said "I can visit when I like, unless they are doing personal care". Another relative who visited the home most days said "They look after me as much as the residents". Relationships between staff and relatives were very friendly and positive. A relative of a person with severe mental and physical disabilities told us the person loved to visit the home's pet farm and see the animals. They said "They (staff) bring in rabbits to sit on his lap, which he really likes". Staff also told us how much "fun" they had with people and their relatives at a recent tea party to celebrate the Queen's 90th birthday.

People looked relaxed and comfortable with the staff who supported them. The atmosphere in the home was calm and cheerful. One staff member told us "I really love my job because we all get on so well and it's nice to get the odd smile from someone". Another member of staff had received dementia training and told us how this impacted on the way they cared for people. They said they had learnt about "being patient and having a 'butterfly moment', like seeing someone smile. Just because their memory is failing, it is important to always try to find a moment of happiness".

We observed many examples of staff demonstrating a friendly, caring and compassionate approach. For example, at lunchtime we observed staff supporting people with their meals in a very caring and considerate way. We heard one staff member say to a person "Be careful, is it hot? Do you want help?" and another member of staff say "Are you OK" when a person coughed, and then "Bless you" when the person sneezed. Another person turned to the member of staff supporting them and gave them a kiss, saying "What a nice girl you are", the member of staff responded "Thank you". We observed lots of similar interactions which showed there was a real and genuine affection between people and staff.

People were encouraged to make their own decisions, as far as they were able to. We observed staff offered people options to choose from and then acted on the person's wishes. Staff also had a very good understanding of each person's needs and preferences. A member of staff said "Even if people can't tell us things, we get to know what they like".

Staff were trained to communicate with people in ways they could understand. Staff were patient and persevered, without rushing people, to ensure they understood people's wishes. Where necessary, people were assessed by a speech and language therapist who advised and supported staff with relevant communication techniques. Where people had limited understanding or communication skills the views of close relatives, or other people who knew them well, were also taken into consideration.

People were able to choose where to spend their time without any unnecessary restrictions. They could spend time in the company of others in the various lounges and other communal areas of the home, or they could choose to spend time in the privacy of their own rooms.

Staff respected people's privacy and dignity. For example, personal care was only provided in the privacy of people's bedrooms or in the home's assisted bathrooms. Staff placed a sunflower sign on the door when personal care was in progress to let others know not to enter. Staff also ensured doors were closed and curtains or blinds drawn, as necessary. If someone knocked on the door while personal care was in progress, staff said they always checked who it was and covered the person before opening the door. Staff respected people's privacy by knocking on people's doors and waiting until they were invited in. Throughout the inspection, we observed staff assisted people in a discrete and respectful manner.

Staff spoke warmly and respectfully about the people they supported. They were careful not to make any comments about people of a personal or confidential nature in front of others. They also made sure people's care plans were not left unattended for others to read. This showed staff respected people's confidentiality.

Information about people's end of life preferences, and any spiritual or religious beliefs, was recorded in their care plans. The service was accredited by the National Gold Standard Framework (GSF) which is a national scheme for ensuring high standards in caring for people at the end of their lives. We were told when a new person moved into the home they had a 'what I want for the future' meeting within two weeks of their arrival. People's relatives were also involved when it was appropriate to do so.

The provider supported people to practice their spiritual and religious beliefs where this was important to them. For example, some people were supported to attend local church services. Local clergy also visited the home to provide pastoral care for people who requested this.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was very responsive to their needs and people had a lot of choice about how they spent their days. One person said "There's something on every day. I usually go, unless I'm deep in a book. I like to read and come out here (the lounge) rather than be alone in my room, but I can choose". Another relative said "They have plenty of entertainment here and I don't have to pay anything".

Each person had a comprehensive care plan based on their assessed needs. People's needs were assessed prior to moving to the home to ensure the service could provide the necessary care and support. Care plans described people's individual care and support needs, decision making and communication abilities, and the things they enjoyed or disliked. Care records provided the necessary information for staff to enable them to respond to people's individual needs. For example, one person's records stated they needed visual prompts to help them make choices and staff needed to speak to them clearly at the person's eye level. We observed staff doing this when the person was invited down to lunch and then asked about their meal choice.

Staff demonstrated a good knowledge of the content of people's care plans. Staff told us they were encouraged to read the plans and keep them with them when delivering care until they became familiar with a person's needs. Care staff said they always informed the nurses if they noticed any changes. A relative told us "I've only got to say a concern and they are on to it. The doctor's seen him today and a nurse is always here". The nurses recorded any changes to people's needs and took appropriate action to make sure people's changed needs were met. Care plans were routinely reviewed on a monthly basis by the nurses and updated to reflect any changes in people's needs or preferences. We found the care plan reviews were all up to date.

Staff had a good knowledge of potential risks to people and how to reduce them. Care records included a section on managing identified risks, such as: the risk of choking, the risk of pressure sores, allergies and the risk of falls. Under each risk, the scale of risk was identified and details were given on how to manage and reduce the risk. Accidents and other incidents were clearly recorded and analysed. If any changes to care were needed the person's care plan was updated accordingly.

We met a person who was keen on sports. However, their care plan did not describe how staff could support the person with their interest. Pursuing their interest may have helped to improve the person's mood and reduce their anxieties. Staff told us they sometimes found the person's behaviours to be challenging but the care plan did not provide full guidance on how to manage this. It was clear from speaking with staff and the registered manager that a lot of time and effort had gone into obtaining professional advice. We were also shown documented evidence in support of this. The registered manager said the work was continuing and every effort was being made to improve the management of these challenges and the associated risks.

People and their relatives told us the care staff generally responded promptly to the call bells or when people needed assistance. One person told us "I have a buzzer in my room. Sometimes they are a bit slow

but not very often. I've been in another home and didn't like that at all. This is the best one I've been in". On the day of inspection, we observed staff were available whenever people needed support and call bells did not ring for extended periods. A number of people with more complex needs were receiving one to one staff support.

People contributed to the assessment and planning of their care, as far as they were able to. People's views were sought and it was recorded where people were unable to make certain decisions about their care. In these cases, staff consulted with people's close relatives and other professionals involved with their care.

The service arranged monthly resident and relatives meetings to discuss the general running and other aspects of the home. For example, the notes of the meeting on 4 June 2016 recorded discussions and decisions about the summer fete, new menus, use of a donation from a deceased person's relative, dining room redecoration and future activities. We met one of the relatives who was the designated Relatives Liaison person. They said they were available to offer advice to new or any relatives who wanted to discuss things with someone outside of the staff team.

People were encouraged and supported to make their own decisions to the extent they were able to. Staff used a range of different communication methods to aid people's understanding and choice. This included pictures and symbols, sign language, and physical prompts for people who had limited verbal communication skills. People and their relatives told us they could choose when they wished to get up or go to bed, what they wished to eat at meal times, where they wished to spend their time, and what activities to participate in. People were also able to make certain choices about the staff who supported them, for example, staff members of the same gender were available to assist people with their personal care, if this was their preference. A member of staff said "People can say if they prefer a man or a woman to help them. We will try to match people's staff preferences, for example, who provides their one to one support".

Care plans included details of people's communication and decision making profiles, mental capacity assessments and any best interest decisions made on their behalf. Care records showed people received regular assessments from a range of appropriate health and social care professionals.

The service responded to people's preferences regarding their rooms. All of the bedrooms were designed for single occupancy and were modern and spacious with ensuite WC and shower facilities. People's rooms were furnished to suit people's individual tastes and choices. Each room was personalised with the person's own belongings including flowers, family photographs, pictures and entertainment equipment. One person told us "I have my own door key to stop others wondering in". We observed people could choose to spend time in the company of others in the various communal areas of the home. Alternatively, people could choose to spend time alone or with their relatives, either in their bedrooms or in the home's secure and well-kept gardens or grounds.

People benefitted from a good deal of individual engagement with the care staff and a variety of organised social and recreational activities. Recreational activities varied according to people's needs and interests. Relatives also input to the planning of activities where people had difficulty in communicating their preferences.

The service employed two activities co-ordinators, with at least one of them on duty every day of the week. They circulated a weekly activities planner to every person and also displayed copies around the home. The activities planner detailed the various morning and afternoon activities organised for each day of the week, including weekends. Activities included group games (reminiscence, cards, dominos), bingo, music, animal therapy, walks in the gardens, arts and crafts. Individual activities were also provided for people who did not

want to, or were unable to participate in group activities. This included staff reading or chatting to individuals, manicures, hand massages and memory mitts. Memory mitts are knitted cuffs onto which a range of items, including ribbons, buttons or beads can be sown. Some people living with dementia find holding and 'playing' with these reduces their anxiety and promotes a feeling of calm.

The home had large, secure and well-kept gardens and grounds. These included a large pet farm with alpacas, goats, geese, and birds. They also kept 'petting animals' that could be brought into the home for people who were unable or did not want to go outside. These included rabbits, guinea pigs and tortoises. The service had its own mini-bus, with wheelchair access and a driver to take people out on trips. This included visits to local garden centres, the seaside, shopping, and other places of interest. The activities co-ordinator said they tried to offer as many people as possible a trip out on a rotational basis. However, some people were unable to participate in these outings due to their complex health conditions or behaviours.

People, relatives and staff told us the care staff, nurses and managers were accessible, approachable and responsive. The majority of people said they could go to the registered manager or their deputy and they would resolve any issues or complaints appropriately and promptly. One person said "I haven't any complaints at all. If I had one I would go to [registered manager's name] immediately. She sorts anything out".

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. In the last 12 months the service had managed three complaints under their formal complaints procedure. These related to the way staff communicated with relatives. The complaints had been resolved to the satisfaction of the complainants.

Good

Is the service well-led?

Our findings

Most of the relatives we spoke with said the registered manager was open, accessible and responsive. One relative said "She runs the place very well. She's definitely focused on the people here. The whole team are dedicated to the residents and to looking after the relatives". Another person's relative said "The manager is approachable and I would have confidence to go to her. She says her door is always open to us". On the whole, relatives were positive about the changes the registered manager had made over the last 12 months, although not all had been positive to begin with. Their main concern related to the turnover of staff although this was now starting to settle down.

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager told us their service philosophy was "For our residents to live as they want to live, safely". Staff training and development was used to promote these values and they were reinforced at staff meetings, shift handover meetings and one to one staff supervisions. The approach was also supported by associated policies, procedures and operational practices.

Staff told us the provider and their management team were very accessible, approachable and supportive. Comments from staff included, "They are supportive and approachable. They try to be flexible and if you help them they help you" and "I can't fault the company" and "They are a very good company to work for and are passionate about what they do. It is like a family, they respect you and you can always talk to any of the managers and to [the home owner's name] himself. Everyone works as a team".

Again, most of the staff we spoke with were very complimentary about the registered manager, although there were some mixed comments about her style and approach. Comments included, "She is absolutely fantastic and she's turned this place around. I now enjoy coming to work" and "She's a good person to talk to. I've no concerns, I love working here" and "She's firm but fair. Our opinions are valued". Most staff said they felt supported by the registered manager and she was approachable and open to suggestions. For example, a member of staff told us the manager had encouraged them in their learning and motivation to always improve. Another staff member told us their good work had been recognised and they were promoted which made them feel valued.

Staff described the registered manager's style as "fair but firm" and "direct". Most of the staff liked this approach as they said they knew where they stood and the manager was fair. However, we received calls from a couple of staff and relatives before and immediately after our inspection who did not appreciate this approach. A staff comment was "The manager is a bully, she is abrupt and shouts at staff" a relative said "The home is ruled with a rod of iron. The manager's approach is: my way or on your way".

During the inspection, we had an open and honest discussion with the registered manager about her approach. She told us when she first moved to the home she had to deal with a number of difficult staff situations, including regular staff absenteeism and staff repeatedly failing to attend mandatory training courses. Some of the staff had been managed through the provider's disciplinary process and some had chosen to resign voluntarily. The provider's external human resource specialists had advised the manager

on handling these issues. The provider also had a clear bullying and harassment policy and no staff grievance had been upheld.

The provider used an electronic online system to monitor staff satisfaction, called 'A Better Place To Work'. Every member of staff had access to the system and was invited to answer questions on a quarterly basis about their working experience and whether they felt valued. Staff were free to complete this anonymously or identify their names. Any issues were then flagged up for discussion at team or individual meetings, as appropriate. Once the results had been collated, a colour coded chart was generated to show the results for each of the provider's homes. The most recent chart showed a high staff satisfaction score at Immacolata House. The registered manager said if a home's score fell below set thresholds, the manager had to send a report and action plan to address this to the provider. The manager said staff morale also appeared very high at last week's staff meeting.

The service had a clear staffing structure, with clear lines of reporting and accountability; from care assistants, to senior care staff, to care supervisors, to qualified nurses, to the deputy and registered manager, to the provider's senior management team. We observed the registered manager was very visible around the home and provided clear and strong leadership. The nurses led the shifts and the nurses and care staff clearly understood their respective roles and responsibilities. The staff appeared to be highly motivated and entirely focussed on meeting people's needs. Decisions about people's care and support were made by the appropriate staff at the appropriate level.

The provider's quality assurance system was effective in ensuring people received good quality care in a safe and homely environment. This included monthly in-house audits of key aspects of the service, such as: medicines, nutrition, wound management, significant incidents, health and safety and the environment. The provider's quality and performance manager also carried out a full unannounced service review of the home every two to three months. The provider's operations manager and the home's owner also visited the service on a regular basis. A member of staff told us the home was visited by a member of the senior management team at least once a month.

Following these audits and reviews, the registered manager prepared and implemented an action plan to address any issues or areas for improvement. For example, the registered manager told us the incidence of falls had been analysed and they appeared to rise at particular times of the day, such as when staff were on their breaks. In response, the registered manager had changed the arrangements for staff break times and they were now monitored closely. The incidence of falls had reduced as a result. Again, following an analysis of skin tears, additional training was arranged to remind staff of correct techniques to use. Staff practices were observed to ensure skin tears had reduced. These examples showed the service learned from experience and took action to continuously improve the service.

To the best of our knowledge, the registered manager notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities. We observed the service kept records and investigated incidents. Where appropriate, action plans were in place to minimise the risk of recurrence. We were told the provider and the registered manager promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People and their relatives were encouraged to give their views on the service through routine conversations, care plan review meetings, monthly resident and relatives meetings, and the provider's annual satisfaction survey. Relatives told us they were always made very welcome when they visited and management and staff

actively encouraged their involvement in care planning and in service developments. Minutes of the relatives meetings showed they were well attended and changes had been made as a result. For example, relatives had asked for a board with staff photographs and names to help them identify and get to know staff, as there had been several changes. This had been actioned and was displayed in the main entrance hall. Also new menus were being introduced following discussions at the most recent relatives meeting.

The registered manager participated in forums for exchanging information and ideas and fostering best practice. These included service related training events, conferences and relevant online resources for obtaining information and advice. The registered manager attended the provider's home managers meetings and various multi-agency meetings with health and social care professionals. The service had achieved the National Gold Standard Framework (GSF) accreditation for caring for people at the end of their lives. They also participated in the nurse training programme with Bournemouth university.

An external consultancy firm was used by the provider to review and update their human resources policies in line with current legislation and best practice. Monthly management and staff meetings were held to discuss and disseminate information and ideas and to keep staff informed about service developments. These various methods helped the service to keep up to date with the latest and best care practices.

The service had links with the local community and people were supported to engage in the community to the extent they were able and wanted to. Staff supported people to participate in a range of social and leisure activities within the home and the community. The service held various events such as open days, Alzheimer's days, Art in the Garden supported by the local Ladies Guild, reminiscence events, fetes and other national celebrations.

The home also participated in the Archie Project, which is part of the school's curriculum. Archie is a fictional scarecrow who develops dementia. As the dementia develops he starts to lose his colour, but the colour soon returns when he is given good care and helped to reminisce. The young school children visited the home several times a year and dressed up as scarecrows. There were lovely photographs of the children in their outfits on the notice board in the home's conservatory. Four of the children were also chosen to write the life stories of four of the people who lived in the home.

The service worked in close partnership with local health and social care professionals. More specialist support and advice was also sought from relevant professionals when needed. We saw records of multi-agency meetings and support in people's care plans. This close cooperation helped to ensure people's health and wellbeing needs were met.