Avery Homes (Nelson) Limited

Birchwood Grange Nursing Home

Inspection report

177 Preston Hill
Harrow
Middlesex
HA3 9UY

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14 October 2016

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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?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 26 September, 4 & 14 October 2016 and was unannounced. Birchwood Grange care home is a 150 bedded purpose built facility in Preston Hill, Wembley. The home provides accommodation and personal care for up to 150 older people, including people with dementia. On the day of our inspection 143 people were using the service.

The service had a registered manager in post. He had been in post since October 2014. 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 service was owned by a different provider when we last inspected it in December 2013. The service met all legal requirements we checked.

Prior to this inspection we received feedback from the local authority contract monitoring team. They gave us their latest quality monitoring report from February 2016, which showed the service had made significant improvements since Avery Homes (Nelson) Limited took over. At this inspection, we also noted the significant improvements, as did the majority of professionals we spoke with.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to minimise the risk of harm. We saw evidence that concerns regarding people's safety had been appropriately managed and staff displayed a good knowledge of safeguarding principles.

When staff started employment they had a four week induction programme which covered mandatory training. The induction included the opportunity for new staff to shadow more experienced staff until they felt confident. Staff also had the opportunity to sign up for vocational qualifications in health and social care.

Staff supervisions, appraisals and staff meetings all happened regularly. Staff told us they were well supported. They spoke highly of the support they received from management and were confident they could raise any issues or concerns, knowing they would be listened to and acted upon.

We saw that sufficient numbers of staff were on duty to meet the needs of people who used the service. Staff underwent a range of pre-employment checks to ensure they were suitable for the role. Checks had also been undertaken to ensure that all the nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC).

We raised concerns about a prescribed supplement (complan) of one person, which the service investigated and rectified. People had their medicines managed safely, and received their medicines in a way they chose and preferred. Staff had completed training in the safe handling and administration of medicines, which was refreshed annually.

We raised concerns about the calculation of people's nutritional risk, which the service rectified. Overall, we saw that people received on-going healthcare support from a range of external healthcare professionals and their health and nutrition were monitored and responded to in line with nationally recognised practice. We also saw the registered manager took a pro-active approach to ensuring people who lived with a dementia related illness received care based on best practice.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People had access to healthcare services. They received regular visits from healthcare professionals, such as occupational therapists, chiropodists, and speech and language therapists. We saw if staff had any concerns about people's health, immediate referrals were made with appropriate follow up meetings. People were involved in multi-disciplinary team meetings which were held regularly to discuss their health concerns.

The service was outstanding in providing caring support. People were supported with care and compassion. People told us they were treated with dignity and respect. Staff understood the need to protect people's privacy and dignity. People told us staff knocked on their doors before they could enter their rooms.

People were supported to express choice. People who used the service and their relatives consistently said staff supported them with care and compassion and got to know people exceptionally well. People who had limited verbal communication were supported to make choices in relation to what they ate by the use of visual prompts. We saw people were offered a choice of drinks with staff showing people two options and allowing them time to choose.

The service responded to people's needs and preferences. People received a personalised service which was responsive to their individual needs. Care records were person centred and developed to meet people's individual needs and reviewed if there were any significant changes.

People were supported to lead a full and active lifestyle. Activities and people's daily routines were personalised and dependent on people's particular choices and interests. People were supported to develop their skills and pursue their hobbies and interests.

Complaints were investigated and lessons learnt from them. Any concerns raised were assessed by the management team to see if any changes needed to be made to the service to minimise the risk of similar concerns being raised and to improve the quality of the service.

The service was managed by an experienced, knowledgeable and motivated registered manager who worked in partnership with other organisations to develop new and best practice. There was a strong commitment to deliver a high standard of personalised care and continued improvement based on the views of people who used the service and the enhancement of their lives.

The provider had a quality assurance system in place and gathered information about the quality of the

service from a variety of sources including people who used the service and other agencies.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

Overall, people received their medicines as prescribed and medicines were managed safely. There were robust systems in place to ensure people's risks in relation to the environment were minimised.

There were sufficient staff deployed to provide care and support to people when they needed it.

Is the service effective?

Good

The service was effective.

Staff were supported through an induction that involved a range of training methods, followed by on-going refresher training and support to complete vocational qualifications.

Communication with other agencies and healthcare professionals was consistently effective to meet the needs of people who used the service.

People were supported to maintain balanced diets based on their preferences. Staff had a good understanding of people's preferences and supported them to make choices.

Is the service caring?

Outstanding

The service was outstanding in providing caring support.

People who used the service and their relatives consistently said staff supported them with care and compassion and got to know people exceptionally well. Positive relationships were cultivated between people who used the service, their relatives.

People could express their views and make decisions, which staff

acted on and people's rights to privacy and dignity were valued. People receiving end of life care were treated with love and compassion, as were their relatives and those that mattered to them.

Feedback from people was unanimously exceptional, with people confirming they were treated with compassion, patience and respect by staff who had built mutually trusting and meaningful relationships with them.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred, with detailed life histories of people and information about their preferences, likes and dislikes. Staff displayed a good knowledge of this information.

Care plans were reviewed regularly and with the involvement of people who used the service and their relatives.

People's changing needs were identified promptly and communicated to relatives, as well as appropriate agencies to ensure people's needs could be met.

Is the service well-led?

Good

The service was well led.

The registered manager He provided strong leadership. The staff were confident they could raise any concerns and these would be addressed to ensure people had a good quality of life.

There was a positive culture within the service and clear values that included involvement, compassion, dignity and respect.

People were included in decisions about the running of the service and were encouraged and supported to have their voice heard.

There were systems in place to assess and monitor the quality of the service. The quality assurance system helped to develop and drive improvement.

Birchwood Grange Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 September, 4 & 14 October 2016 and was unannounced. The inspection was carried out by two adult social care inspectors, a specialist advisor who was a qualified nurse and specialised in nutrition, CQC pharmacist, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted social and healthcare professionals who visited the service, and commissioners who fund the care for some people using the service, and asked them for their views. Before the inspection, the provider completed a Provider Information Return (PIR.) This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with 13 people who lived at the service and the relatives of three people. We also spoke with 11 members of care staff, a member of the social care staff, the cook, members of the management team which included a deputy manager, registered manager and regional manager. We observed care and support in communal areas including lunch being served. We looked at the care records of 12 people who used the service. We also saw a range of records which related to the running of the service, including nine staff records and records of internal audits carried out.

A high number of people who used the service lived with a dementia related illness and so some of them

could not describe their views of what the service was like and so we undertook observations of care and support being given. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe when they received care and treatment from staff. Comments from people included, "I feel very safe here" and "I feel completely safe here". Relatives of people were also complimentary. Compliments included, 'we are pleased [our relative] is in a safe environment' and 'I am very pleased with everything, and would certainly recommend to anyone I know'.

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed in relation to many areas including moving and handling risks. We saw care plans had been put into place to help reduce or eliminate the identified risks.

The home had a 'falls prevention champion'. The role involved conducting monthly meetings with staff, updating staff about evidence based practice and completing a monthly falls audits. We saw there had been a monthly reduction in the number falls at the home since the new provider acquired the home in November 2014.

There was a process in place for reporting incidents. Records showed all incidents were logged and discussed at management meetings. The reporting process involved completing an intranet incident form, sending an alert to the regional manager, reviewing the alert and then, if required, actions added by the home. The home undertook a reflective practice for each incident to ensure that any lessons learnt were transferred to practice.

The equipment within the home had been serviced and maintained on a regular basis. These checks helped to ensure the safety and wellbeing of people who used the service, including staff and visitors. A fire risk assessment was in place and regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear.

There were suitable contingency plans in place to ensure the continuity of the service in the event of staff sickness, IT failure or the loss of utilities such as water, gas and electricity.

People who used the service were protected from the risk of harm and abuse. There was a safeguarding policy and procedure together with contact details of the local safeguarding team. Staff had received training in safeguarding adults. Staff knew and were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, care coordinator or where appropriate, the local authority or Care Quality Commission (CQC).

We looked at the recruitment process. Staff files were well organised and included a checklist to confirm the required checks and documentation were in place. Documents included proof of identity, job description and at least two references. Checks had also been undertaken to ensure that all the nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC). The files showed checks had been carried out with the Disclosure and Barring Service (DBS).

Review of staff rosters confirmed there were sufficient staff deployed to provide care and support to people when they needed it. The registered manager told us that any staff absences were covered by home staff and that agency staff were never used. This helped to ensure people received safe and consistent care. We noted there was also a team of volunteers who undertook a range of roles throughout the home. The regional manager told us that staffing levels were assessed on a daily basis by the registered manager. She told us checks were made to ensure there were adequate numbers of staff on duty by speaking with staff and assessing people's health needs.

On the first day of the inspection we saw that one person who was on prescription of nutrition supplement (complan) had not received their supplement for five days. We saw that a repeat prescription had been completed and faxed to the GP surgery. However, the repeat prescription request included other items and there was no annotation to indicate the person was without any in stock. The management were unaware that the person had run out of their prescribed supplement. Following our feedback, the home had investigated this and found that the person had not been affected. The investigation also concluded that this was a staffing error in not following procedures. We were told about the action taken by the provider which included the provision of refresher medicines management training by a community pharmacist.

On the second day of the inspection, we checked to make sure people received their prescribed medicines as prescribed. The service had suitable arrangements to ensure people were protected against the risks associated with the inappropriate management of medicines. Other people we spoke with told us that staff gave them their medicines when they were supposed to and relatives said they were happy with the way staff managed their relations' medicines.

We checked medicines audits, medicines administration record (MAR) charts, and medicines supplies. We saw all other prescribed medicines were available at the service and were stored securely in locked medicines trolleys. This assured us that medicines were available at the point of need. When the medicines trolleys were not in use, they were secured to the walls in an appropriate manner.

Current fridge temperatures were taken each day, including minimum and maximum temperatures. During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. Staff told us how to reset the fridge should it go outside of the recommended range. Overall, people received their medicines as prescribed, including controlled drugs (CD). We looked at five MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, and as prescribed. Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by the pharmacy (as evidenced by the pharmacy returns book). Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's medical conditions were not managed by excessive or inappropriate use of medicines. Where a variable dose of a medicine was prescribed such as one or two paracetamol tablets, we saw a record on MAR charts of the actual number of dose units administered to the person. We saw four PRN forms for pain-relief/laxative medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. The service followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the CCG pharmacist, the service and pharmacy supplier. These included safe storage of medicines, room and fridge temperatures, CDs and stock quantities of non-blister packed medicines on a daily basis.

People who attended the home were cared for in a clean and safe environment. Infection prevention control policies and procedures were in place. Staff demonstrated their awareness of the actions they would take to prevent the risk of cross infection.

Good

Is the service effective?

Our findings

People and their relatives told us they were cared for and supported effectively, according to their needs. They told us staff responded quickly to their health needs. This was consistently confirmed by most GPs and other health care professionals we spoke with. One GP commented, "I feel that since the change in management the nurses refer patients to GPs more easily and now fortnightly ward rounds pick up problems early. The nurses are very professional and follow the GP instructions easily."

When staff started their employment they had a four week induction programme which covered mandatory training. This included shadowing experienced staff to get a good overview of the running of the service. Staff were expected to complete 'The Care Certificate'. The Care Certificate is a relatively new method of inducting care staff in the fundamental skills and knowledge expected within a care environment. Staff confirmed that they had completed an induction programme at the beginning of their employment that had included the opportunity to shadow more experienced staff until they felt confident. Staff also had the opportunity to sign up for vocational qualifications in health and social care.

There was a comprehensive training programme that was delivered to staff as part of the mandatory induction. Modules included safeguarding, moving and handling, fire safety, Mental Capacity Act 2005 (MCA), medicines and infection control, which were refreshed on an annual basis. Staff also received training which was specific to people's individual needs, including, dementia awareness (including, experiential dementia training), falls awareness, continence care, and pressure sore awareness. Staff spoke highly of the training available to them and how it improved their understanding of their role. Face to face revalidation training was also provided to ensure that nursing staff were supported to perform their roles. A staff member told us, "This new company has given us good quality training. Previously, we would do training on-line but we are now receiving face to face training."

Staff had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. We saw that the records were detailed and individualised. Items discussed included recent issues involving people they supported, learning and development, work place matters and actions from previous meetings.

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff demonstrated a good understanding of the process to follow where it was

thought that people did not have the mental capacity required to make certain decisions. We saw records that showed best interests meetings had taken place and when mental capacity assessments had been completed. For example, we looked a MAR chart for a person who was administered their medicines covertly. They had the appropriate authorisation and input from professionals to enable them to have their medicines covertly. There was evidence of a best interests meeting, mental capacity assessment and a medicines form which was signed by the GP and the pharmacist. This assured us that people in this location were administered medicines covertly in an appropriate manner in accordance with legislation and recommended guidance.

We saw DoLS authorisations for people who were under constant supervision and not free to leave the building for their own safety. There were records of extensive involvement with health care professionals when staff had concerns about people's capacity, involving dementia specialists, and best interests' assessors.

On the first day of the inspection we raised concerns regarding the way MUST scores were calculated. We looked at a sample of five care records, which showed the MUST Scores had all been incorrectly calculated. However, we saw no instances where this had any negative impact on the affected people. For example, one person had a MUST Score of 3, which was incorrectly recorded as 1, indicating low risk. However, the person was receiving fortified food as staff knew the person's needs even though this was not documented in the person's eating and drinking plan. The nurse in charge was not able to explain the calculations for MUST Scores. The registered manager and the clinical nurse lead agreed that it appeared some nurses did not understand how to calculate the MUST score. The service reassured us they were making amends and sent an action plan to us following the inspection.

People were provided with a choice of suitable and nutritious food to ensure their health care needs were met. The home provided a variety of foods to suit different people's preferences, including an Asian kitchen which catered for Asian people receiving care or otherwise those who wished to eat this style of food. The main kitchen provided three course meals, three times daily and snacks, which were served throughout the day. The chef could evidence that high calorie snacks, low sugar snacks and fresh fruit were freely available.

People were shown menus; written and pictorial, the day before and supported to make their choices. If the person decided to choose something different the next day the chef explained this would not be an issue as he took pride in supporting people's enjoyment of food. The chef had picture evidence of how puree or soft meals were prepared to include the use of moulds to ensure food looked aesthetically pleasing and we observed food was presented in an appetising manner.

The kitchen had a supply of adaptive cutlery and plate guards. The kitchen supplied whatever was needed to the unit if staff assessed this will support people's independence. During the inspection the chef was seen to visit the dining rooms and interacted with people, discussing their meals as he was well known to people and could converse with them in more than one language.

The chef had evidence of taster sessions and was keen to discuss his support for nutrition and people's enjoyment of food. This also involved people's families. The chef had developed an information board for the catering team designed to hold key information for staff. Information flow between units and the main kitchen was also shared on a kitchen questionnaire form and daily meal sheets. Information included dietary preference such as vegetarian, egg free, consistency (puree or soft), and special meals to include allergy or diabetes.

People and their relatives told us they were consistently supported to have food and drink of their choice.

We saw entries in care documentation of the food people had chosen and the means by which staff supported people to have a nutritious diet. For example, one person had a medical condition, which required that their diet was monitored. Like others receiving care, this person had a 'choices and preferences plan' in relation to eating and drinking. This person had an additional care plan to support swallowing difficulties which gave staff clear information on how they were supported and how the food was prepared. This person had been weighed regularly and the weight had remained relatively consistent .There was an additional care plan for weight loss and a risk assessment related to weight loss. We saw this support strategy was regularly reviewed.

We saw information in people's care records where staff had made contact with a number of health and social care professionals, including occupational therapists, physiotherapists, speech and language therapists (SALT) and dietitians. They were involved in multi-disciplinary team meetings which were held regularly to discuss people's health concerns.

The service catered for a large number of people who lived with a dementia related illness. The registered manager had shaped the service based on the Bradford university dementia care mapping, which is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence. There were a variety of lounge areas for people to choose from, and in each one there were objects of reference which people would recognise from their past, such as radios and telephones. Different themes were placed in every corner. A 'dementia garden' had been created. This was covered with colourful watering cans, pots, bunting, butterflies and windmills. The home had erected an outside lounge so that people could shelter against the wind, sun or rain in the garden to encourage using the space. The other gardens were full of interesting features including fruit and vegetables, carved sheep and chickens, carved wooden plinths, fountain, giraffe and a commemorative poppy field. There was a tepee, where people could sit and listen to birds. The activities coordinator told us people had sessions every other day with reminiscences and coffee mornings. She told us, "When relatives are upset, we also bring them here. It is quiet and peaceful." Relatives were complimentary to the change of scenery at the home. One relative commented, "The subtle changes that are being made to the outside spaces and the colours and contrast in the building are noted and make a real difference. You have focussed on ensuring the look and feel of the Birchwood Grange is homely."

Outstanding ☆

Is the service caring?

Our findings

People and their relatives spoke positively about the care provided at Birchwood Grange Nursing Home. One person told us, "This is an excellent home. The manager and staff go beyond their duty of care. They are exceptionally compassionate." Relatives were extremely pleased with the care and support their family members received. They were consistently complimentary about the attitude of staff, who they said treated people with kindness. One relative said, "I will be away for two weeks but I know mum will have wonderful care whilst I am away. To be able to go away and not worry about her means so much to me and I do appreciate all the care and attention (in all aspects) that you and your outstanding team deliver." Another relative commented, 'The level of care, specific to the needs/illness of the person is truly outstanding here, and to have committed, caring and hand-picked qualified staff makes all the difference'. The feedback from professionals was consistently positive about the caring attitude of the staff.

Throughout the inspection we observed positive interactions between people and staff. The registered manager and staff were always observed to be compassionate and interested in the needs of the people. Staff spent a lot of time sitting with people, chatting and listening intently to what they had to say. They offered reassurance and diversion to people who lived with a dementia related illness and responded to their requests. This was carried out in a way that demonstrated compassion. As we walked around with the registered manager, some people warmly embraced him and talked with great fondness about him. One of the people said, "He is so wonderful. We love him. He really cares about us." We also observed the registered manager calling to each of the people we met by their name, showing that he knew people well.

People were supported to have their privacy and were treated with dignity. In a survey conducted in June 2016 they rated staff as good, very good and excellent at respecting their privacy and dignity. Regular meetings were held for people and these included discussions about each of the dignity values and what these meant. People had extensive plans in place which detailed the different aspects of how staff should support them with privacy and dignity to promote individualised care. People confirmed their preferences were respected.

People and their family members were involved in planning care. People's life history was recorded in their care records, together with their interests and preferences in relation to daily living. "The quality of staff and how training has been implemented enables staff to help [my relative] express their needs, whilst maintaining his dignity and treating them as an adult. Staff know [my relative], his history, routines and interests, which makes such a difference." People's bedrooms were personalised and contained photographs, pictures and personal effects each person wanted. A relative commented, 'You ensure [my relative's room] is hers, this does really help a dementia 'patients' settle in familiar surroundings reminiscent of their own homes'

It was evident from the following examples how staff had gone the extra mile to ensure that people were cared for and enjoyed a meaningful life. One person was emotionally unstable prior to moving to the home. We saw from their records they used to be upset and angry, and not interested to be involved in activities.

However, we saw considerable positive changes in relation to their emotional, behaviour and physical well-being since moving to the home. The person now enjoyed participating in activities and social events. A relative of this person commented, 'You have made a meaningful connection with [my relative] and you have helped [my relative] to feel at home'.

A second person also told us of how their life had been transformed. We saw from their records that they had lost confidence due to some life changes. Since moving to the home, we saw this person gradually gained confidence and had been involved in many activities, including sitting on the 'residents' committee, running the home shop and showing visitors around the home. The home had also supported this person to complete an introduction video, for other people who were not able to go around to view the facilities of the home because of their complex needs. At this inspection we saw this person had become a dementia champion and a blogger on the provider's website and newsletter where they wrote material about dementia. We read a compliment a relative had written to staff. This read, 'One hand on heart I cannot thank the team at Birchwood Grange enough, [the manager] goes the extra mile due to being the man he is and that he is the most

In another example, one person who had anxiety problems and refused to be engaged in outdoor activities was supported to re-engage with the community. The person had refused to be engaged in outdoor activities, and became aggressive if staff attempted to engage with them. Through months of support from staff, the person now volunteers at a local charity shop. Since making this progress, the person has been able to visit their family. A relative of this person commented, "Your activities coordinator has done an amazing work with [my relative]; endeavouring to work with [my relative], being compassionate and patient to gently encourage [my relative] from their room where they were like a recluse to now being an important part of the activity team."

Another person enjoyed talking about her life and felt happy when given opportunities to recall their life experience and achievements. The service ensured these opportunities were created by introducing the person to a range of media outlets where they talked about life achievements. The person was interviewed by a media outlet regarding older people who were over 100 years old. The person spoke about their life and experiences. This had produced a short film which celebrated the lives of older people. This involvement had played an important role in this person's wellbeing.

The home provided outstanding end of life care and people experienced a comfortable, dignified and pain-free death. The home was part of St Luke's Hospice project to support nursing homes in North Brent to deliver good palliative and end of life care. This followed the principles of the Gold Standards Framework (GSF) indicators to identify people who may be close to the end of their life and to plan for this eventuality. The GSF is an accreditation services can work towards and achieve and is aimed at improving the quality of care for all people nearing the end of life, in line with their preferences. The Nursing Home Facilitator from the Hospice told us, "Birchwood Grange has facilitated end of life care effectively and to a high standard."

We saw that a 'supportive care register and palliative and end of life care checklist' had been implemented on each unit. The supportive care register was being reviewed during each medical round every two weeks with an allocated GP, Clinical Commissioning Group (CCG) pharmacist, unit nurse and 'nursing home facilitator'. Consequently, the medical rounds provided allocated time to plan regular structured reviews of each person's condition and to identify people whose condition was deteriorating. A report by the Nursing Home Facilitator confirmed, through the implementation of the 'supportive register' each unit in the home had been able to undertake appropriate actions to ensure that people's needs were met as their conditions deteriorated. We saw the home was able to identify people entering the last year of life, assess and plan their identified needs, respond to people's changing condition and ensuring people died in the place of their

choosing. We saw evidence the service had prevented admissions to the acute sector on a number of occasions, which meant people were enabled to remain in their preferred place of care and die in their preferred place of death.

Selected staff had attended 'End of Life Care Champion Training' and a 'Palliative Care' module provided by St. Luke's Hospice. This helped staff to identify the needs of people at each stage of their life, assess their needs, wishes and preferences, and to plan care on that basis, enabling them to live and die well with dignity when they choose.

Visiting health and social care professionals described to us their impression of how the service supported people when they reached the end of their life. One healthcare professional told us, "End of life care is excellent. Staff have reviewed advanced care plans at early intervals and identified with [people] and their relatives the preferred places of care and death."

People who had made advanced decisions regarding end of life care had their decisions respected. For instance we saw that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were in place for those who had made this choice and this was highlighted in their care plans. All DNACPR paperwork was well written and demonstrated choice and relatives wishes where appropriate, signed by a GP and staff nurse. People receiving end of life care had a separate care plan, with hourly assessments by nurses for pain, agitation, nausea, vomiting, mouth care and positioning. This helped to ensure that people were supported to maintain their dignity and wellbeing at the end of their life.

We were also shown compliments that families had sent when their loved ones had passed away. Comments included, '"[Our relative's] stay at Birchwood Grange was a happy one and the manager and his team made sure [our relative's] stay was as comfortable as can be" and "A year has gone since the passing of [my relative] but once again we are all so grateful for the care and attention given to her during her stay at Birchwood Grange."

People, where possible, had outlined specific funeral arrangements. Some people had requested for last rites to be performed by the priest or in line with particular customs relevant to their religions when the time came. We saw this was supported. A room was also made available for relatives who wished to stay overnight during the last few hours of life. The home supported relatives with the Cortege, which proceeded from the home. Staff and the registered manager also confirmed they always attended the funerals when invited. In one example the registered manager was invited to a funeral to read the eulogy. The home made sure people who had passed away were able to be remembered by loved ones. There was a memorial garden where relatives were able to visit.

The home has hosted the end of life NHS consultant to deliver talks to families about end of life care. The registered manager told us; through this work the home has gained confidence from families, which has enabled people to receive the most appropriate care.

We saw sensitive personal information was stored securely in locked cabinets Relatives and people who used the service confirmed their permission was sought before their confidential information was shared with other healthcare professionals and we saw this documented in care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act.

Good

Is the service responsive?

Our findings

People told us the staff responded to them as individuals. This was also backed up by their relatives who told us, people were involved in all aspects of their care and that staff had worked with them to determine the support they needed. One person told us, "Staff put my needs first." Another person said, "The [activities coordinator] has helped me understand my illness and to be able to cope with everyday tasks and the odd drama that I find distressing."

Assessment of all needs had been undertaken before people were admitted into the home and person centred care plans were written for each person. Care plans were centred on people's individual needs, preferences and goals. They covered a range of areas such as likes and dislikes, personal care, nutrition and hydration, personal histories, mobility nursing needs and communication. There was reference to people's wishes and how they wanted their care needs to be met. This was supported by relevant documentation. For instance, one person's care plan reflected their needs for personal privacy and their personal choice related to how they wished to spend their time. The person's choices and preferences plan in relation to eating and drinking stated they liked to eat independently. They liked to eat their meals in their room, which we observed being facilitated throughout the inspection. The home stressed on people setting their own goals and how staff would assist them in that.

Care plans were detailed and had been appropriately updated when there were changes, with regular reviews. This meant that there was an up to date record for staff about how to meet people's individual needs. For example, one person had Type 2 diabetes. Detailed guidance was included for staff to support the person in the safest way. The diabetes care plan provided guidance for staff to check BM levels (self-monitoring of blood glucose levels), administer medicines regularly, refer to diabetic eye clinic, control diet in relation to sugar and carbohydrate, and encourage food and fluid intake. Care was well evidenced, well documented and tracked regularly. We evidenced this person had a healthy lifestyle care plan, diabetic eye screening had been completed, annual health checks with the GP had been carried out, BM monitoring chart and MAR charts had been regularly completed. This person's MAR chart confirmed administration of medicines to treat diabetes. All these documents were regularly reviewed.

The service was part of the local community. The registered manager and staff had worked to include the home and people using the service with the local community. A team of 50 volunteers had been recruited to assist with this as well as provide additional activities in the home. People were encouraged to be part of their local community and integrate into community groups in the area. The volunteers engaged with people in such activities as reading groups, walking, knitting, baking and playing board or card games. People were encouraged to continue with hobbies and interests that they were involved with before they moved into the home. For example, people attended local religious groups and churches, libraries, community social groups, and book clubs. This benefitted people as they were able to maintain existing interests and contacts. It also ensured they met new people and had different experiences.

The home also linked with a local school. Children from the school visited the home. The registered manager told us these links enhanced the quality of life of people and offered befriending opportunities and

further opportunities for more trips out. We saw that people had attended a spring concert at the school. We saw photos of people, which showed people having fun. All this reflected the work and benefits that this wider community engagement had provided to people living at the home.

People using the service requested specific activities and we saw these taking place. Activities were coordinated by the head of activities and well-being. We saw the activities coordinator had been nominated by relatives, volunteers and staff and was a national finalist in the Dementia awards 2016. People participated in a wide range of activities, including bingo, yoga, netball, table tennis and board games. Outside activities included the visits to dementia café, church, temple and shopping trips. We visited one of the people in their room doing painting. Their hobby was painting and drawing pictures. They told us they held classes for other people to teach them how to draw and paint. The person said, 'Doing my painting keeps me going and I am so happy that I can carry on doing what I enjoy. I am so lucky.' A social worker from the local authority told us, "The manager attempts to keep the community engaged with Birchwood Grange by his photo shots and regular newsletters. I feel the home is much improved."

People were assessed when they moved into the home so that the activities team got to know them and establish their interests as well as build up relationships to gain people's confidence. We saw that weekly activities sheets were available on the communal notice board. There was a monthly newsletter both in English and Gujarati so that people and their families were kept informed. This was also on social media to keep families involved. Activities for each person were also noted in their care plans and were reviewed on a regular basis.

Staff used innovative and individual ways of involving people. We saw that in consultation with BAT Foundation (Bounce Alzheimer's Therapy); the service was involved in an initiative to promote table tennis as an exercise intervention for people in the early stages of dementia. This was also consistent with The National Institute for Health and Clinical Excellence (NICE) evidence, which suggests exercise may be protective against developing dementia. Birchwood Grange was selected following a nomination from London Sport to take part in the trial. We saw people playing table tennis. One person participating told us, "I am enjoying playing tennis. This has made my stay at the home more enjoyable." The registered manager told us, apart from the researched evidence; this had created more opportunities for socialising and fun in the home.

Staff used innovative and individual ways of involving people so that they were consulted, empowered, listened to and valued. One of the people living at the home, who was also a dementia champion has hosted a table tennis project at the home as part of BAT Foundation. The person was also the representative of the home at the Alzheimer's show Olympia London and they had appeared on BBC Radio 4 to talk about the benefits of participating in the trial. Another relative told us, "Under the wonderful watch of the manager, I can say with hand on heart having had experience of two previous homes, this is 'THE' most amazing facility. The care and personal attention that every resident receives goes beyond what I can assure you is standard."

People told us staff had skills and excellent understanding of their cultural and religious needs. For instance, the home had its own temple within an Asian unit. The Asian unit was decorated by staff with involvement of families and people to ensure that it reflected their religious and cultural beliefs. We observed people praying in the Temple. One person in the Asian unit told us how they felt, "This is my home. I have everything I need here. I am so happy." The unit also operated a separate kitchen to serve people with different cultural needs. People were involved in the preparation of meals as they would do if they were living in their own homes.

We looked at the complaints recorded in the service and saw these were recorded in detail with evidence of them being investigated and resolved with the person raising the concern. Any concerns raised were assessed by the management team to see if any changes needed to be made to the service to minimise the risk of similar concerns being raised and to improve the quality of the service. Staff were aware of how to respond to complaints and records showed that discussions were held with people during regular meetings to embed the culture that people should feel able to complain without fear of retribution. There were accessible and detailed complaints procedures displayed in the service so that people would know how to escalate their concerns if they needed to.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. The registered manager had worked at the service since early 2015 and had significant relevant experience in health and social care, as did the deputy manager and the regional manager. The registered manager was nominated for Dementia Care Home Manager of the Year and was shortlisted to the final three at the National Care Awards'. We were shown an email from a relative which said, 'All in all I think you, your team and the home are outstanding. Excellent! Keep up the great work'. People who used the service and staff told us they considered the leadership of the home as exceptional. One person told us, "This is an outstanding home." Another said, "The care is exceptional."

The home has raised its profile on the Care Homes UK review of homes by families to 9.6. A maximum review Score is 10. This is an independent survey completed on London care homes based on recommendations made by people who used the service and their family and friends.

Staff spoke positively and passionately about working at the home. When we asked staff about the culture of the service, a member of staff told us, "We are like a family. We feel very well supported by the management. We put [people's] needs first. Speaking about the registered manager, another staff told us, "It does not matter if he is busy. He is always available to listen." On the day of the inspection the registered manager and senior staff team demonstrated they had the experience, capacity and capability to run the home.

Staff told us the registered manager were approachable and always took time to listen to all members of staff. Staff also confirmed that the management were always around at the home, which meant they always had the support they needed. Staff had opportunities to feedback or discuss any issues with the registered manager. They told us that appraisals, supervision and meetings were all platforms to feedback. Provider supported and resourced the service to enable and empower staff to develop their skills through training and personal development and this in turn helped to drive improvement.

Feedback from professionals was predominantly positive. Their feedback included, "The home has been turned around from a home no-one wanted to go to, to one where there is a waiting list for residents and a low turnover of staff", "The staff at Birchwood Grange deliver high standards of nursing care" and "The home is well-led."

There was a clear management structure in the home with senior staff allocated lead roles. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the operation and direction of the service. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve.

Birchwood Grange worked in partnership with other organisations and the local health and social community to ensure they followed and shared best practice. The service had been involved in a range of projects, pilot schemes and research projects. The registered manager told us this was used to enhance the lives of people who used the service and to encourage improvements. A healthcare professional told us,

"There are many initiatives that we have identified, to further improve the standards at this care home, which are already quite outstanding." The service had signed up for a falls prevention pilot, dementia care pilot, end of life care, audits of significant events and ambulance callouts. In all examples, we saw evidence the home was working in partnership with key organisations to support care provision, service development and joined up care.

There were methods of monitoring the quality of the service, which were used to improve the care people received. There were comprehensive audit systems in place which covered all aspects of quality and safety. The audits included care based audits, medicines administration, care documentation, maintenance, catering and social activity audits. There were also audits regarding health and safety checks and infection control.

Monthly audits were completed on any falls that occurred. These were analysed to identify whether there had been any environmental hazards or identifiable trend. An assessment was also carried out to ensure staff had taken the appropriate and on-going action needed to reduce the risk of further falls.

We saw that as part of the quality monitoring system, the home also relied on quality indicators. The indicators tracked changes over time to highlight potential quality concerns. Although this was useful to enable the management to have an overview of performance in relevant areas, this did not fully reflect the accuracy of the original data in some cases. For example, some information relating to malnutrition data that had been incorrectly calculated in people's files was not reflected as such in the quality indicators. Without checking the original data, the management would not have known about this discrepancy. Following our feedback the management team took immediate action to rectify the identified gap.

The registered manager and company director recognised the importance of capturing people's comments and sharing information via a range of different methods. There was a comments and a suggestions box in the reception area of the service, along with forms for people to either leave feedback on the service or make suggestions for improvements. A regular newsletter was circulated to people who used the service and their relatives. This gave information including an introduction to staff and what their area of delegation was, an update of staff training completed, details of social events, how to access health services and a record of any achievements in the service. Compliments were captured and used as a way of celebrating success with the staff.