The Royal British Legion

Mais House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Mais House on the 28 August 2017 and the 3 September 2018. The inspection was unannounced.

Mais House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mais House provides accommodation, personal and nursing care for up to 54 older people living with a range of physical health problems, such as Parkinson's disease, diabetes, strokes and cancer. There were also people who were now living with early stages of dementia and those who were receiving end of life care. There were 46 people living at the home at the time of our inspection.

At a comprehensive inspection in 28 and 30 October and 02 November 2015, the overall rating for this service was Inadequate and it was placed into special measures by the Care Quality Commission (CQC). Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by May 2016. During our inspection on 22 and 24 June 2016, we looked to see if improvements had been made. We found that the breaches of regulation had been met but needed time to be embedded in to everyday care delivery and Mais House therefore was rated as requires improvement. We inspected Mais House in August 2017 to see if the improvements had been sustained. We found that whilst the necessary improvements had been sustained, it was identified that whilst people's health needs were monitored but not all were effectively managed and monitored.

We undertook this comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan and confirm that the service had sustained the improvements. We found improvements had been made and sustained and the overall rating for Mais House has been changed to good.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

People felt safe living at Mais House. We were told, "I am safe and very happy," and "I am looked after and still as independent as I can be." Risks associated with people's care had been appropriately assessed. Medicines were managed and administered in a safe manner. There were sufficient staff available to ensure people received person centred care. Staff were safely recruited. Systems and processes were in place to ensure people were protected from abuse.

Staff had received regular training, supervision and an annual appraisal to support them to provide effective

care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People had choice around what they ate and were supported to maintain good health.

We observed kind and caring interaction between people and staff. People living in the home and their relatives praised the caring nature of the care staff and registered manager. People were supported to increase their independence and maintain strong links with their families. People were involved in planning their care.

Care plans were person centred, detailed and updated as and when people's care needs changed. People were supported to lead active and fulfilling lives and went on regular daytrips. Systems were in place to manage complaints. People and relatives told us they were happy with 'Everything about Mais House.' Quality assurance processes were in place to monitor the quality of care delivered. The registered manager worked in partnership with external health and social care professionals to ensure people's health and social care needs were met.

Further information is in the detailed findings below.

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

Mais House was safe

Measures were put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it.

Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

Mais House has improved to Good.

People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink. They had a choice of what that wanted to eat.

The service complied with The Mental Capacity Act 2005.

Is the service caring?

Good

Mais House was caring.

People's dignity was protected and staff offered assistance discretely when it was needed.

Staff provided the support people wanted, by respecting their choices and enabling people to make decisions about their care.

People were enabled and supported to access the community and maintain relationships with families and friends

Is the service responsive?

Good

Mais House was responsive.

People's preferences and choices were respected and support was planned and delivered with these in mind.

Group and individual activities were decided by people living in the home and regularly reviewed by them.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Good

Mais house has improved to good.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

A quality assurance and monitoring system was in place. The registered manager used this to identify areas that could improve.

Feedback was sought from people through regular meetings and from relatives, friends and health and social care professionals through satisfaction questionnaires.

Mais 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on the 28 August 2017 and the 3 September 2018 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with 18 people who lived at the home, four visiting relatives, ten care staff, four registered nurses, the area manager, the registered manager and the activity co-ordinator. We also contacted external health professionals, such as the paramedic practitioner, GP and speech and language therapists to gain their views of the service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the inspection. 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 reviewed the records of the home. These included staff training records and

policies and procedures. We looked at four care plans from the nursing floor, one respite care plan and three care plans from the dementia unit. We also looked at risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Mais House this is when we looked at people's care documentation in depth and obtained their views on how they found living at Mais House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At our last inspection this key question was rated as Good and this inspection found that it remained Good.

People told us they felt safe living at Mais House. One person told us, "I'm happy to say that I think this is the safest place you could be. Where I lived before I came in here was getting quite unsafe and it was a relief for me to feel safe again." Another person said, "I definitely feel very safe here. One of the reasons I came here was because I no longer felt safe at home. I have a buzzer round my neck, I only have to press it and they'll be here." A relative said, "It's absolutely safe here. My father came in here first after he'd had a stroke. They cared for him superbly and he improved rapidly. Mum came in a couple of months after him. I'm happy that they're being kept safe." Staff expressed a strong commitment to providing care in a safe environment.

People were protected as far as possible from abuse. Staff had received training in safeguarding adults and records confirmed this. Staff understood their roles and responsibilities in supporting people to keep safe from potential harm or abuse. Staff were knowledgeable about the different forms of abuse and how to recognise the signs if abuse was taking place. Staff told us, they would not hesitate to report abuse to the registered manager and were confident they would take appropriate action. The registered manager understood their responsibilities in reporting any concerns about people's safety which included reporting incidents of potential harm or abuse. A staff member said "I would report any issues or safeguarding concerns to the manager or local authority." They also told us told us, "There are various kinds of abuse; physical, financial, emotional, sexual. If I come on shift and I am alerted to something I'd check the person to make sure they're ok and then do an incident report and tell the manager." Procedures were in place for whistleblowing and safeguarding, as well as policies in relation to emergencies, fire safety, medicines, bullying and harassment.

Risk assessments identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. This included risk assessments for health-related needs, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, people with mobility problems had had an assessment and that was used to give clear guidance for staff to follow. This included specific equipment, such as hoist, type of sling and sling size.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

People were supported to live an independent life-style as far as possible despite living with a wide range of illnesses such as dementia, Parkinson's and diabetes. The manager and staff understood the importance of risk enablement, this meant measuring and balancing risk. One staff member said, "We want to ensure people live life to the full, taking risks is part of it." The staff team recognised the importance of risk assessment and not taking away people's rights to take day to day risks. With support from staff, people were supported to go out with family and take part in activities. Staff recognised the importance of respecting and promoting people's right to take controlled risk.

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "Everyone should be treated the same and be treated with dignity and respect. The same for the staff, we are all here to do a good job and personal differences and cultures don't change that." Staff were mindful of racism or sexism and respectful of people's differences. Staff had received training in equality and diversity.

Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or aprons when needed. The home was clean, and there were regular audits to make sure cleanliness levels were maintained. People told us, "Always very clean, never any odours."

Accidents and incidents were documented and recorded. Incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

The provider had ensured the proper and safe use of medicines within the service. Records confirmed medicines were received, disposed of, and administered correctly. Medicine records showed that each person had an individualised medicine administration record sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts are a document to record when people received their medicines. MAR charts showed that medicines were administered appropriately. There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. People's medicines were securely stored in the staff clinical room and they were administered by senior care staff who had received appropriate training and had been assessed as competent. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Staff arrangements included separate staffing on a daily basis for the residential and nursing units. Deployment of staff was based on the skills and competency of staff and the individual needs of people. For example, each shift on the residential unit required a senior carer with competency in medicines. The nursing unit had two registered nurses to oversee and monitor the clinical care provided. People told us there were enough staff to respond to their needs. Comments included, "Excellent staff, there when needed, I only have to ring," and "There are enough staff, and they are looking for more staff all the time." We observed people received care in a timely manner and call bells were answered promptly.

Recruitment processes were safe. Staff records included application forms, confirmation of identity and of the person's right to work. The recruitment process included a thorough interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring

checks (DBS) completed by the provider. These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Good

Is the service effective?

Our findings

At our last inspection this key question was rated requires improvement and improvements were needed to ensure peoples health needs were acted on effectively. This inspection found that steps had been taken by staff to ensure peoples' heath needs were followed up appropriately.

People and relatives had confidence in the skills and abilities of the staff employed at Mais House. People told us, "You can't fault the staff. They're kind and know what they're doing. They have good instincts and know when someone isn't feeling up to par and will find out why. They are polite and cheery when they talk to me and always call me by my name," "The staff are lovely and, yes, I think they are well trained. There's a good rapport with them and they know me and my likes and dislikes. I have days when I get particularly bad and can't even get into my electric wheelchair. They know when I'm bad and are always popping in saying; 'Is there anything you want? Visitors said, "I regularly eat with mum and dad, the food is very good. I think the menu rotates every four weeks. The kitchen staff are very good."

People's had access to care, support and treatment in a timely way with referrals made to appropriate social and health services when people's needs changed. We saw records of visits and letters from healthcare professionals in people's care files, such as speech and language therapists (SALT), tissue viability nurse, chiropodists, opticians and dentists. We saw SALT had assessed a person with swallowing problems and guidance was in place regarding food texture and thickening levels for fluids. All this information was on the person's care plans and in the kitchen. People had access to their GP if needed. One person told us, "They're very supportive. I have a hospital appointment next month. I'll get hospital transport but they will send a carer with me so I'm not on my own." Another said, "Doctor comes when I need him." Visiting healthcare professionals told us people were referred to them appropriately. One health professional said, "They respond quickly when a health problem is noted and work well with us." Another health professional said, "They are organised and seem to know their residents well."

People's needs were assessed before they came to the home. Information was sought from the discharging service, people's relatives and other professionals involved in their care. Care, treatment and support was delivered in line with legislation and evidence-based guidance. For example, the service had a copy of newly published guidance by the International Dysphagia Diet Standardisation Initiative (IDDSI) which described new definitions for texture modified foods and thickened liquids for people with dysphagia (difficulty swallowing).

Staff were working within the principles of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People commented they felt able to make their own decisions and those decisions were respected by staff. People told us, "The carers always tell me what they want to do and ask if that's okay with me," and "Usually it's me who does the asking so there's no consent needed for that. I try to do as much as I can to keep as much independence. I have a care plan and at least once a year it is reviewed, or if things change."

Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. The provider had up to date policies and procedures in relation to the MCA and staff were provided with information on how to apply the principles when providing care to people who lived at Mais House. We were also made aware of people subject to DoLS authorisations. At the time of inspection the registered manager informed us some people had been referred for a DoLS authorisation but some were still pending. A file was kept and updated when the DoLS was authorised.

The service had completed appropriate assessments in partnership with the local authority and any restriction on the person's liberty was within the legal framework. The service had submitted notifications to the CQC about the decisions of applications submitted for DoLS for people who used the service.

The provider had ensured that staff had the skills, knowledge and experience to deliver effective care and support. Staff were supported to complete an induction programme before working on their own. The induction was set specifically for each role and included shadow shifts with an experienced member of staff. One new member of staff said, "I had a really good induction and was supported working until I felt confident to work on my own." Staff completed training which included safeguarding, infection control, moving and handling and fire safety. During the day we observed staff supporting people with moving and re-positioning. Staff followed good practice guidelines, ensuring that people who needed hoisting had their personal sling, explaining what was happening and offering reassurance throughout. Since the last inspection the organisation had introduced a Practice Development Facilitator in each care home to oversee training requirements and support staff. Training sessions were followed by on the floor monitoring. This enabled senior staff to monitor how effective the training programme was and had resulted in bespoke training. These on the floor sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff told us they were supported through supervisions. Records showed staff had received supervisions as well as appraisals. A member of staff said, "I feel supported and receive supervisions regularly".

People were supported to eat and drink enough. People said that they liked the food and they were given choices, food that they enjoyed eating which was cooked well. We saw that alternatives were available if people wanted something different. Throughout the day we saw that people had access to drinks with staff offering hot and cold drinks. People had plenty of drinks in their room and communal areas were well supplied with drinks. Food and snacks were available throughout the night.

People's weight was regularly monitored and documented in their care plan. Some people didn't wish to be weighed and this was respected. Staff used other ways of assessing peoples weights such as arm measurements. Senior staff told us, "The kitchen staff and care staff talk daily about people's requirements, and there is regular liaison with SALT and GP." Staff understood people's dietary requirements and how to support them to stay healthy. Staff kept the kitchen informed of any changes to peoples' dietary needs and who needed their food fortified. Guidance was readily available in people's care plans about any special dietary requirements such as a soft or pureed diet. One person's care plan had a report which identified they

required a 'thick pureed diet. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this and contained information about how to increase calorie intake.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. All rooms had an ensuite facility and there were specialised baths and wet rooms for communal use. People were supported to move around the home and were assisted to remain mobile by staff. Communal areas and most corridors were suitable for people who used mobility scooters and self-propelling wheelchairs. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using electrical hoists. The lift enabled people to access all parts of the home. The garden areas including the greenhouse were safe and accessible to people who lived at Mais House. People brought they own ornaments, pictures and furniture to the home if they chose to and most rooms had been personalised pieces of furniture and photos of relatives and pets.

Good

Is the service caring?

Our findings

At out last inspection this key question was rated Good and this inspection found it remained Good.

We observed and heard that people were treated in a kind and positive manner and there was a warm and friendly atmosphere throughout the home. People commented, "I get on with the all of the staff. Some are better than others, but that's life. I like it here very much, they're all kind and very patient." and "I think the staff are saints. They are always cheerful and willing. They encourage me to just enjoy myself. I try to be as independent as I can, and the staff frequently tell me how independent I am."

We saw one person receiving palliative care from staff that were very attentive and demonstrated empathy and compassion whilst supporting them. Staff were vigilant and were always present in the communal area to supervise and tend to peoples' needs. For example, a person wanted to pet the visiting 'sensory' rabbits and so a staff member sat next to her until she was comfortable to hold the rabbit on her own.

Staff had developed good relationships with people and we saw warm interactions between staff and people. Staff spoke respectfully to people and knew the people they supported well. Staff recognised when people needed emotional support. We observed a person receive emotional support from a member of staff who recognised that they were becoming upset. The staff member sat with them, holding their hand and talking to them in a kind, reassuring way. The person's body language indicated that it had made a real difference to their wellbeing. On another occasion we observed a member of staff sitting with, and calming a person, who had become anxious. All the relatives we spoke with were positive when asked if they felt their family members were cared for and happy. Comments included, The staff are excellent. My parents are well known, well liked and well looked after," and "Mum is bed bound but has a physio come in to do work with her. The carers and nurses are just great. One of the carers, who is in today is just the best. She's always bubbly and buoyant, just the tonic anyone needs who's not at their best. Mum loves her."

The staff team had the information they needed to provide individualised care and support because they had access to people's plans of care. These included details about people's past history, their personal preferences and their likes and dislikes. A member of staff said, "We have an equality policy in place. Everyone is different and I treat people as I would like to be treated." one person told us, they liked to dress smart but casual and told us staff ensured that their clothes were clean and pressed, we were also told, "I like to wear make-up especially if I am going out, I can't do it myself but staff help me."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. We saw that staff sought accessible ways to communicate with people. We saw that people's communication needs was recorded in their care plans providing information and guidance on how best to communicate with people who had limitations to their communication. For example, whether the person had hearing or sight difficulties. We saw staff communicating with a person who had difficulty expressing themselves verbally. Staff spoke to the person slowly, listened and observed for facial expressions. This meant peoples' opportunity to communicate

effectively had been considered by the service.

We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I accompany you to the dining room." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. People were able to use mobility scooters both in and out of the home. One person said, "It's my lifeline, I like to go out on my own and staff support me and make sure it's possible."

People were supported to make their own decisions. Staff told us, "We let people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." People confirmed that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the dining area. Staff always ask me." Another person said, "I think they are just wonderful. In April I was admitted to hospital with pneumonia, when I came out I had lost a lot of weight and the kitchen staff were very good to me. They saw how much weight I'd lost and did special treats to help me put some weight back on. They were very kind to me. I've now put a lot of the weight back on. Everyone is treated with dignity and respect."

People were supported to express their views and were involved in making decisions which were respected. During the day we saw that people were making a variety of choices. People chose what drinks they wanted, where they sat, where they wanted to go and what they wanted to do in the way of activities.

We saw, and were told, that peoples' privacy and dignity was respected. We saw staff knocking on people's doors before entering and closing them before delivering care. A member of staff said, "We always knock before we go in. We close curtains and doors during personal care". When staff assisted people to move using an electrical hoist in communal areas they ensured their modesty was protected and they were moved respectfully. Staff told them what was happening and explained what they were doing. One person said, "They are very good about ensuring my dignity at all times." Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private." This showed staff understood the importance of privacy and dignity when providing support and care.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. Newspapers and books were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. One relative told us, "I visit every other day at the moment because mum and dad haven't been so good. I'm always made to feel very welcome. I'm offered drinks or can make my own in the kitchenette." people told us, "No problem with when visitors want to come, they can come when it fits in with them and they'll be made to feel welcome," and "When my visitors come everyone knows them and they're made to feel welcome and part of the family."

Staff understood and respected confidentiality. A member of staff said, "We do not talk about residents to anyone even people we work with unless they need to know". We saw that records containing people's

personal information were kept secure. Where information was stored on a computer, the service complied with the Data Protection Act. The registered manager and staff had an understanding of General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Staff confirmed that they had received training in GDPR.

Good

Is the service responsive?

Our findings

At our last inspection this key question was rated as Good and this inspection found that it remained Good.

People told us the staff looked after them very well. Staff understood their needs and their relatives or friends were involved in decisions about the care provided.

People were involved in developing their care, support and treatment plans as much as they wished to. A registered nurse said, "Not everyone wants to be involved but we encourage and try to involve them, if some people can't be involved then we approach the family." One person said, "I know I have a care plan, it was all discussed but don't ask me what's in it now." Another person told us, "The carers always tell me what they want to do and ask if that's okay with me. I'm not sure that I've been asked to sign anything. A care plan was done when I first came in here. Not much has changed since then."

Care plans had been reviewed regularly and updated when people's needs changed. A new computerised care plan was to be introduced in October 2018. The management team were looking forward to introducing this new technology to enhance person centred care delivery. We found some inconsistent recording within three care plans and these had been identified by the clinical lead and were amended and updated during the inspection process. As staff were fully aware of the identified people's needs, there was no negative impact on the care people received.

Staff undertook care that was suited to people's individual needs and preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw that staff had spoken with families and friends. Staff told us, "People change and we adapt their care accordingly with help from family, friends and our staff." A visitor told us, I've had regular meetings about mum and dad's care. I've been fully involved and kept informed at all stages. I'm very happy with the care they're receiving." Another visitor told us, "They don't do anything without saying to mum what it is and asking is she happy with it."

Each care plan looked at the person's individual needs, the outcomes people wanted and the action staff had taken to achieve this. For example, one person's mobility had deteriorated and staff had updated the care plan to ensure staff prompted the person to use a walking aid, wear suitable footwear and ask for assistance when walking around the communal areas. Staff followed these care directives and this person was seen walking confidently around the home. Another person who lived with diabetes had guidance within their care plan of how staff were to respond if their normal blood sugar varied and what action to take. For example, if their blood sugar was lower than their normal range, staff were to give a glass of milk or a biscuit and to retake their blood sugar. This meant that care delivery was responsive to people's individual needs. The clinical lead had identified that the diabetic care plans could be more person centred and informative and was looking forward to developing these with all staff once the new care plan system was introduced.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home

at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. We looked at the care plan for one person who was receiving end of life care. The documentation had not fully reflected that care had been adjusted for this stage of their life. However this was addressed during the inspection process. It emphasised the need for constant monitoring of pain and of ensuring that food and fluids should be offered regularly in small amounts. On discussion the clinical lead stated, "It needs to be more person centred but we are working on this. The new care plan system will enable a much more person centred approach than our current system."

The service employed specific staff to organise and facilitate activities and entertainment and they worked as part of the team. They knew people well and were attentive to people's individuality and differing needs and abilities. There was a strong respect for the British Armed Forces and the staff incorporated this in to people's life histories and ensured special dates were remembered. Special events were planned to commemorate these. The activity person was available and gave support to people in the group sessions as they needed. People told us, "We have a really good social life here, always something going on and lots of events take place." Another person said, "I love living here, I can join activities or not as I wish." Photographs of events were displayed in the communal areas and one person showed us pictures of the summer fete which they said was really good fun.

Activities at Mais House were planned and tailored to meet peoples' preferences and interests as much as possible. A programme of events was displayed in the communal areas of the home and a copy given to each person. These were produced on yellow paper so as people with a vision impairment would be able to read it. Activities included one to one sessions, quizzes, craft sessions and musical and film sessions. During our inspection we saw a number of activities taking place and enjoyed by people. During the inspection visit, there were visits from sensory rabbits, a Henry VIII themed visit and quizzes. Outings for people were arranged and people talked of trips out. Special events for people were planned as part of a wish tree experience. People shared what they would like to do with staff and staff then put a plan together to achieve this. We saw pictures of some special events that were still being talked about which had been a success and something to remember. The bar area continued to be a popular meeting place for people to meet before meals and socialise. We also saw that people could use the bar area to have an intimate meal with family and friends. The activity room upstairs had been developed since the last inspection and now included an area to receive communion with a pew, and cinema seats to watch films. Since the last inspection people had requested a green house so they could grow plants and vegetables and this had been really successful and enjoyed by many people at Mais House.

Regular staff and resident/family meetings were held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the chef. The minutes of meetings were shared with people and families and displayed in the home.

People told us that they valued the extra facilities within the home that were available, such as a hair dressing salon, church area, garden areas and green house. Families told us that the varied communal facilities enabled them to visit and have private times which were 'Really appreciated."

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the

service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log was kept and monitored by the registered manager. There was evidence that complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I have been asked to complete forms about Mais house - I give feedback all the time."

Good

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in April and May 2017. At that inspection we found a breach of the legal requirements. This was because the systems for monitoring quality were not effective. At this inspection we found improvements had been made and the provider was now meeting the previous legal breach.

The registered manager was supported by a clinical lead and the senior management team. The registered manager said, "I am really supported by the organisation and feel it's a good team." The registered manager was currently recruiting for a deputy manager and interviews had been arranged.

Effective management and leadership was demonstrated in the home. The registered manager was knowledgeable, keen and passionate about the home and the people who lived there. The management team were open and transparent about the challenges they had faced, but were very proud of what the staff team had achieved in the past eighteen months. They were committed to embrace the changes and continue to grow and develop the service.

Staff told us that the philosophy and culture of the service was to make Mais House a home. Staff had contributed to developing values for the home. The values of the service included 'It's somewhere our residents can feel is their real home, for as long as they are with us.' Staff spoke of the home's vision and values which governed the ethos of the home. They told us, "It's their home and we are the visitors," and "I am really proud of Mais House and our residents, they have fantastic stories to tell." The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The registered manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was apparent staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly, by people and staff. The registered manager said their door was always open if staff, people and visitors wanted to have a chat with them. One member of staff said; "You're not going to get any better bosses," Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Quality monitoring systems had been developed and sustained since the last inspection. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so quality of care was not compromised. We saw that learning objectives were taken forward by the management team." Areas for improvement were on-going such as care documentation. The registered

manager said recording was an area that they wanted to continuously improve. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned, such as laundry service, visual aids and menu choices.

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. Call bell responses were monitored to ensure staffing levels were sufficient. On discussion with the registered manager, future actions of persistent falls included looking at a more suitable room location for certain people. This would only happen if it was in the best interest of the person. Medicine audits looked at record keeping and administration of medicines and the registered manager said action would be taken through the supervision process if issues were identified.

The management team had been working consistently to develop the support and care provided at the home. The registered manager said, "We are continually looking at ways to improve people's lives and are really supported by the British Legion." All the staff spoken with were enthusiastic about their role in the service. One staff member said, "Its a good place to work, supportive and approachable." Another staff member said, "We get lots of training and are encouraged to develop our skills."

Systems for communication for management purposes were established and included a daily meeting with the staff. These were used to update staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The shift leaders are open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are involved in developing the service here," "I think the management is really approachable" and, "We feel listened to."

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Really good communication and they are pro-active when something needs changing, they ask for advice and listen."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "I can talk to the staff and the manager is always around, so I have always felt listened to." The management team were constantly looking at ways to involve people in the running of the home, this included inviting them to staff interviews, occasional staff meetings that focussed on improving the service such as activities and event planning.

The service had notified CQC of all significant events which had occurred in line with their legal obligations.