Westcare (Somerset) Ltd

Beech Tree House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 13 and 15 November 2017.

When we completed our previous inspection on 27 September 2016 we found concerns relating to the administration of medicines. There were now records in place to demonstrate how many tablets people had been given if a variable dose. All handwritten entries were counter signed to reduce the risk of errors. However, people with medicine patches were not always having them administered safely.

At the last inspection, we also found concerns with people's privacy and dignity not being respected when they were in a shared bedroom. At this inspection we found there had been improvements. People and their families were consulted prior to moving into a shared bedroom. If a person lacked capacity their best interest had been considered.
Beech Tree House Residential Home 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.

Beech Tree House Residential Home is registered to accommodate up to 16 people in one building. The home specialises in providing care and support for older people with dementia. Most people had limited verbal communication. At the time of the inspection there were 16 people living at the home.

There was a registered manager in place who was present for the first day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager was supported by a deputy manager to run the home. There were two directors for the provider who provided regular support to the registered manager and staff.

One person was at risk of choking and the speech and language therapist had not been consulted on safe practice. Staff had not received training or provided with guidance about people requiring soft diets. Most accidents and incidents had lessons learnt identified and action taken. Sometimes these actions had not been recorded.

Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. People were protected from potential abuse because staff were able to recognise signs and knew how to report it. Most medicine was managed safely but the application of medicines patches did not follow relevant guidance..

The provider and registered manager promoted a clear ethos. People had a positive relationship with the registered manager and provider. There was a positive approach to improving the service Staff felt supported and the new registered manager had brought about positive improvements. The registered manager and provider had systems to monitor the quality of the service and made improvements in accordance with people's changing needs. They had completed statutory notifications in line with legislation to inform external agencies of significant events.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. When people lacked capacity the statutory principles of the Mental Capacity Act 2005 had been followed. People and their relatives were positive about the food and meal times were treated as a social opportunity. Staff had most of the skills and knowledge required to effectively support people. People and their relatives told us their healthcare needs were met and staff supported them to see other health and social care professionals.

People and their relatives told us, and we observed that staff were kind and patient. People's privacy and dignity was respected by staff and their cultural or religious needs were valued. When people had specific needs or differences they had been considered by staff. People, or their representatives, were involved in decisions about the care and support they received. There were enough staff to meet people's care and health needs.

Care and support was personalised to each person which ensured they were able to make choices about their day to day lives. A programme of activities was in place to provide a range of opportunities. People were encouraged to suggest activities and trips which would respect their hobbies and interests. There was an available complaints policy and there had been no formal complaints about the service since the last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Most people could expect to receive their medicines as they had been prescribed. Some improvements were required for people who used medicines patches.

Most accidents and incidents had lessons learnt. Improvements were needed for the recording of the actions taken.

People had risks of potential abuse or harm minimised because staff understood the correct processes to be followed and who to report concerns to.

People were protected from the risks associated with poor staff recruitment because a safe recruitment procedure was followed for new staff. There were enough staff to meet people's care and health needs.

Is the service effective?

Good

The service was effective.

People's rights were respected because the principles of the Mental Capacity Act 2005 were followed. People's choices were respected.

People who had recognised differences had adaptations made in line with their needs.

People benefitted from good medical and community healthcare support.

People had access to a varied and healthy diet to meet their preferences and needs.

People were supported by staff who had most of the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able have visitors at any time, and could meet them where they liked.

People's privacy and dignity were respected and supported.

People were able to make choices and these were respected by staff.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff because their care plans contained important information which was personalised to their needs.

People benefitted because staff made efforts to engage with people throughout the day. Activities were in place in accordance with people's interests. These were adapted to meet people's preferences.

People and their relatives could be confident any concerns would be managed in line the provider's policy.

Is the service well-led?

Good

The service was well led.

People were supported in a home where the provider and registered manager had robust quality assurance which identified concerns and took action to rectify them.

People benefitted from living in a home where the provider and registered manager supported staff and there was a staffing structure to provide lines of accountability.

People and others were able to make changes at the home as they were consulted about their views on how the service could be improved.

People were able to receive high quality care because the provider and registered manager were constantly striving to make improvements and learn from others.

Beech Tree House Residential 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 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 service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 13 and 15 November 2017 and was unannounced.

It was carried out by one adult social care 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.

Prior to this inspection the provider completed a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the home before the inspection visit.

We spoke with 11 people that lived at the home in various amounts of detail, five relatives and one social care professional. We also had informal conversations with people at the home as we walked around and completed the inspection. We spoke with the two providers, the registered manager, deputy manager and four members of staff including care staff, cleaning staff and kitchen staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at three people's care records in various depth and observed care and support in communal

areas. We looked at three staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, staff meeting minutes, medication files, environmental files, activity records, statement of purpose, provider internal communication documents and a selection of the provider's policies.

Following the inspection we asked for further information including provider's policies and actions taken by the registered manager and provider. All these were responded to in the time frame we asked for the information.

Requires Improvement

Our findings

At the last inspection we found some concerns with the management of medicines. This included a lack of recording by staff of the amount of tablets administered when a person was prescribed a variable dose. During this inspection we found improvements had been made. However, other concerns were found with medicine management. People's medicine patches were not placed on different parts of the body each time they were changed. One person's medicine patch instructions stated "Must be applied to a different location daily". There were no records this was occurring. The registered manager was unaware the patches were not being rotated regularly. These patches need applying in this way to reduce the risk of skin damage and ensure the medicine is effectively absorbed. The registered manager told us they would put body maps in place so the patch applications could be recorded and monitored. Following the inspection, the provider confirmed staff were rotating medicine patches and were not recording this process. They confirmed a system of recording the patch administration location was now in place at the home.

In July 2017 and October 2017 the medicines fridge temperature was found to be high. No actions were recorded in the medicine audit. The registered manager told us they must have missed it. One of the providers said this had been a result of changes in management recently. They both thought there were no medicines in the fridge on the dates where high temperatures were recorded. We found concerns about recording of fridge temperatures had been raised by the pharmacist in May 2017 during their visit. The provider had responded by introducing a daily log to record the temperatures. However, there were 12 days the temperature had not been recorded since October 2017. This meant auditing systems were not always identifying whether the medicines fridge was safe to store medicines in.

One person had been identified as requiring a soft diet by staff as they had problems with swallowing. They had seen their doctor who confirmed this. However, staff had not made a referral to a speech and language therapist for specialist advice and support to ensure it was done safely. One member of staff told us they would puree up the person's food. They were unaware some foods would be unsuitable for this person because they had not received specific training or guidance. During the inspection the registered manager organised a referral and guidance was provided for staff. Following the inspection they updated us the person had been provided with a safe diet and training was being sourced for staff.

People lived in a clean home and there were systems to make sure infections would not spread. One member of staff told us there was a 'bed changing book' to make sure everyone had fresh sheets regularly. They told us the care staff helped with deep cleaning of bedrooms. Staff told us they used gloves and aprons when supporting people with personal care. One member of staff told us they referred to a person's catheter

bag which provided instructions about how to change this. However, care plans contained minimal guidance for staff to refer to. The registered manager told us they had trained all staff using their experience. They had not received recent training themselves. The registered manager told us they would speak with the district nurses and source further training.

People were relaxed around staff and were free to move around the home. Their relatives told us they felt their family members were safe One relative spoke about their family member and told us, "He is safe and has settled in well." Other relatives said, "I know he [meaning their family member] is safe here", "We know he is safe here which makes it easier for us not to worry", and "He is very happy here. It's safe for him and he seems to like it". One social care professional said, "I haven't seen anything unsafe" during their visits to the home.

People were kept safe from potential abuse because staff knew how to identify it and who to report it to. Members of staff described signs they could look out for such as unexplained bruising or people being threatened. Staff told us, "I go straight to [name of registered manager]" and "I would speak to [name of registered manager]". Staff were sure action would be taken if they reported their concerns. All staff knew they could go to the provider or outside agencies if nothing was done.

The PIR told us and we saw people were supported by staff who had been through a robust recruitment procedure. This included checks on staff suitability to work with vulnerable people and references from previous employers. One member of staff recently employed confirmed they started work once their checks had been completed. The provider told us the process they went through to speak with previous employers for references.

People were supported by enough staff to meet their care and health needs. One person said, "If I need help they are here in seconds if I need them". Staff responded to people immediately when they asked for help. Some staff said, "I think, yes" and "I think so" when asked if there were enough staff. One member of staff said, "Just" when they were asked if there were enough staff. They said it depends upon the day. During the inspection people were not being rushed and staff were able to spend time with them not just fulfilling tasks.

People had their medicines administered by staff considering their needs and wishes. One person refused all their morning medicines. The member of staff respected this person's choice. They recorded all of this and disposed of the medicines safely. Staff were patient and kind when supporting people when administering their medicines. If a person became confused they were not rushed. Staff took time to explain what the medicines were and how to take them. For example, one person needed to use their inhaler and had forgotten how to use it. The member of staff spent time demonstrating how the person needed to use it. Once the person had managed to inhale their medicine they had a joke together about "Getting there in the end". The person smiled and appreciated the support.

Medicines requiring additional storage were managed safely. All the medicine administration records had two staff sign for each time this medicine was received or administered. The stock matched what was in stock. People who had 'as required' medicines had clear guidelines in place. This told staff what the medicine was for, when and how much should be given. Staff we spoke with were aware of these guidelines and how to use them.

There was a system to record accidents or incidents and lessons learnt to prevent recurrence. For example, one person had an increased amount of falls in a short space of time. The registered manager had explored a variety of options such as bed rails and a low bed with an extra mattress to keep the person safe. However,

there were some gaps in recording the actions which had been taken to support effective monitoring. The provider informed us they would amend recording systems to ensure all lessons learnt were recorded accurately.

Most risks had been assessed and appropriate action taken to mitigate them to keep people safe. One social care professional said, "Risk assessments were always updated" for the person they came to visit. People at high risk of pressure related wounds had specific risk assessments. This outlined actions in place to reduce the chance of pressure related wounds. Staff were aware of people's support needs around moving and handling to keep them safe. For example, staff liaised with each other to ensure someone moved safely using a hoist. This reflected the person's care plan and the risk assessments in place to keep them safe. Another person's risk assessment said, "Must wear slippers when mobilising" because they were at high risk of falls. We saw them wearing slippers.

People who could display behaviours which could challenge were supported in a calm and positive way by staff. Care plans contained information about what might cause their anxiety and the type of behaviours they could display. Staff were aware of how to support people in line with these. One health and social care professional said, "There is a very calm atmosphere and staff are very calm". The person's behaviour had changed from being angry to calm and they were a happier person. The Court of Protection had also recognised this positive impact when ruling on a best interest decision for the person. During the inspection, there was an altercation between two people. Members of staff immediately stepped in to support them both. The staff remained with the people until they were calm. This was handed over at a later handover between shifts. By doing this they were ensuring all staff were aware so could provide the relevant support required to keep people safe.

People were kept safe because health and safety checks were routinely completed. For example, all fire equipment and fire alarms had up to date certificates from an external agency. Wheelchairs had daily observations to ensure the breaks were working and they were clean. Each person had an individual fire evacuation plan. In the event of a fire there was a 'grab and go' sheet outlining all these specific needs and staff support required. For example, one highlighted the person was deaf and required two staff to help them mobilise. Another explained the person used a walker when moving around the home. When faults were found during routine checks action was taken to rectify them. For example, a door guard to the lounge had been listed as faulty during a check in June 2017; this was working at the time of the inspection.

Good

Our findings

People were asked for consent if they had capacity to make a decision. One member of staff said, "Give clients' choice". They gave an example of a person having a right to refuse their medicine. Most people living at the home lacked capacity to make some or all important decisions because of their dementia. 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.

We checked whether the service was working within the principles of the MCA and found people who lacked capacity had their needs considered in line with current legislation. For example, one person with a history of falls had a special alarm pad in their bedroom on the floor. Their capacity had been assessed for this decision and others. When a person lacked capacity staff knew to make a decision in their best interest. They consulted important people for the person. For example, one person was assessed as lacking capacity to decide to live in a shared bedroom. Their family had been consulted and agreed on the decision being in their best interest. There were occasions where these best interest decisions had not been clearly documented in records. The registered manager and provider were going to review how best interest decisions were recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People who were being deprived of their human rights had DoLS in place or applications made. One person had conditions as part of the DoLS. The registered manager and staff had taken actions to meet these conditions. They worked with family members and contacted other organisations. By doing this they were depriving this person's liberty in line with current legislation.

People were protected from discrimination by recognising each person as an individual. One member of staff said, "Everyone with dementia is different". They gave an example of how they communicated with one person who could become anxious. They said, "I look in eyes. Go down. Need contact with eyes". For another person, who was hard of hearing they said, "I write for [name of person]. Does not want to use hearing aids". Other staff were aware of writing down questions so this person could read and then respond. Their care plan reflected this. This meant staff were adapting how they communicated whilst recognising

individual needs and preferences.

People were positive about the meals and liked the food. They told us, "Food is good just the right amount", "I like the food" and, "Food is good, lots of it, more if you like". Relatives confirmed the food was of a good standard. They said, "Quite good food. I would be happy with it" and "The food is excellent they will offer me food if I am here". There were choices at each meal which were on a four week rota. At lunch there were options of roast chicken or gammon with roast potatoes and vegetables. Members of staff asked each person what they would like to eat. When one person was asked they were undecided so the staff member explained the choices again. Once the person had chosen the staff member repeated their choice back to them to check. Another person thought the member of staff had said 'salmon' instead of 'gammon'. The member of staff made sure they understood the choices before asking which they would like. Their relative said, "I think he gets confused when asked about food he was asked the another day if he wanted quiche and I know he loves quiche but he didn't know what it was so unfortunately he opted for the other choice, I don't know how often this might happen". One of the providers told us they had visual menus and made sure staff would use this in future to help people make meal choices.

People were able to choose where they ate and most of the time support was provided if required. This was either through encouragement or supporting a person to eat if they were struggling. One member of staff told us some people forget what they order at mealtimes. They explained if the person changes their mind seeing other people's plates of food then they will change it. People with special dietary requirements were communicated to the kitchen by the care staff. They knew about people with diabetes and how to adapt pudding choices for them. For example, offering fruit or alternative low sugar puddings.

People had their needs assessed prior to moving into the home so the appropriate support could be organised and staff could have clear guidance to follow. One person's care plan identified they had fallen in the past. Their mobility plan included the importance of their walking frame and one member of staff to assist with standing and walking. If this was not possible they were told to help the person transfer to the wheelchair.

People received care and treatment which helped promote their wellbeing because staff worked with other health care professionals. For example, one person had a health condition prior to moving in the home; their legs were swollen and sore. Staff had been informed the person's feet should be elevated and heels to rest on a stool when they are sitting. Also, the person needed to be encouraged to mobilise during the day. As a result of staff following the health professional's advice, the person's legs were healing. One member of staff told us the person's legs were better and the "Family were very happy". They knew what to do if the legs deteriorated again. Another person was having their medicine reviewed since moving into the home. As a result of this, they were able to reduce the amount of medicine they needed to take each day.

People were supported to see other health and social care professionals when it was required. One relative told us their family member kept the same doctor when they moved in. This GP visited once when the person was feeling unwell and the home alerted them in a timely manner. During the medicine round a member of staff identified another person was not feeling well. The person said they felt sick and so the registered manager was consulted who made a phone call to their GP. Other people had recent records of having input from their GP, the district nurse and an optician.

People were supported by staff who had most of the skills and training required to meet their care and health needs. One relative said, "Staff seemed to know what they are doing". One member of staff told us, "The [registered manager's name] is really good. We have individual training and group training". They told us for moving and handling they could practice how to use the hoist and support people to transfer. During

the inspection one person was transferred safely using a hoist. Other people were appropriately supported with tasks such as intimate care and taking their medicines. There were occasions when staff had not received training to support people with specific needs such as requiring a specialist diet or needing a catheter emptied. As soon as this was raised with the provider and registered manager began sourcing guidance and training.

New staff completed the Care Certificate. The Care Certificate is a nationally recognised standard all staff new to working in care should achieve. It outlines all the basic skills and knowledge care staff should have. One new member of staff confirmed they had completed the Care Certificate. Others were still in the process of achieving it. We saw others had begun or had completed various modules as part of their induction. Staff were given the opportunity to work alongside more experienced staff so they could learn about the people and the role.

People were assisted by staff who felt supported in their role which meant they were happy and provided appropriate support. Staff had regular supervisions. These were opportunities to discuss their performance, review any learning and identify training needs. Some of the supervisions included professional development and observations. For example, one member of staff had been developing their understanding around specific activities. Other members of staff had their understanding of fire safety checked including the use of specific equipment in the home. All staff who required annual appraisals had them completed. These provided a chance to celebrate good practice and discuss future opportunities and training.

Good

Our findings

At the last inspection we identified people's privacy and dignity was not always respected. This was because one bedroom in the home was able to accommodate two people. There had been no recorded information about how the decision had been made and people had not met their future 'roommate'. During this inspection we had found improvements had been made. When people were unable to choose for themselves their family were consulted.

People were supported by kind and caring staff who demonstrated lots of patience. One person said, "It's comfortable here. It's the first time I've stayed here. It's lovely. People [meaning staff] are so kind". Other people said, "People [meaning staff] are so kind, I am happy" and "It's very nice here, people [meaning staff] are pleasant and that shows in their work". One relative said, "Very happy with everything. The staff are so kind. It feels like home and we looked around a lot of homes and this was where we felt dad would be happy. We have had no problems settling him in". Another relative told us, "My dad is always happy when I visit him. It's just like home for him" and continued "The staff listen to his needs and talk to him on his level".

Staff spoke fondly about people who lived at the home. One member of staff said, "Love her very much" when speaking about a specific person. Other staff told us, "I am really, really happy. Really good relationship with residents" and, "All staff are really kind to the residents". This positive culture was driven by the management of the home. When people became distressed staff would take time to support them. For example, a person got upset and started crying when staff talked to them about an upcoming birthday. The staff showed compassion and comforted this person by giving them a hug; they immediately stopped crying. Another member of staff stayed with the person to check they were settled.

Staff always acknowledged people as they walked through the home completing tasks. For example, one member of staff came from the kitchen and said, "Alright [name of person]" and then stopped to listen to their answer. The person said, "I'm fine thank you" and smiled. On other occasions staff responded to people straight away when asked. The staff would kneel down to the person's level to communicate. Nothing appeared too much trouble for staff as they were often stopped by people when they were busy to be asked questions.

The management promoted kind and caring relationships with people and led by example. They were always walking around the home having conversations with people and their relatives. When the registered manager was in the office people would be talking to them and coming in and out freely. One relative told

us, "He [meaning their family member] likes to sit in the office and chat". Another relative said, "I have met the owner and he is very nice and shows an interest". One person was sitting eating their breakfast. They became distressed because they had not slept well. Both providers and the deputy manager all provided reassurance to the person in a gentle, reassuring way. Over time the person calmed down and appeared to appreciate the comfort they had just received.

Compliments received at the home reflected what we were told and saw about the positive experiences people had. One relative had written, "I recently visited my father at Beech Tree House and I was thoroughly impressed with your facility and the staff. He appears safe, healthy and well cared for". Others said, "Thank you for your care, support and your humour. It not only helped mum in her last months, but it helped me too, hugely" and "Thank you so much for the care and kindness you gave mum [name of person] over the past four years".

People were supported to make choices and these were respected by staff. For example, one person was offered lemonade or squash when they were supported to take their medicine. Once they made their choice the staff member got the chosen drink. To aid people making choices when they had memory and communication difficulties staff would show photographs or write down the options. Staff were aware of who would respond to these alternative methods of communication.

People were free to move around the home and spend time where they wanted. Due to their dementia some people had different sleeping patterns. These choices were respected by all the staff. For example, one person asked to go to bed in the afternoon. A group of staff sitting at the handover said this was fine and the person went to their bedroom. One member of staff said, "[Name of person] got up before 2am. Other days does not get up. As long as clean and safe she can have a lazy day". There was an 'Owl club' for people who struggled to sleep at night to provide reassurance and support for people.

People's privacy and dignity was respected. All staff knocked on people's bedroom doors and waited prior to entering the rooms. All people were clean and well dressed. One member of staff identified a person's clothes had become stained during lunch. They immediately offered to help this person change their top. The person agreed so the staff member suggested going to the person's bedroom where it could be done privately. All intimate care for people was completed in private and staff took time to find out people's preferences. One relative said, "He [meaning their family member] wasn't happy at first about receiving personal care but it's all sorted now, as he has gained their trust".

The PIR told us and we saw people could have visitors at any time. Throughout the inspection relatives and visitors arrived. Relatives said, "I can visit anytime" and "I take him out every day for fresh air we walk around the garden". People could meet visitors in their bedroom or in a communal area of the home. One relative waited in the person's bedroom whilst they finished their lunch because they did not want to disturb them eating. Another person sat with their relative in the lounge.

Most people were from a similar cultural or religious background. When they had specific wishes these were respected and recorded in their care plans. For example, one person's care plan informed staff they did not follow a religion but had always been interested in the spiritual aspect of life. It then gave guidance to staff about what this meant and how to support them. Another person's care plan stated they were part of the Church of England. Staff had arranged the opportunity for people to have holy communions once a month.

During our conversations with staff it was clear they understood people's care needs well. Staff were able to explain people's individual care and support needs together with their social and lifestyle preferences. For example, staff told us people's preferred daily routines, for instance what they liked to eat and their

preference for where they spent time during the day. Staff commented on people's behaviours and told us how they managed them to reduce anxiety or distress to others living at the service. This included being able to identify times of the day they were more likely to be distressed. By understanding people's needs staff were able to provide kind and caring support for them.

Good

Our findings

People were able to take part in a range of activities according to their interests. On the second day a hairdresser was going round asking if people would like a haircut. One person said, "Ooh I would like that" and went with them. The activities coordinator was holiday. The registered manager had organised an additional member of care staff to come in. They provided one to one activities with some people and group activities with others.

People were being engaged at the home if they were in the communal areas. Music was played in one of the lounges which some people were singing along too. One person was knitting squares all morning and said, 'I am making a blanket'. Staff were aware some people found it difficult to access the community because of their dementia. Therefore, they found ways to engage people around the home. For example, two people were sitting with photo albums and a member of staff was talking about the photos. One of the people started talking about clocks and so the member of staff instantly found photos of clocks.

The PIR told us and we saw there had been a mini shop introduced to the home plus a nail bar. One of the providers explained some people found going into the community overwhelming or had mobility issues. Therefore, by creating a shop where people could get basic items such as toiletries, snacks or cards for relatives there was still a feeling of independence. They had started to plan work in the garden for a sensory space. This would have textures, sounds and smells to stimulate people with dementia. During the inspection we were told relatives and people enjoyed accessing the garden.

One of the providers told us a focus for the organisation was improving activities across all their homes. This included having prompt sheets available for all staff to access ideas. It was especially important when the activity coordinator was on leave. Their aim was to encourage activities which reflected people's interests and hobbies. At the same time respecting their differences such as memory loss. There were reminiscent activities and memory games such as recognising what was hidden in a box. Experiences including pets as therapy animals and a local falconry group would come and visit the home. The activity timetable on display included other opportunities such as entertainers and exercise sessions.

People's care plans outlined their daily routines which was important because many of them had memory loss and communication difficulties. One member of staff said, "[Registered manager's name] encouraged me to read care plans and look for updates". Therefore any new staff or staff not regularly working at the home could find out their preferences. For example, one person's care plan said, "I like to go to bed between 19:00 and 20:00". Staff were able to tell us about people's care needs. One member of staff said, "Has to be

on a person by person. No set guidance for dementia". They gave us three examples of different people's routines in detail. This included one person who walked around the home between certain times in the afternoon. To help them settle an activity was offered. One social care professional said, "From what I have seen, staff know the resident really well".

People's care plans included information including about their life history and care needs. This was important because many had memory loss so were unable to recall or communicate to staff about this. People and their relatives were involved in writing the care plans so the information reflected the person's likes and dislikes. One person said, "I was involved in the care plan as was my daughter. Staff seemed to know what they are doing and are very kind". One relative told us, "I helped them with the care plan as I knew what he needed'. Care plans contained important and relevant information. For example, one person's said, "Studied classics at Cambridge" and provided information about their interest in computers.

People's current interests and hobbies were reflected in their care plans. For example one person's plan said, "Likes to talk about Donald Trump and the PM [meaning prime minister]". During the inspection staff chatted to them about current affairs. Another person's plan said they liked to read the newspaper daily. During the inspection they had a daily newspaper delivered to them and they were reading it

People's care plans were reviewed and reflected their changing needs. During the inspection, one person had a review from other health and social care professionals. One social care professional explained the person's "Care plan was always up to date". Two people who had recently had serious falls had updated care plans. The falls and mobility sections reflected their changing needs. One of the care plans stated they needed support from one carer to help with transfers and now used a walking frame instead of a walking stick. Other care plans had been reviewed every month, even if no changes had been recorded to ensure they were up to date with people's current needs.

People and their relatives knew who to complain to and there was a robust procedure in place to manage them. One relative told us, "I would take it straight to [name of registered manager]". Whilst other relatives said, "I haven't needed to complain, but I know who the manager is if I needed to let her know about anything" and, "Yes would tell manager". There had been no complaints since the last inspection. The registered manager told us, "I have an open door policy". One of the providers told us, "Family's know we do our best". They told us there had been people from the same family coming to live at the home at different times. To them this was a sign they were having a positive impact for people and their relatives.

Good

Our findings

There was a registered manager at the home. 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. People had positive relationships with the registered manager. They smiled when around them and appeared comfortable. When people became distressed the registered manager would comfort them. They always acknowledged people by their names. One social care professional said, "[Name of registered manager] is really approachable. [Name of registered manager] will answer the phone and knows current situation. Really good." They explained it was positive to have a registered manager able to speak about people without consulting everyone.

Staff spoke highly about the registered manager. One member of staff told us, "[The registered manager's name] is very, very nice" and explained they all got on well as a staff team. Other staff members said, "Very good manager. She do her duty properly. She is really right" and "[Name of registered manager] is calm and knows what she is doing. Knows a lot." One member of staff explained it was why they sought promotion within the home.

People lived in an open and flexible culture with an emphasis staff were working in the people's home. This was created by the provider and registered manager's ethos. There was a poster to remind staff about this. One member of staff said, "It is their house. I am coming in to help". Another member of staff said, "It is about the residents. They can do what they want". One of the providers told us since the last inspection there had been a management change. This had achieved a positive impact on the culture of the home. They said it was, "A more laid back environment". People were able to do what they want when they wanted and this had helped to reduce their anxiety levels. The other provider explained people can choose when they get up and go to bed.

There was a staffing structure in the home which provided lines of accountability and responsibility. Staff received regular constructive feedback from management to ensure they were providing high quality care and were accountable for their actions. This was often through supervisions or observations of them delivering care. One member of staff said, "Absolutely" when asked if they felt supported. Another member of staff had a written record of being observed supporting a person with intimate care. The feedback to them said, "Uses stand aid with confidence. All the time talking to the resident ensuring they knew what was happening at all times". Staff confirmed they went to staff meetings to discuss the home and how improvements could be made to deliver care. They agreed their suggestions would be listened to and acted

on when possible.

The provider and registered manager had a clear system in place for auditing the home. Audits were completed either weekly or monthly in line with identified needs and risks. When concerns had been found through the audits actions were taken. For example, damaged and old furniture had been identified in the lounge. As a result, the provider had replaced all the chairs. On another occasion a training need for staff had been identified so had been actioned. The provider told us the biggest improvement the registered manager had completed was to redesign the care plans. However, there were times the actions taken had not been documented. This meant there was no audit trail of how the provider and registered manager were demonstrating improvements.

The provider and registered manager were constantly learning and improving the service people received. When awareness had been raised for a topic they had not considered they researched it and made changes within the home. For example, one of the providers told us since the last inspection they had introduced a daily audit to check all medicines had been signed for. There were no missing signatures within the medicine administration records. Additionally, they rolled the learning and improvements to their other homes. During this inspection their awareness was raised about children's safeguarding because they had occasional young people visiting. Following the inspection, the provider sent us a copy of a new safeguarding policy for children and positive actions they had taken across all their homes.

Both providers had experience of being a registered manager. One provider told us, "Being a registered manager is a lonely place and have been there". As a result, they supported the registered manager as much as possible. This included regularly visiting the home and always being accessible. They communicated regularly through email and each provider was assigned homes they specifically supported. The registered manager told us they felt supported by the provider.

The provider held regular management meetings with their registered managers from across the homes. They told us this was an opportunity to share good practice and learn from each other. For example, the provider and one registered manager had recently attended a care home association conference. They explained any useful information was going to be shared with all the registered managers. On other occasions, they had held management meetings to share lessons learnt from recent CQC inspections in their homes. For example, at another home it was highlighted more detailed protocols were needed for 'as required' medicines. At this inspection we found these had been put in place in this service and were told by the provider it was the same in all their homes. This meant the provider and registered managers were continuously learning and improving their homes.

The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. They regularly liaised with the local authority including the safeguarding team. By notifying external bodies responsible for monitoring provider's people's safety could not be monitored.