Wyndham House Care Limited

Wyndham House Care

Inspection report

Wyndham House
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Date of inspection visit:
05 December 2017

Date of publication:
23 January 2018

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

This inspection took place on 5 December 2017 and was unannounced.

At our last comprehensive inspection on 27 October 2016 the overall rating of the service was, 'Requires Improvement'. This summary rating was the result of us rating the key questions 'safe', 'responsive' and 'well led' as, 'Requires Improvement'. In relation to the key question 'responsive' and 'well led', we found that there was a breach of regulations. This was because the registered manager had not ensured everyone had a care plan which met their needs at all times. We also found the registered manager had failed to maintain accurate and complete care records in respect of each person.

At our last inspection for the key question, 'is the service safe?' we found peoples risk assessments did not include enough detail to ensure people were supported safely. For example, we saw 'repositioning' charts were in place but there was not detailed information or guidance on the risk assessment to say how this was to be managed. Another person had been identified to be at risk of choking. There was no risk assessment in place to provide guidance to staff on how to manage this. We also found one staff member not following good hygiene procedures. Whilst supporting people to take their medication they used their hands to give it to them instead of using an appropriate hygienic method such as a spoon. They did not wash their hands in between each person's administration. This put people at risk of cross contamination.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question's 'safe', 'responsive' and 'well led' to at least good. At this inspection the overall rating of the service was changed to, 'Good'. We found significant improvements had been maintained and we rated each of our key questions as being, 'Good'.

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

Wyndham House accommodates 44 people in one adapted building. There were 37 people living in the service at the time of our inspection visit.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. In addition, the necessary provision had been made to ensure that medicines were managed safely. Suitable arrangements had been made to ensure that

sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff had been appointed. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Care staff had been supported to deliver care in line with current best practice guidance. People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet. In addition, people had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They were also supported to express their views and be actively involved in making decisions about their care as far as possible. Confidential information was kept private.

People received personalised care that was responsive to their needs. Care staff had promoted positive outcomes for people who lived with dementia including occasions on which they became distressed. People's concerns and complaints were listened and responded to in order to improve the quality of care. In addition, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met. The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Quality checks had been completed to ensure people benefited from the service being able to quickly put problems right and to innovate so that people consistently received safe care. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. In addition, the registered manager worked in partnership with other agencies to support the development of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Care staff knew how to keep people safe from the risk of abuse.

People had been supported to avoid preventable accidents and untoward events.

Medicines were safely managed.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs.

Background checks had been completed before new care staff were appointed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

Care was delivered in line with current best practice guidance.

People enjoyed their meals and were helped to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Positive outcomes were promoted for people who lived with dementia.

People told us that they were offered the opportunity to pursue their hobbies and interests and to take part in a range of social activities.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well led.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Wyndham House Care

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.

We visited the service on 5 December 2017 and the inspection was unannounced. The inspection team consisted of two inspectors'. There was also an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

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 any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with seven people who lived in the service and with four relatives. We spoke with the registered manager, regional manager, trainee regional manager and activities co-ordinator. We also spoke with one team leader, one senior member of care staff, two members of care staff and the chef.

We looked at the care plans and associated records for six people. We looked at five people's medication records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks.

Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

After our visit we invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

Good

Is the service safe?

Our findings

At our last inspection in October 2016 for the key question, 'is the service safe?' we found peoples risk assessments did not include enough detail to ensure people were supported safely. For example, we saw 'repositioning' charts were in place but there was not detailed information or guidance on the risk assessment to say how this was to be managed. Another person had been identified to be at risk of choking. There was no risk assessment in place to provide guidance to staff on how to manage this.

At this inspection we found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls. We viewed six peoples care records which included risk assessments regarding nutrition, possible falls, diabetes, choking and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff.

Four people had a record to show they were repositioned at regular intervals to relieve the pressure on their skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place.

Moving and handling assessments gave staff clear guidance on how to support people when moving them. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

At our last visit we found one staff member not following good hygiene procedures. Whilst supporting people to take their medication they used their hands to give it to them instead of using an appropriate hygienic method such as a spoon. They did not wash their hands in between each person's administration. This put people at risk of cross contamination.

At this inspection we found that the necessary arrangements had been made to ensure the proper and safe use of medicines. There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and senior care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of

medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

People told us that they felt safe living in the service. One person told us, "I feel safe here; they [staff] are always coming to check on me." Another person told us, "I have got rails on my bed to stop me falling out." Another person told us, "I am quite safe here. They [staff] are always around. They help me when I am getting about." Another person echoed this "They keep an eye on me when I am walking around to make sure I don't fall over." A relative told us, "My [person] is safe here. The staff check on her. [Person] has had some anger issues and they are managing this through her medication."

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

The registered manager told us that suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. One person told us, "I have never seen a shortage of staff. They [staff] always seem to be floating about doing something." Another person told us, "The staff are always around for me to talk to if I need them." Another three people told us the same thing. One relative told us, "There always seems to be plenty of staff around when I visit." Another relative told us, "There is always staff around and they check on [person] when she is in her room." However, most of the care staff with whom we spoke raised concerns about there not being enough care staff on duty.

We saw that the registered manager had established how many care staff needed to be on duty at each time of day based upon an assessment of the care each person required. They told us that there was always a team leader or senior care staff on duty at all times who was supported by a varying number of care staff depending on the time of day.

Records showed that at all times in the month preceding our inspection visit the planned deployment of care staff had always been met. They also showed that on most days the number of care staff on duty had met or almost met the minimum level that the registered manager considered to be necessary. Although we were told that a small number of care staff shifts had not been filled in the month preceding our inspection visit, we concluded that in practice there had been enough care staff on duty to provide people with the assistance they needed. This was because we were assured that when care shifts had not been filled the registered manager and other members of staff worked flexibly either to provide care themselves or to relieve care staff from having to undertake non-essential duties.

In addition to the care staff, the service had a team of domestic staff, a chef and one activity coordinator. This enabled the care staff to attend to people and their needs. Furthermore, during the course of our inspection visit we observed people receive care and support in a timely fashion and call bells were responded to promptly. We observed staff having time to interact with people positively throughout the inspection. Staff acknowledged they were getting used to new systems and paperwork which put pressure on their time.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.

There were suitable systems to protect people by the prevention and control of infection. Records showed that the registered manager had assessed, reviewed and monitored what provision needed to be made to ensure that good standards of hygiene were maintained in the service. We found that the accommodation was clean and had a fresh atmosphere. We also noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean. In addition, we noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. We saw that care staff recognised the importance of preventing cross infection. They were wearing clean uniforms, had access to antibacterial soap and regularly washed their hands.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the need to refer people to specialist healthcare professionals who focus on helping people to avoid falls. They also included practical measures such as a person being given a special low-rise bed so that there was less risk of them falling if they got up at night.

Good

Is the service effective?

Our findings

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

We found that robust arrangements were in place to assess people's needs and choices so that personal care was provided to achieve effective outcomes. Records showed that the registered manager had carefully established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the registered manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Induction training was followed by a minimum of four shadow shifts.

The provider maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people and the Mental Capacity Act (MCA). Additional training was available to staff in specific conditions such as end of life care, dementia and diabetes. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date. We found that care staff knew how to care for people in the right way. An example of this was care staff knowing how to provide clinical care for people who lived with particular medical conditions. Other examples were care staff knowing how to correctly assist people who experienced reduced mobility or who needed help to promote their continence.

Staff received supervisions with the registered manager approximately three times per year and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

We found records demonstrating other ways staff were supported. This was through staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents'

needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

People told us that they enjoyed their meals. One of them remarked, "I like the food, I think it is really good. I sit at my chair and eat it and I like that." Another person told us, "I eat in my room and they bring me what I want. I am happy with the food." Another person told us, "I really enjoy the food, I will eat anything but I think it is really good." Another person told us, "I love the food. There is always a choice and we never go hungry."

We were present at lunch time and we noted that the meal time was a relaxed and pleasant occasion. The dining tables were neatly laid, people were offered a choice of dishes and the meals were attractively presented.

We found that people were being supported to eat and drink enough to maintain a balanced diet. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

We also noted that care staff were making sure that people were eating and drinking enough to keep their strength up. This included assisting some people to eat their meals and gently encouraging others to have plenty of drinks. In addition, the registered manager had arranged for some people who were at risk of choking to have their food and drinks specially prepared so that it was easier to swallow.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff readily having to hand important information about a persons' care so that this could be given to ambulance staff if someone needed to be admitted to hospital. Another example was the registered manager liaising with care managers (social workers), the hospital and relatives when a person had suggested that they wanted to receive their end of life care at Wyndham House rather than the hospital. Wyndham House had been their home prior to admission to hospital. This had been done with full consideration as to which placement might be best placed to meet the person's needs and expectations. The persons wishes was respected and they had returned back to Wyndham House.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians. Speaking about this a relative remarked, "When [person] was at home she had to walk with sticks or a frame. Now she is here she is walking without either. I don't know what they have done, or who they involved but I think it is marvellous." In addition, we noted that care staff informed people about the healthcare they were receiving. An example of this was a member of care staff who we overheard explaining to a person why their doctor had prescribed one of their medicines in terms of symptoms it was intended to relieve.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. People were able to move about their home safely because there were no internal steps and there was a passenger lift between the two floors. There was sufficient communal space in the dining room and in the lounges. In addition, there was enough signage around the accommodation to help people find their way around. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

The environment at Wyndham House was undergoing refurbishment. One member of staff commented, "It's improved. The décor is much better. Bedrooms are better and there is new artwork. It's fresher." Some doorframes on people's rooms had been painted in a different colour to the door and wall to help people find their rooms. Staff said this approach had been helpful.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. This involved the registered manager and care staff following the Mental Capacity Act 2005. This law provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that the registered manager and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who lived in the service, explained information to them and sought their informed consent. Records showed that when people lacked mental capacity the registered manager had ensured that decisions were taken in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a person needed to have rails fitted to the side of their bed. This was in their best interests because without them the person was at risk of rolling out of bed and falling.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that the registered manager had made the necessary applications for DoLS authorisations so that people who lived in the service only received lawful care.

Good

Is the service caring?

Our findings

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

We saw that the service ensured that people were treated with kindness and that they are given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed positive conversations that promoted people's wellbeing. An example of this occurred when we overheard a member of care staff chatting and laughing with a person about a story both of them had been told by a visiting relative. The person, relative and the member of care staff enjoyed reflecting on the events in question. One person could not remember where the toilet was and staff kindly said, "I will show you where the toilet is. I am going that way anyway." Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms. We observed staff kneeling down to speak with people, stroking their arms and backs and calling them by their names. One person became distressed during the sing a long and a carer took them to a quiet area and sat and talked with them.

Care staff were considerate and we saw them making a special effort to welcome people when they first moved into the service so that the experience was positive and not too daunting. We also noticed that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Records showed that the registered manager had encouraged their involvement by liaising with them on a regular basis.

People's communication needs were detailed well in care plans and support was provided in accordance with people's needs. For example, one person's care plan stated they often became confused and 'needed reassurance'. Staff were seen to provide reassurance to this person who was cared for in their room. Another person's support plan for communication noted they wore glasses and could be difficult to understand. Staff checked this person's glasses at lunch and were patient.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms. When one person needed urgent personal care in the lounge, staff responded immediately, gave the person reassurance and used a screen to maintain the person's dignity.

We found that people could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.

Good

Is the service responsive?

Our findings

At the last inspection in October 2016, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found care plans had not all been updated and did not contain all the required information. Monthly care plan reviews had been recorded, but these did not reflect the area they were reviewing. When people's needs had changed, staff had made appropriate referrals to healthcare professionals. However, care records had not always been updated appropriately.

At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9 and this regulation was now met.

We found that people received personalised care that was responsive to their needs. Records showed that care staff had carefully consulted with each person about the personal care they wanted to receive and had recorded the results in an individual care plan. These care plans were being regularly reviewed to make sure that they accurately reflected people's changing needs and wishes.

Other records confirmed that people were receiving the personal care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing, changing position safely and promoting their continence.

We saw that care staff were able to promote positive outcomes for people who lived with dementia including occasions on which they became distressed. We noted that when this occurred staff followed the guidance in the people's care plans so that they supported them in the right way. An example of this was a person who was becoming upset because they could not clearly recall information. This had resulted in the person displaying unpredicted behaviours which included verbal and physical aggression. The registered manager had made a referral to the Dementia and Intensive Support Team (DIST). The DIST team offer assessment and interventions for adults with age related needs suffering from mental health problems including anxiety, depression, confusion and dementia. A detailed care plan had been compiled involving the person, their relatives, care staff and DIST. The care plan included how to support the person, their warning signs of becoming upset/anxious and detailed distraction techniques. We observed these techniques being used during our visit. As a result of the techniques the person was supported to remain calm and remain fully included in the activities planned for the day.

People told us that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. On the day of our visit an external entertainer visited. 16 people participated in the music session with others choosing to sit nearby to listen from another room. The activities co-ordinator encouraged people to sing and dance. People were encouraged to name the singer and the instruments in the tune. Most people were engaged in the session, for example no one was asleep, some people hummed and danced. One person commented, "I have loved every minute of this [activity]."

During the course of our inspection visit there was a lively atmosphere in the main lounge and we saw a number of people being supported to enjoy exercise movements. Other people were assisted on an

individual basis to enjoy things such as reading the newspaper and completing word puzzles. In addition, we noted that the service arranged trips out into the local community. Four people due to a decline in health remained in their bedrooms. One member of staff told us, "People in their rooms are not left out. We take them tactile resources, dress their rooms up and on movie days, we make sure they are offered popcorn and ice cream." The activities co-ordinator also showed us records of when they have spent 1:1 time with people in their rooms, offering people company. Activities ranged from sitting and holding their hand to getting to the person by talking about their history and personal interests.

We saw that suitable provision had been made to acknowledge personal milestones. An example of this was people being helped to celebrate their birthdays in a manner of their choice which usually involved the chef baking them a special cake. In addition, people had been enabled to share in community commemorations. There was an example of this on display at the time of our inspection visit in that staff had prepared an elaborate display of Christmas decorations and trees were being prepared to decorate.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. For example, one member of staff told us, "A couple of people like their own vicar to come in, but we also have a vicar that comes in on the last Sunday of every month." This corresponded with information in care records.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the registered manager, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

We spoke with a relative of a person on end of life care. The relative told us, "[Person] has been here three years and I can't praise the staff enough. What they have done in the last few weeks has been amazing."

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We also noted that care staff had supported relatives at this difficult time by making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

Good

Is the service well-led?

Our findings

At the last inspection in October 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found risk assessments were not all in place and care records were not up to date and did not contain detailed information for staff to ensure that their care and support was provided consistently. This meant that audits and quality assurance processes were not as effective as they should have been. Records were incomplete and had not been kept up to date.

At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 17 and this regulation was now met.

Quality assurance systems were in place that included audits by the registered manager and quality assurance manager. The audit conducted in October 2017 identified that further work was needed in relation to some people's care plans for specific health needs and also aspects of mental capacity assessment. These reflected the findings of our inspection which gave us assurances that improvements to the provider's quality monitoring systems had taken place as previously these had not identified shortfalls without the assistance of external agencies.

Records showed that the registered manager had regularly checked to make sure that people were reliably benefiting from having all of the care and facilities they needed. These checks included making sure that personal care was being consistently provided in the right way, medicines were being managed correctly and staff had the knowledge and skills they needed. In addition, records showed that fire safety equipment, hoists and kitchen appliances were being checked to make sure that they remained in good working order. The last monthly medication audit on 15 November 2017 identified some issues for example staff not always recording the temperature in the medication room and medication fridge. These issues had been addressed.

Without exception people and relatives told us that they considered the service to be well run. A member of care staff told us, "The manager is supportive, she is very good." Another member of staff told us, "Management is very good, they are approachable. The Regional Manager is here a lot and is very approachable."

We found that the registered manager understood and managed risks and complied with regulatory requirements. Records showed that the registered manager had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all of the key questions we ask when assessing the quality of the care people receive. In addition, we noted that the registered manager had correctly told us about significant events that had occurred in the service. These included promptly notifying us about possible safeguarding incidences. Furthermore, we saw that the registered manager had suitably displayed the quality ratings we gave to the service at our last inspection.

Staff were clear about their responsibilities. We noted that each shift was led by a senior member of care staff. These members of staff shared an office and worked closely together. We heard them discussing the personal care needed that day by each person who lived in the service. We then noted that this discussion was reflected in the tasks we saw care staff being asked to complete. In addition, we were present when a senior member of care staff met to hand over information from one shift to the next. We noted the meeting to be well organised so that detailed information could be reviewed in relation to the current care needs of each person.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend joint residents' and relatives' meetings at which they had been supported to suggest ideas about how the service could be improved. We noted a number of examples of these suggested improvements being put into effect. An example of this was changes that had been made to the menu so that it better reflected people's changing preferences. Another example was changes that had been made to the calendar of social activities in which people could choose to take part.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in March 2017. We noted all expressed a high degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.

Care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. They told us they were sure that any concerns they raised would be taken seriously by the registered manager so that action could quickly be taken to keep people safe.

We found that the registered manager had established suitable arrangements to enable the service to learn and innovate. This included members of staff being provided with written policies and procedures that were designed to give them guidance about their respective roles.

We noted that the registered manager adopted a prudent approach to ensuring the sustainability of the service. This included operating efficient systems to manage vacancies in the service. We saw that the registered manager carefully anticipated when vacancies may occur and liaised with local commissioning bodies so that new people could quickly be offered the opportunity to receive care in the service. Records showed that these arrangements had been largely successful in that relatively high levels of occupancy had been maintained. This helped to ensure that sufficient income was generated to support the continued operation of the service.

One person told us, "I love it here. I am really happy and this is my home. I wouldn't want to be anywhere else." One relative told us, "I looked round several homes before [person] came here and this seemed the best for her condition." Another relative told us, "The home caters for people with dementia and as [person] has this we thought it was the best place for her. I am very happy she is here and I don't have to worry so much."

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the registered manager recognised the importance of ensuring that people received 'joined-up' care. One of these involved the provider's membership of a county-wide association that worked to identify how commissioners and service providers could better develop a cross sector approach to delivering high quality care.