St. Fillan Healthcare Limited

St Fillans Care Centre

Inspection report

St Fillans Road
Colchester
Essex
CO4 0PT

Tel: 01206855407

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

St Fillans provides residential and nursing care for up to 71 adults and older people. The service is supporting people with a range of needs which includes; people living with dementia and those who have a physical disability or require palliative care. The service is separated into four units. Two specialist dementia units, one nursing unit and one residential unit. There were 52 people living in the service when we inspected on 19 December 2017. This was an unannounced inspection.

There was a manager in post who had applied to become registered. 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.

At our last inspection in September 2016, we found a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to care plans not always reflecting people's needs.

At this inspection we found that there had been improvements in this and people were receiving personalised care that was responsive to their needs. Care plans were written in a person centred manner and reflected the care and support each person required and preferred to meet their assessed physical and emotional needs. Further work was still needed to ensure that daily records were an accurate record of care being provided.

Staffing levels had improved since our last inspection although some people raised concerns that there were times when deployment of staff could be improved further on the Dutch unit, and we have received assurances that this will be monitored closely to ensure deployment of staff is effective to meet people's needs at all times.

There was a positive, open and inclusive culture in the service. The atmosphere in the service was warm and welcoming. There were systems in place to minimise risks to people and to keep them safe. Staff were trained and supported to meet people's needs effectively.

Staff understood the importance of gaining people's consent and were compassionate, attentive and caring in their interactions with people. They understood people's preferred routines, likes and dislikes and what mattered to them.

The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

People were complimentary about the way staff interacted with them. Independence, privacy and dignity was promoted and respected. Staff took account of people's individual needs and preferences and people were encouraged to be involved in making decisions about their care.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. They were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

People were provided with their medicines in a safe manner. They were prompted, encouraged and reassured as they took their medicines and given the time they needed.

The service had improved their quality assurance systems. These were used to identify shortfalls and to drive improvement. As a result the quality of the service was continually improving. This helped to ensure that people received a high quality service. The management team were open and transparent throughout the inspection and sought feedback to further improve the service provided.

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 not consistently safe.

Staffing levels had improved overall, however there were times when staffing levels needed further improvement.

There were systems in place to minimise risks to people and to keep them safe.

Procedures were in place to safeguarded people from the potential risk of abuse.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet people's needs effectively.

The service was up to date with the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

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

Staff took account of people's individual needs and preferences.

People were involved in making decisions about their care and their families were appropriately involved.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

People were supported when making decisions about their preferences for end of life care.

Is the service well-led?

Good

The service was well-led.

The service provided a positive, open and inclusive culture.

People were asked for their views about the service and their comments were listened to and acted upon.

The service had a robust quality assurance system and identified shortfalls were addressed. As a result the quality of the service was continually improving. This helped to ensure that people received a high quality service.

St Fillans Care Centre

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 19 December 2017 and was carried out by two inspectors, a specialist advisor in nursing care 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.

Before our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information that we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with eight people who used the service, nine relatives and two visiting health and social care professionals. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed 11 people's care records and other information, for example their risk assessments and medicines records.

We spoke with the manager, care manager, clinical lead and two other members of the provider's regional management team. We also spoke with 11 other members of staff.

We looked at five staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

At our last inspection in September 2016 we found that there were not always enough staff on duty to meet peoples care and support needs. At this inspection we found that staffing levels had improved. We received mostly positive feedback regarding staffing levels in the service although there were some mixed views regarding the deployment of staff regarding on the Dutch unit at certain times of day.

On the Dutch unit there were times of the day when staff could have been deployed more effectively to improve the quality of the care provided. One person told us how they liked to go to bed early but that wasn't always possible due to the numbers of staff on duty. "[Staff] are too busy doing teas at 5pm and then care after, I would have to wait until after 7pm and that is too late for me." One relative told us, "It is wonderful, staff are terrific, I go away from here knowing [person] is being well looked after." However, they went on to say, "They need more staff at meal times and in the evenings when they are changing people and need two carers. Sometimes we have to wait 20 minutes in the lounge for staff to appear, they are off doing others, or on the computer." Another relative commented, "In the evening between 5 and 7 pm there are not enough staff. Sometimes there is no one [staff] in the lounge they are all doing one to ones and feeding and people are left in the lounge. They need one more [member of staff] floating." Following our inspection we received detailed information from the provider as to how they will address any shortfalls in deployment of staff and that this will be continuously monitored to ensure people received good care at all times, including at mealtimes.

On the Charter Hall unit there were sufficient numbers of staff to meet people's needs. One relative told us, "There is always plenty of staff, always visible, [people] get plenty of care. They only take one patient at a time and get them settled in before the next one comes in. They more or less get one to one care." Another relative commented, "Always visible staff, no resident is left out and carers manage to interact with all the residents at the same time."

Most of the staff that we spoke with on St Johns felt that there were enough staff available to meet the needs of people. They told us that they did not feel rushed when providing care and that they were able to spend time getting to know people. However, one member of staff commented, "There is always someone [staff] in the lounges," They went on to say, St Johns could possibly do with more staff, we assist at lunch times and it is very busy."

The service used a dependency tool, which the manager reviewed monthly for each individual and adjusted staffing levels accordingly. We discussed the comments made about staffing levels on the Dutch unit at certain times of the day and they agreed to look at how staff were deployed throughout the service at these times to establish where improvements could be made.

Employment records confirmed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the vulnerable adults who used the service.

People told us that they felt safe living in the service. One person commented, "I feel safe, they know me and everyone is nice." Staff had completed training which enabled them to identify different types of abuse and they were confident in the actions that they would take to report any concerns both within the service and to outside agencies. A health and social care professional told us how staff and management team had a good understanding regarding safeguarding procedures and took appropriate action to report concerns when needed in order to safeguard people from the risk of abuse.

Risks to people's daily lives had been assessed and there were clear plans in place about how to manage and monitor risk including behaviour, falls, mobility, risk of pressure areas, dehydration and risks associated with the use of bed rails. For example, The care plan for a person with a history of seizures included clear guidance for staff about how to recognise potential indicators for seizures and the action to take should this occur. This meant that staff had the information they needed to guide them how to keep people safe.

Staff recognised that some people's behaviours due to anxiety or agitation put the person and others at potential risk of harm. When required, behavioural risk assessments for people included potential reasons for changes in behaviour such as a urinary tract infection (UTI), dehydration or lack of sleep. Details were also included to guide staff in how to manage these behaviour changes. One person's care plan stated, "Can verbalise wishes and is independent but needs guidance and security sometimes with decisions. Does not like to be surrounded by crowds and may feel uncomfortable in these situations." We saw staff supporting this person in their room rather than in the communal areas. A member of staff explained to us, "The team have a good understanding of [person] by constant engagement with them. The recording on the ABC charts [charts which monitor a person's behaviour] have helped us to identify the possible triggers and the place the behaviour is likely to occur. Keeping [person] busy doing things they like and making sure they have their medicine has helped immensely." This demonstrated that staff were using the records they kept effectively to be aware of potential triggers which may upset people and took appropriate steps to minimise the risk of distress and harm in the least restrictive way.

The environment was regularly audited and risks assessed to ensure that it was safe for people to use. Water temperatures, call bells and fire safety equipment were checked and personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order.

Suitable arrangements were in place for the management of medicines and people received their medicines in a supportive way. People were prompted, encouraged and reassured as they took their medicines and given the time they needed. We observed a member of staff gain consent from a person before they supported them with their medicines. They got down on their knees beside the person and held their hand whilst talking with them. The person asked, "Could you give it to me?" the member of staff placed the cup in the person's hand and directed it to the person's mouth." The person expressed their pleasure at the support given.

Medicines were stored safely and available to people when they were needed. One person told us, "Medicines are always on time." A member of staff told us, "I respect that people with diabetes, Parkinson's disease, or those on antibiotics need to have their medicine at specific time. I normally ensure that they are on top of the list."

Staff had been trained to administer medicines safely and they were observed to ensure that they were competent in this role. Medicines administration records (MAR) showed when medicines had been given or if not taken the reason why. Medicines which were prescribed to be taken as and when required [PRN] were given according to the individual's choice as to whether they felt they needed it. Protocols were in place to give clear guidance to staff on what each PRN medicine was for, when it should be given and how often, and

any proactive strategies to use prior to using the medicine.

Procedures in relation to medicines administered covertly needed to be strengthened. One person who was assessed as lacking mental capacity was receiving their medicines in this way. A best interest decision meeting had taken place involving staff, a relative and the person's GP. However, advice had not been sought from a pharmacist regarding the suitability of the person's medicines to be administered covertly. There was also a lack of guidance regarding how staff were to administer the medicines. For example, whether they should be crushed and mixed with drink or placed in food. This meant that there was a potential risk people may not receive their medicines as they had been prescribed in a way which would not compromise their safety or effectiveness.

People were protected against the spread of infection. One person told us, "[The service] is clean." Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). An infection control policy was in place, which provided staff with information relating to infection control. This included PPE, hand washing and information on infectious diseases. We observed the home to be clean and there were suitable infection control systems in place which were regularly monitored. A healthcare professional commented, "I come once a month. There are no smells."

Systems were in place to record and monitor incidents and accidents and these were monitored by the manager. This meant that if any trends were identified prompt action would be taken to prevent reoccurrence. For example, the manager monitored the number of falls occurring in the service and analysed the root cause of these to establish whether improvements were needed to help to prevent future falls occurring. Action was taken such as referrals to the falls prevention team, input from peoples GP, and consideration of health associated risks and medication which may increase the likelihood of falls.

Good

Is the service effective?

Our findings

At our last inspection in September 2016, people told us the food was not always of a good standard and our observations at that inspection showed us that people were not always supported appropriately with their meals. At this inspection we found that there had been improvements in the meals offered. One person told us, "I am alright, the food is smashing." Another person said, "The food is not bad, the roast beef was nice." A third person explained, "We've now got a new cook and the food is good. It has improved."

There had also been improvements in the way people were supported to eat their meals. Staff recognised when people needed assistance and provided support respectfully. A member of staff noticed that a person was not eating their meal. They knelt beside them and asked, "Are you enjoying that? No? Would you like some scampi and chips instead?" A fresh plate of food was provided and the person then ate well.

Throughout lunchtime staff encouraged people to eat and made sure the mealtime experience was a positive one. A member of staff went to sit next to a person who was sitting on their own, they asked, "Can I join you, are you enjoying that?" When some juice was spilt on the next table the member of staff said, "Would you excuse me" to the person they had sat beside and provided assistance, "Can I just lift your plate up? I can get rid of that." The member of staff removed the wet tablecloth and re-laid the table in a respectful manner without drawing attention to the spillage. One person was sleeping in a chair during the meal. A staff member approached them, gently touched their knee and said, "Are you going to wake up and have some lunch? I've come to have some lunch with you." The person responded, "Oh I can't think of anything nicer!" They then sat up and ate their lunch with the staff member.

People told us they were offered plenty of choice of what they would like to eat and drink and were supported to have a varied and balanced diet. One person said, "We get two choices, and if don't like that I can have jacket potato and salad, I get enough fruit and veg, sometimes I have a banana for breakfast, I take fruit from the fruit bowl in the lounge or the [staff] go to the kitchen and fetch it for me."

Where appropriate people were shown two plates of food to help them make a decision about what they would like to eat. A member of staff provided encouragement to a person when choosing a dessert, "What do you want for dessert?" they showed plates of strawberries and cream and chocolate tart and added, "Or would you like some yogurt, how about some strawberries in that?" Choice continued to be offered throughout the meal time, for example, a member of staff serving lunch said to their colleague, "Please take to [person] and ask if [they'd] like lemon squeezed on it."

People's nutritional needs were assessed, they were provided with enough to eat and drink and supported to maintain a balanced diet. People had protocols in their care records to assess the risk of malnutrition and dehydration and staff were observed to encourage people to eat and drink to reduce these risks. Where people had been assessed as requiring a pureed diet we saw that their meals were pleasantly presented, divided into sections and explained by staff so people knew what they were eating and could decide for themselves if there was any part of the meal they would rather not eat.

People's needs were assessed in order to develop individual care plans in consultation with people, relatives, professionals and through observation. Care plans reflected people's needs, choices and preferences.

People were supported by knowledgeable and skilled staff who received training relevant to the needs of the people who used the service. A member of staff told us, "I am always offered training. I've done dementia awareness, challenging behaviour and falls prevention last week." Where additional training needs had been identified arrangements had been made to deliver this training. For example, 12 staff were due to attend conflict management training later that week. Staff told us the service supported them to gain additional qualifications to aid their own personal development and improve their practice. We spoke with a member of staff who the service was supporting to complete a QCF level 5 diploma in Health and Social Care.

New staff received a thorough introduction to the service. Staff told us that when they started in their role they had spent time working alongside colleagues, which had helped them to understand people's needs and feel confident in their new role.

Staff told us that they had access to regular formal supervision sessions and in addition to this the clinical lead and manager informally supported them with any concerns that arose. Supervisions give staff the opportunity to talk through any issues, seek advice and receive feedback about their work practice. Annual appraisals took place and provided an opportunity for the management team to look at staff's performance and to support them in their continued professional development.

People had access to health care services and received ongoing support where required. One person told us, "[Staff] would get the doctor if I wanted one, you can see a chiropodist if you want to." We heard a member of staff explain to their colleague the action they had taken when a person needed additional medical assistance, "On handover I was told [person] was chesty. The doctor comes this morning but at 9.00am, I wasn't happy as [person's] breathing was not good so I rang 999. I couldn't wait for the doctor. I also rang both [person's relatives]." This demonstrated that prompt action was taken to involve relevant healthcare professionals in people's care in order to keep people in good health.
An information board in each unit gave details to help people have a better understanding of life inside and outside of the service to help them make informed decisions. For example, what the weather was like that day and what was on the menu.

The use of technology to promote peoples independence was encouraged and supported. One person told us how they were using a voice activated control unit, "I've got [voice activated speaker] and it gives me independence, it means a lot to me. I can put music on, turn the TV channels over and turn the volume up and down." Staff assisted the person to attach the microphone to their wheelchair or near to their bed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. They told us about examples of this and the actions that they had taken to make sure that people's choices were listened to and respected. They understood when applications should be made and the requirements relating to MCA and DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. Where people lacked capacity, the appropriate best interest processes had been followed and mental capacity assessments were specific to the decision to be made. For example, in relation to administration of medicines, uses of bed rails or assistance with nutrition.

Staff sought people's consent and acted in accordance with their wishes. One person told us, "I've told them please don't come before 10am, they keep to that and if they don't they get short sharp shrift." A relative commented, "[Person] has settled well here, no restrictions and they can go where they want, their choice where they are, either in [bedroom] or lounge, their choice where they eat, at the table or in the armchair." We observed a member of staff obtaining consent from a person before assisting them, "I am just going to help you stand up, going to turn you round now, well done." Encouragement was offered at the same time as checking that the person was happy with the way they were being assisted.

Good

Is the service caring?

Our findings

The atmosphere within the service was warm and welcoming. One person told us, "I like it here, they make so much fuss of you and you get to know the other residents." A relative said, "[Person] is well looked after, staff are becoming family, they really care, they laugh, talk and cuddle, they take [person] out for walks in the wheelchair and if it's too cold they walk [person] around the home and look out the windows at the trees. Staff go along with what the person wants, there are not lots of rules, [person] is just living in a different house with different people, they are becoming family."

People and their families were positive and complimentary about the care they received. A person told us, "It's alright here, the staff are good, they listen to me." A relative commented, "Some staff are exceptional and the nurse is excellent. We can go to them and they listen." Another relative said, "Staff are so caring, we bring [person] back and [person] beams when they see the staff and holds out their hands to them, they treat them very well." Staff showed a genuine interest in the people they were supporting and spoke affectionately about them. One member of staff said, "I just love doing the work, being with the residents."

Staff understood people's preferred routines, likes and dislikes and what mattered to them. We observed a person become distressed when a member of staff was speaking with one of our inspection team who was wearing a red top. The member of staff explained, "[Person] does not like the colour red, you are [gender] and [person] does not know you, they are triggers. We understand it is a frustration or a memory from the past and we can change the staff member or change and support [person] into a different environment like a quiet room or a different unit." This showed that staff had a good knowledge of situations which may trigger a person to become anxious or agitated. They understood how to use appropriate diversion tactics to support people with their emotional well-being and prevent the risk of harm to them or others.

People, relatives and visitors told us about staff who showed empathy and understanding. We observed this throughout our inspection. We saw one person carrying a doll. They were tearful and believed that the doll was unhappy. They said to a member of staff, "Please make her happy." The member of staff took the doll and said, "Are you sure, what would you like me to do to make her happy". The person replied, "Cuddle her and hold her". The staff member went to sit next to the person and they cared for the doll together which helped the person to relax and become less tearful. This demonstrated that staff understood what was important to people and supported them in line with their specific needs, both physical and emotional.

People wherever possible were encouraged by staff to make decisions about their care and support. This included what activities they wanted to do, what they wanted to eat and where they would like to be. A member of staff told us how they had offered a person their lunchtime meal, "[Person] declined, they were sleepy but I offered all the options, [person] might eat with [their relatives] when they come in." They went on to explain, [Person] is peg fed but some days does eat really well. We include [person], we try and give person centred care." Peg feeding is a way of providing food via a tube which is passed into a person's stomach through the abdominal wall, to enable a means of feeding when oral intake is not adequate. The approach of staff to the support required by this person showed they understood the importance of supporting and empowering people to make their own decisions wherever possible.

Where appropriate, people's family were also involved in their care and told us that they were always made welcome. A relative commented, "The communication is good, they phone and inform me of the slightest thing." Another family member said, "I don't feel cut off in any way, I can phone anytime, they are so friendly and I don't feel a nuisance."

Staff explored with people and their families how they could best communicate when this may be difficult due to language barriers or health conditions which made communication more of a challenge. One person spoke very little English but staff were working with them and their family to be able to recognise key words in their own language in order to communicate more effectively. A family member of another person told us, "It is perfect, staff cannot do enough, Staff printed out the British sign language greetings to help [person]."

People told us that they felt that their choices, independence, privacy and dignity was promoted and respected. One person said, "I am listened to. Respected." We observed staff supporting people in a dignified manner, promoting their privacy at all times. For example, staff discreetly adjusting peoples clothing to maintain their modesty. People were encouraged to be independent as much as possible and live their lives in accordance with their wishes. A family member of one person gave an example, "They gave [person] a duster and [they] dust, go in and washes up, makes cups of tea supervised and doing things they would normally do at home." A person commented, "I might look old but I can do things for myself, I wake up and go to sleep more or less when I want to, I don't need their help to choose my clothes."

Good

Is the service responsive?

Our findings

At our last inspection in September 2016 we found that people did not always receive personalised care that was responsive to their needs and care plans did not always reflect people's individual needs or preferences.

At this inspection we found that there had been improvement in this. One relative told us, "It is wonderful, staff are terrific, I go away from here knowing [relative] is being well looked after." Another relative said, "Staff are very attentive, they have settled [person] in well." People told us how they were encouraged to contribute to the planning of their care and their views were listened to and acted on. One person said, "In the care plan I can say what I want or don't want, like or don't like. It's best if they use my right arm rather than my left, my nightdress they have to roll me to get it off. It's all in the care plan. It's done [reviewed] once a month, we've just done one."

Care plans were written in a person centred manner and reflected the care and support each person required and preferred to meet their assessed physical and emotional needs. For example, the care plan of one person who became anxious and agitated at times gave details to guide staff how to recognise that they were unsettled and that this may lead to behaviour that staff might find difficult. This information had been gathered from consultation with the person's family, relevant mental health professionals and through analysis of past situations where the person had been very unsettled. This helped staff to understand potential triggers and provided them with positive ways to encourage and support the person to reduce the risk of this behaviour. Staff told us that they referred to care plans to help them to learn more about the people they were supporting. One member of staff told us, "[Person] moved in yesterday. The first thing I did was check their care plan. Then you update as you go along, as we get to know them. We never go in blind."

Although we found improvements to the care plans overall, further work was needed to ensure that daily records accurately reflected the care and support being given. Peoples care records were being recorded on a computer based system. Staff were recording fluid intake for everyone living at the service. We discussed with the management team whether this approach was effective as it may be difficult for staff to establish how much a person who independently managed their fluid intake had consumed meaning the records may not be accurate. The management team agreed that it may be better to focus on the fluid intake of those assessed as being at risk of dehydration to ensure that their records were accurate and used to take action when needed. Repositioning charts for people at risk of pressure ulcers were completed but did not always reflect the guidance given in peoples care plans. We also discussed this with the management team and saw that some of the inconsistencies in recording were due to limitations with the computer system and options available to staff when completing the records. The management team agreed that this needed to be addressed as without accurate records they were unable to fully demonstrate that care and support had been provided in line with peoples care plans.

There were a range of activities taking place throughout the week which people had a choice of attending or not depending on how they were feeling that day. One person told us, "I like to watch people here in the lounge, I like the dancing and the bingo." One of the activities co-ordinators explained, "We made

gingerbread houses and played dominoes, cards and carpet bowls this morning, some just had communion blessing." A family member said, "They've got lots more entertainment and now have two [activities co-ordinators], they have animals come in, panto, party today and the entertainment is better. Some of the older residents were joining in with the singing at the Rat Pack party and some of them never speak." This demonstrated how the provision of a varied programme of activities was having a positive impact on people's well-being.

People who preferred not to join in the activities taking place in the communal areas of the home were still supported with their social needs. The activities co-ordinator told us, "I do one-to-ones in rooms, and try for at least two to three times for 30 minutes a week. I go to every resident each day for a few minutes and chat and offer them to come to activities. Every Monday they get a list of what is happening that week, it is coded with pictures so that they know what it is." This inclusive approach helped to reduce the risk of social isolation.

A Christmas party was taking place on the day of our inspection. There was a vibrant and friendly atmosphere. One person was sitting on their own at the back of the room as they had preferred not to be in the centre of the entertainment. A member of staff went to chat with them so they would still feel part of the celebrations.

There was a complaints procedure in place which explained how people could raise a complaint. Records of complaints showed that they had been responded to appropriately and dealt with in a timely manner by the manager. People and their families told us that they felt comfortable about raising any concerns. One person told us, "If I don't like something I feel I can say something." A family member said, "We've had a few issues, but anything we raise is sorted." This showed that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right.

People were supported when making decisions about their preferences for end of life care. The service kept important information, which included advanced care plans and preferred priorities for care documents. Where appropriate a DNACPR was in place. A DNACPR is a way of recording the decision a person, or others on their behalf had made that they were not to be resuscitated in the event of a sudden cardiac collapse. We saw how one family had expressed their gratitude to staff for the care provided for their relative at the end of their life. A thank you card from them read, "Words cannot really express the gratitude I feel towards you for the outstanding care you gave to my [relative] in [their] last few days. Not only were you all true professionals you were all so caring and kind, thinking of the distressed family. A fantastic team of thoughtful individuals."

Good

Is the service well-led?

Our findings

There was a person centred, open and inclusive culture in the service. One family member explained, "Excellent care, beautiful place, not a gilded cage, relatives can come and know they are being looked after. The care and patience they give is what makes it."

At our last inspection in September 2016 we found some shortfalls in the systems in place for monitoring the quality of the service. At this inspection we found that improvements had been made in this area and systems were now more robust. There were a range of audits and checks in place to monitor safety and quality of care. The manager explained how the electronic system they used assisted them to have oversight of the operation of the service. This was also shared with the regional management team who provided an additional level of audit and quality assurance in order to identify shortfalls and ensure action was being taken to make improvements where needed. The manager commented on the quality assurance system in place, "As a manager it makes you feel confident that you can get the information you need."

People, relatives, visitors and staff gave positive feedback about the management and leadership of the service. They described the management as visible and approachable. A member of staff commented, "I feel that there has been good progression made over the last two years. The introduction of clinical management has made a big difference."

Staff were encouraged and supported by the management team and were clear on their roles and responsibilities. They were encouraged to support and value each other to ensure they worked effectively as a team. One member of staff told us, "I love it. I love the residents. I love the home. I get support from everyone and training is always updated. If there is something you don't know you can ask." One of the activities co-ordinators told us, "The manager is really good, and if I need to I can go and talk to them, really supportive, I've got a brilliant budget, 100% supported. It's one of the best homes I have worked in."

Families told us how they were always made to feel welcome and that their involvement and input into the service provided was valued. One family member told us, "I have been invited to stay overnight on Christmas day into Boxing Day, that is lovely." They went on to tell us, "I've not been to Relatives meetings but I did a survey which asked what I thought about the care and the staff." Another relative commented, "At relatives meetings you can say what you want to say."

People, their families and staff were provided with a range of ways in which they could express their opinions including surveys and meetings. Where people had made comments in a survey carried out in October 2017 these had been responded to and action taken to make improvements to the quality of care provided. For example, one person had requested that more snacks were made available and these were being distributed around each unit daily. Another person had requested more newspapers to read so arrangements had been made for a selection of newspapers to be delivered to the home each day. There was an emphasis on continually striving to improve in order to provide a high standard of care.

The management team had an openness and willingness to learn from incidents, investigations and

complaints in order to improve the quality of the service. When incidents occurred a 'Lessons Learnt' form was completed which asked staff to consider what had gone wrong, what assumptions may have been made, the impact of the incident, the probable cause, whether there were any training needs and what action was to be taken. These forms were reviewed regularly and showed that lessons had been learnt and improvements made in order to raise the standard of care and support people received.

The service worked in partnership with other agencies such as the local authority, clinical commissioning groups, specialist and district nurses, and mental health services, to ensure they were following correct practice and providing a high quality service. Records showed CQC had been informed of incidents when the provider was legally obliged to do so. This showed us the manager was aware of their responsibilities in reporting events to CQC when required.

The management team were open and transparent throughout the inspection and sought feedback to improve the service provided. They demonstrated how they intended to use our feedback to make further improvements within the service.