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Primley Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced on the first day and took place on 5 and 10 June 2017.
Primley Court is a large service set over two sites, providing care for up to 80 people. The Court (New Wing and Old Wing) can accommodate and provide nursing and personal care for up to 51 people. The View is also part of Primley Court. This building is up the road and not attached to The Court and provides care for up to 29 people. There were 48 people living at The Court and 18 people living at The View at the time of the inspection.

The service provides care for older people, mainly people who have more complex needs and are living with dementia or a cognitive impairment. The service is part of a family run group of four other homes in the South West, two specialising in mental health care. Many people are physically fit but the nature of their condition may require a degree of staff supervision and support to maintain their safety, promote independence and well being. Other people were at the end stage of their dementia and less mobile and responded at varying degrees to sensory stimulation and one to one engagement. For example, one person with limited focus or verbal communication had tea and biscuits with their relative as staff knew this made them more receptive to their loved one's visit.

People had their needs met. However, during our inspection we found a breach of regulation relating to some issues relating to the environment and infection control such as a dirty kitchenette and fridge on the New Wing, dirty mobility aid equipment and a poor standard of cleanliness of furniture in one room in particular.

There is a registered manager who is responsible for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

On the day of the inspection people were going about their day as they wished. On the Old Wing there were two lounge/diners, one upstairs and one downstairs and people were sitting relaxing or mobilising freely with discreet staff supervision at all times to ensure they were safe but remained as independent as possible. Staff were very visible and allocated to manage certain areas and named individuals at higher risk. Staff were vigilant in monitoring people's body language to help them ascertain what they needed, such as company, food and drink or support with pain or anxiety. There was a calm and relaxed atmosphere on the Old Wing where the communal areas were smaller. For example, although the four people in the upstairs Old Wing lounge had very limited verbal communication, staff were always present and engaging with people, enabling one person who liked to constantly mobilise to do so freely, and reassuring another person who had little spacial awareness to move up and down off the chair safely which they liked to do. Staff sat with another person who made regular vocal sounds reassuring them when they recognised the sounds changed, indicating possible anxiety. People appeared comfortable with the staff who were knowledgeable about their individual needs.

The New Wing at The Court was a purpose built extension comprised of a large communal space, divided into an open plan area and dining area leading to a kitchenette. Seating around the large windows and space led into a smaller seating area and cinema/TV room. There was a quiet seating area off the corridor where people were listening to music or napping. The majority, (26 of the 29) people living with dementia on the New Wing were independently mobile with limited verbal communication but displayed frequent vocal noises. In response to clear risk assessments, staff were allocated to discreetly supervise and provide care and support to small groups of 3 to 5 people or on a one to one basis. This enabled people who had a need to constantly mobilise to do so safely without restriction in a circular way throughout the communal spaces. 19 people also had regular disturbed nights having minimal orientation to time despite encouragement from staff to rest. This meant some people could be very sleepy during the day. Staff knew people's routines and which people liked to nap in the day and where they liked to be. Staff encouraged those who were constantly walking to have periodic rests if the person was looking tired. For example, one person liked to nap at a particular time of day in a particular place which staff ensured was free.

Because staff were very knowledgeable about people's background, routines and needs. Staff were able to keep people as safe as possible. 27 people living with a cognitive impairment could often display behaviours, including aggression, which could be challenging for staff. Staff knew, and care plans supported, what potential triggers each individual could react to. However, most people displayed unpredictable behaviour based on their past history and background memories. Staff were visible and vigilant to ensure they recognised changes in mood, used distraction techniques, chatting, retreating or introducing a focus to minimise those people presenting with aggressive/destructive behaviours. For example, staff used humour to manage and diffuse any potential issues with a person who displayed overly familiar behaviour and staff ensured they did not speak to one relative in front of the person as they became angry and territorial. One relative told us they felt relieved that they could leave the home and know their loved one was safe because staff would look after them. Another relative said in a recent letter, "We must say how wonderful everyone was to Dad at Primley Court. At times he was not the easiest but that did not mean he was treated any differently. In fact it endeared him to the staff even more!"

The New Wing was a busy space but there were easily accessible quieter areas. The design of the space had been a concern during the previous inspection. During this inspection we felt the open plan space was used well. Staff knew how to encourage people towards a quieter area if they noticed a person showing signs of anxiety. However, during our inspection people did not appear distressed with staff minimising any potential triggers. Some people did not like to pro-actively engage with staff and preferred to be passively watching. Staff allowed people to be quiet and knew which people liked to watch events or activities rather than join in and included them. One relative told us, "Staff are marvellous, they allow people to be who they want to be in that moment. There is a lot to do and watch. I'm very happy." Their relative liked to touch things and was encouraged by staff in a safe way, for example encouraging them to help with taking lunch plates to the kitchenette and fold napkins. This minimised the risk of them picking up random items and leaving them around such as shoes.

The View has a separate nursing wing and a dementia care wing. Both homes had patios and outside space. It was stormy during our inspection but staff said people did use these spaces. All the areas were in the process of being made more pleasing ready for better weather. There was a small patio through french doors on the Old Wing and a larger patio on the New Wing. A small patio area at The View was accessible from the dementia care unit. A relative said they did use this area and told us the home were planning to upgrade it. The home planned to make this more secure. One relative had suggested an outside tap to the provider so they could water the plants and this had happened. Staff said they usually accompanied people especially on the New Wing where most people required supervision to keep them safe.

People and their relatives at The View said, and we saw, staff throughout Primley Court interacted with people in a friendly and respectful way. As they supported people they all acknowledged people as they passed, stopping to chat to people walking around or sitting next to people to see if they wanted to wake and talk. Their comments were pertinent to individuals, such as asking about ballroom dancing with a ex-ballroom dancer or discussing military self defence with an ex-military trainer. One person had a very short attention span so the care worker kept popping over when they looked responsive to look at photos of dogs on an electronic tablet which the person was able to smile at.

People were encouraged and supported to maintain their independence. They made choices about their day to day lives which were respected by staff, despite their cognitive limitations. For example, choice of clothes to wear (many people liked to wear no shoes or constantly removed their socks). Two people looked unkempt but when we asked why, staff told us the people became aggressive if pressed to wipe their mouth or tuck in their top. They offered assistance when one person was calmer and left wipes within the other person's reach.

Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. On occasion there were incidents between people as they met as they mobilised but staff quickly diffused the situations. They recorded any events looking at triggers and location to inform future care. Staff had previously informed the local safeguarding team of each incident between people or people and staff but had recently been sent a letter saying only to report any incidents resulting in actual harm. There had not been any recently. Staff spoken with were confident that any allegations made would be fully investigated to ensure people were protected.

Relatives said they would not hesitate in speaking with staff if they had any concerns. They knew how to make a formal complaint if they needed, with information included in the home's brochure but felt that issues would usually be resolved informally. There had not been any formal complaints for a long time. The registered manager and a relative said any issues were quickly resolved. The home was considering a 'grumbles' book to record action taken in this way.

People's health was well cared for and overseen by knowledgeable registered nurses, including two registered mental health nurses. Few people were able to be involved in planning and reviewing their care but care plans were written with advocate input. For example, the staff collected background information and history about a person's previous life to inform the care plan on an on-going basis using a dementia tool such as the Altzheimer's Society 'This is Me'. There were regular reviews of people's health and staff responded promptly to changes in need. For example, there were regular medication reviews prompted by the home depending on changes in behaviour. One person was about to have a medication review and the registered manager was already pre-empting a possible need for staff give the person one to one supervision as the person could become less stiff and more mobile. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. For example, a mobile dentist was visiting the home at the time of our inspection. One person did not want to see the dentist so staff took instruction, adding this to the care plan and resourced denture fixative to try later when the person was calmer.

Staff had good knowledge of people including their needs and preferences, and they could access care plans easily on a computer system. There were detailed handovers and any important changes were highlighted as an alert on the system. Staff felt valued and were well trained with good opportunities for on-going training and for obtaining additional qualifications. For example, training was relevant to the client group and all staff had received training in challenging behaviour. We looked at recent feedback received by the service from families. Comments included, "We know [person's name] was challenging but we could see

they were receiving much more care and attention than had previously been the case [in another service]. Although you did not know [person's name] as I did you did know her love of animals. Her pockets always had an ample supply of dog biscuits ready for a chance encounter which they loved. Thank you, I hope you have happy memories of her." Another person said, "We have been very blessed in the love and care which you gave to [person's name]" and another recently commented in a card, "We would just like to say a very big thank you to everyone for all the wonderful care Dad received during his years with you."

People's privacy and dignity was respected. For example, staff knocked on doors before entering and called people by their preferred names. A health professional said, "The staff do a very good job considering people's needs. I always have a private room for consultation and all the staff are nice, well meaning and caring. I have never seen anything of concern. I go to a lot of homes and they look after people who other homes would struggle with." One person liked to stay in their room and had a survivalist attitude and background making them distrustful of people. Staff knew how the person liked to be supported and were encouraging but respectful of their wishes when offering support, whilst monitoring the risk of social isolation.

Staff ensured people kept in touch with family and friends. Relatives said they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private. One relative said they came at all different times of the day and staff always offered hot drinks and asked how they were.

People's individual social stimulation and leisure were met in very individualised ways due to people complex needs. This had been a concern raised in our previous inspection report in October 2016. During this inspection we did not find this a concern. Due to the nature of people's level of need, most engagement could be subtle and sensory rather than an 'activity' and more spontaneous depending on opportunity and understanding of the individual. There were some group activities such as sing-a-longs with a printed songbook and an upcoming Alzheimer's Bake a Cupcake day where people would decorate cup cakes and relatives were invited. During the previous week people had sown seeds with equipment brought into the lounge as some people enjoyed gardening. There was a full time activity co-ordinator and an advert out for a second. The registered manager said they had had applications but often potential staff would not be suitable or want to work with the client group. The activity co-ordinator worked with the staff team as a whole, mainly supporting people individually with one to one engagement or in small groups for short periods. This was tailored to people's needs, their responsiveness at a given time and their mood and related to their preferences and background. For example, the activity co-ordinator knew one person, who was previously very withdrawn and uncommunicative, liked dogs. A pet dog visited the home and staff put it on a chair in front of the person so they could see it and staff spent an hour chatting with the person and looking at the dog. Eventually the person reached out and stroked the dog and staff have gradually built up visits. The activity co-ordinator told us, "We work on trying to let the person inside come out." One person living with dementia loved classical music and liked to pray. Staff understood how important this was to the person, and had helped the person used signs to tell them when they wanted to pray. Staff recognised how this comforted and reassured the person, especially when they were unwell. The activity co-ordinator told us how on the previous day before our inspection the maintenance manager, who also had music therapy background, gave an impromptu concert in the Old Wing lounge. One person with limited understanding began to lead the song singing loudly. Staff were moved as they had not heard the person's loud voice before.

Staff were passionate about their job and caring. They enjoyed the challenges and shared the rewards such as seeing someone come out of themselves to show their personality. One registered mental health nurse told us, "It's not for everyone but I find it rewarding and it's different every day. I love it here." The registered

manager said they were careful to ensure potential new staff understood what the job involved due to the complex needs. There was a robust recruitment process with a flexible induction depending on staff competency.

There was a management structure in the home which provided clear lines of responsibility and accountability as well as good corporate support from the provider from the head office. A provider director was also based at Primley Court with an administrator. The registered manager and deputies showed great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people and worked as a team focussing on the people they cared for.

There were effective quality assurance processes in place to monitor care and plan on-going improvements. This included regular audits such as medication, care plan reviews and a monthly clinical audit report sent to the head office. This analysed people's weight, food and fluids and actions taken, health professionals visits, falls and incidents and maintenance of the premises. Due to the sensory stimulation required by some people the service managed and budgeted for an on-going décor and maintenance programme, especially at The Court. For example, pictures were kept higher on the walls and hand rails and window sills were in regular need of painting as people using the service often picked the paint off. The provider was looking for a paint that would be less likely to peel. There had been issues relating to the standard of the décor in the previous report but we spent time observing people using the spaces and saw how the space had been made safe in the first instance and appropriate homely touches added. One health professional told us there had been a lot of improvement in the décor in the last year and felt it was difficult as people did try to destroy things unfortunately. For example, dementia friendly signage for bathrooms and name plates on bedrooms had been ripped off so the home were looking at alternatives. The lack of signage did not affect people's ability to recognise or access a toilet or room and only two people with capacity chose to spend their time upstairs. In the Old Wing where people had been identified as at risk of putting items in their mouth, the space had been made safe to enable free supervised movement and staff offered people items which were safe whilst trying to maintain some homely touches such as plants and pictures.

There were systems in place to share information and seek people's views about the running of the home. People's views were acted upon where possible and practical. One relative told us staff had been happy to discuss whether their loved one would be happier in a different room and this move had gone well, with staff taking other people's personalities into account. The service gained feedback from people, relatives and stakeholders through surveys, complaints and compliments to continually develop the service. A quality survey was due and the director was organising the sending out of questionnaires.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. This was because not all areas had a good standard of cleanliness and infection control.

People with complex needs benefitted from being cared for by a staff team who were knowledgeable about people's risks , challenges and needs.

The provider had systems in place to keep people safe in relation to suitable staffing levels to meet people's needs and robust recruitment.

Staff were aware of how to recognise and report signs of abuse to keep people safe. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training, especially in managing medication relating to behaviours which could be challenging.

Is the service effective?

Good

The service was effective.

People and/or their advocates were involved in their care and were cared for in accordance with their preferences and choices, despite complex cognitive needs.

People benefitted from care from staff who had good knowledge and training to ensure their needs were met.

People's health needs were well met.

People's legal rights were protected.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect. They often used their knowledge of people's

body language to ascertain what people were trying to communicate.

People and/or their advocates were consulted, listened to and their views were acted upon.

People benefited from receiving care from staff who were trained and knew people's specific wishes about the care they would like to receive at the end of their lives, also linking with the local hospice.

Is the service responsive?

Good

The service was responsive.

People and/or their advocates were involved in planning and reviewing their care. They received personalised care and support which was responsive to their changing needs, especially in relation to behaviour which could be challenging.

People made choices about all aspects of their day to day lives as they were able.

People took part in social activities, mainly one to one due to the level of people's needs and knowledge of people's personal background, experiences and interests were used to inform person centred care.

People and/or their advocates shared their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not always benefit from quality assurance systems that identified, monitored infection control management and cleanliness of the home

There was an honest and open culture within the stable staff team who knew people well and had robust methods of communication.

People benefitted from a staff and management team who had were clear lines of accountability and responsibility and good corporate support from the provider.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Primley Court

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 7 June 2017. It was carried out by three adult social care inspectors and an expert by experience on the first day and one inspector on the second day.

Before the inspection we looked at information we had received since the last inspection. This included previous inspection reports, notifications, concerns and complaints and information from health and social care professionals.

During the inspection we spoke with the registered manager, the provider, operations director, two deputy managers and three registered nurses. On the second day we discussed 42 individuals' needs with staff. We spoke with 11 care workers including wound care lead, seniors and the dignity champion care worker. We also spoke at length with the activity co-coordinator and the maintenance manager, cook, kitchen porters and housekeeping.

We spoke with seven people who were able to directly tell us about their experiences. We spent long periods observing care provided in the communal areas in each unit and wing, nine people in the lounges on the Old Wing and 29 people in the New Wing communal spaces. As most people were unable to talk to us directly we spoke to 19 relatives who visited the home regularly, including five on the telephone. We also spoke to four visiting health professionals,(two on the telephone). We also emailed two health professionals from the Chadwell mental health team but did not receive a response.

We also looked at records the service is required to maintain including eight care plan files and daily records, activity records, nine medicine administration records, three staff recruitment files, staff training records, staff rotas, menus, complaints and compliments, maintenance records, and quality assurance checks and audits. We also walked around all areas in both premises and looked at each bedroom, bathroom, toilet, communal areas and the laundry.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in August 2016 we found that not all windows had window restrictors. At that time an unlocked room contained unattended potentially harmful chemicals. People's room's had wardrobe furniture that was unstable and could potentially fall on people causing injury. We discussed these issues at the time with the provider and management team and immediate action was taken. During the second day of that inspection we found all of the issues identified during day one had been addressed. We did not find these issues re-occurring during this inspection in June 2017.

However, during this inspection we found some issues relating to the environment and infection control. Staff understood the importance of infection control measures, such as the use of personal protective equipment (PPE) including disposable vinyl gloves and plastic aprons and we observed staff using these appropriately. But the New Wing kitchenette, used by staff only, off the communal space, had not been included on the housekeeping audit and was very grubby. The small fridge did not have regular temperature monitoring and some food items were mouldy putting people at risk of food contamination.

Some of the armchairs and dining chairs required discarding as it could not be kept clean, had worn areas or had food stains over time. The home had recently bought a large stock of furniture and was slowly swapping over items. Some equipment such as hoists, screens and mobility aids were dirty at the base and staff were not always using individual slings to mobilise people which is good practice. One bedroom was particularly dirty with stained bed rail bumpers, curtain, armchair and wall. This person did display some behaviour which could be challenging for staff when managing cleanliness. The housekeeper told us that as people at The Court did not often use their rooms in the day, this area was cleaned in the afternoon. However, this room and some items in it could have been cleaner to make it a nicer place to spend time. The floor and fridge door in the main kitchen at The Court was dirty. All of this was rectified by the second day of our inspection.

This was a breach of Regulation 15 Premises and Equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager immediately rectified these issues and the cleanliness of the kitchenette. By the second day of inspection staff had carried out another room by room audit to ensure any other items unable to be cleaned to a good standard were replaced in a timely way. The maintenance team were seen removing some furniture throughout the second day.

All other areas of both premises were well-maintained, clean and free from any malodours. There was an on-going maintenance programme and the maintenance log where staff wrote smaller issues. This was looked at each day and all items had already been ticked and completed.

We discussed the issue of ensuring there was a homely feel, especially at The Court. People were more mobile and displayed more behaviours which could be challenging. Staff balanced identified risks of some people eating or throwing and damaging items. For example, one internal window sill and corridor hand

rails were worn and peeling at The Court. The registered manager explained they had been repainted a few weeks ago but people picked off the paint. They were looking into trying different paints which may be tougher. There was also a programme of installing low, unobtrusive perspex sheeting to protect some walls, doors and beside one bed due to some people hitting them for sensory reasons. For example, one person repeatedly banged items on one door making large marks which had already been replaced once. However, the space was bright and airy and spacious, making the most of natural light and views over the patio towards the bay.

At our previous inspection in August 2016 we identified that the provider did not have adequate infection control arrangements for managing laundry at The View; particularly the system for the separation of clean and contaminated laundry. At this inspection, we found improvements had been made. The laundry room had been completely re-decorated and was clean and clear from the build-up of excessive laundry waiting to be washed. There was a clear system for the separation of clean and contaminated laundry.

People and relatives told us they felt people were safe at Primley Court and with the staff who supported them. One relative said in a recent letter to the home, "We must say how wonderful everyone was to [person's name] at Primley Court. At times they were not the easiest but that did not mean they were treated any differently. In fact it endeared them to the staff even more!" One relative was visiting the home for the first time since their loved one died there a few months ago. They still visited the home and said, "I can't fault it here, I was very happy with the care" adding, "Everybody is treated as an individual and the staff know what works for different people." Another person said they felt safe in their room. They spent their time in bed due to their condition and enjoyed the view of the sea. They had venetian blinds and air conditioning to manage direct sun and were comfortable in a specialist bed. They said they loved their room and could use their call bell for assistance, adding, "[I'm] absolutely safe, completely. It's a wonderful, secure place to be." Another relative said, "The staff are re-decorating the rooms but it's more about how the staff look after people [that's important]." Their loved one had one to one care and resisted resting. Staff spent time gently encouraging the person to rest with eventual success. Their relative had chosen the home for the good care and cleanliness found during previous respite visits. Another person said, "I find it wonderful, clean, safe, everything."

People were protected because the provider had systems in place to make sure people were protected and staff were aware how to keep people safe from harm or potential abuse. Staff had received training in safeguarding adults. This was mandatory for all staff and the provider's training matrix showed this was up to date or refresher training was booked. Staff had a good understanding of what may constitute abuse and how to report it. All were confident any allegations would be fully investigated and action would be taken to make sure people were safe. Staff recorded all incidents within the home, taking appropriate action and sharing information appropriately. They analysed these records monthly so risk could be minimised as much as possible, for example looking for triggers and patterns such as location or time of day, which had informed staff allocation. For example, the space minimised 'dead ends' which could make some people living with dementia frustrated and enabled continuous mobilising without restriction. Some people liked to choose their own books and their was space around the area to minimise possible confrontation.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable to work with vulnerable people. References had been taken up when staff were appointed and were obtained from their most recent employer. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Many people at The Court were physically fit but the nature of their condition required a degree of staff

supervision and support to maintain their safety, promote independence and well-being whilst living communally. Staff presented as strong advocates for people, and were aware that changes in people's behaviour may be an indicator they were unhappy about something they could not verbalise. Staff knew each person's personality, who liked to spend time where and who got on well or interacted well with who and used their knowledge to manage risk. On the Old Wing there were two lounge/diners, one upstairs and one downstairs and people were sitting relaxing or mobilising freely with discreet staff supervision at all times to ensure they were safe but remained as independent as possible. Staff were very visible and allocated to manage certain areas and named individuals at higher risk, some people were supported on a one to one basis. One relative said they were very grateful as their loved one was very active but had poor visual perception and would try to walk through anything. They said staff had to be vigilant at all times and they had implemented an individual activity board to give staff ideas of ways to try to keep the person occupied with some success.

Staff were vigilant in monitoring people's body language to help them ascertain what they needed, such as company, food and drink or support with pain or anxiety. This helped staff to minimise potential frustrations and confrontations between different personalities. There was a calm and relaxed atmosphere on the Old Wing where the communal areas were smaller and people were less independently mobile. For example, although the four people in the upstairs Old Wing lounge had very limited verbal communication, staff were always present and engaging with people, enabling one person who liked to constantly mobilise and dance to do so freely, and reassuring another person who had little spacial awareness to move up and down off their chair safely, which they liked to do. Staff sat with another person who made regular vocal sounds reassuring them when they recognised the sounds changed, indicating possible anxiety. People appeared comfortable with the staff who were knowledgeable about their individual needs. For example, one person displayed behaviour which could be challenging if 'their' chair was not available. Staff removed this chair and saved it for the person until they came downstairs so a confrontation with other people was avoided. The person also liked to bang their walking frame so staff had covered it with foam strips to minimise possible damage to the building or other people. The person was doing this when we arrived. Staff told us they had used their knowledge of the person's birthplace to distract them and keep them safe. One registered nurse sat with the person telling them they would print off some old photographs of the area and show them.

On the New Wing the majority, (26 of the 29) people living with dementia or cognitive challenges were independently mobile with limited verbal communication but displayed frequent vocal noises. In response to clear risk assessments, staff were allocated to discreetly supervise and provide care and support to small groups of three to five people or on a one to one basis. This enabled people who had a need to constantly mobilise to do so safely without restriction and for staff to engage with people if people wanted to. Nineteen people also had regular disturbed nights having minimal orientation between day or night despite encouragement from staff to rest. Their care plans contained information to staff on how to promote good sleep at night time such as encouraging people to change into night clothes, milky drinks and dim lighting and how staff engaged people individually during their night waking. This meant some people were very sleepy during the day, which increased risk from independently mobilising. Staff knew people's routines and which people liked to nap in the day and where they liked to go. Staff also ensured they encouraged those who were constantly walking to have periodic rests if the person was looking tired. We did suggest the chemical store be moved from the middle of the New Wing quiet lounge as this could be disruptive for people resting as it was used regularly by staff.

Because staff were very knowledgeable about people's background, routines and needs, including the individual world they lived in, they were able to keep people as safe as possible. Twenty seven people living with a cognitive impairment could often display behaviours, including aggression, which could be

challenging for staff. Staff knew, and care plans explained, what potential triggers each individual could react to, if any. However, most people displayed unpredictable behaviour based on their past history and background memories. Staff were visible and vigilant to ensure they recognised changes in mood, used distraction techniques, chatting, retreating or introducing a focus to minimise those often aggressive/destructive presenting behaviours. For example, staff used humour to manage and diffuse any potential issues with a person who displayed overly familiar behaviour and staff ensured they did not speak to one relative in front of the person as they became angry. Some people had a military background and could display suspicion about other people. Staff said, "Sometimes we just know from the look in their eyes that they may target someone they see as a threat, some people are [protect their space] so we have to keep our eyes open." One such person enjoyed a newspaper so staff ensured they always had one nearby in 'their' cinema area. One relative told us they felt relieved they could leave the home and know their loved one was safe because staff would look after them.

People's electronic care plans contained detailed risk assessments and management plans, which covered a range of identified risks in relation to people's needs. These also included bed rail assessments to ensure people only used these for safety if they were not at risk of climbing through them. People's individual risks were identified and managed in relation to minimising the risk of behaviours which could be challenging. Staff documented behaviours, noting any triggers. For example, one person constantly shouted. Staff had spoken with family and tried distraction techniques, reviewed medication levels with the GP and monitored possible pain triggers and health reasons. Staff had recognised that food and change of routine could be a trigger so they ensured an early breakfast and always responded with meals when the person indicated they could be hungry, at whatever time. The records showing this instruction had been followed successfully by staff and the person was calmer. They also ensured the person's dentures were not a safety issue when continuously shouting. When behaviour was unpredictable and communication limited, staff followed risk assessment instructions to retreat and discreetly monitor until the person was calm. When the person experienced hallucinations staff recorded how reassurance was given and what to do when the person put themselves on the floor, discussing with the person the use of a mattress on the floor. Staff prompted a best interest discussion with other health professionals when the person would not enter into conversation about safety aspects of their care. Daily records clearly showed what actions staff had taken with success and there had been more regular calm periods for the person over time as staff got to know them.

Risks associated with skin care, poor nutrition and the risk of falls due to reduced mobility had all been assessed. There were no pressure sores at the home. One person said, "My skin is perfect. [Staff] always check that." Risk assessments contained information about the person's level of risk, indicators that might mean the person was unwell or at an increased risk and action staff should take in order to minimise these risks. For instance, one person's skin integrity had been assessed as being at increased risk. This person had a specialist pressure reliving mattress in place and staff had been instructed to support them to change position regularly, which we saw happening. Only one person was nursed in bed due to their needs.

Risks associated with poor nutrition or from choking were being managed. Guidance from speech and language teams (SALT) regarding textures of diet needed for people to reduce risks of choking, was being followed. This information was clearly displayed in the kitchens with each person's relevant diet. For example, some people received prescribed supplementary nutritional drinks and enriched foods to help maintain or increase their weight where this was low and input records were maintained and highlighted on a notice board. Staff physically supported some people to eat and drink and prompted other people. This was done at a pace that meant people had enjoyment and company from their meal experience and could eat the meal in peace and safely. There was no hurry and individuals started and finished their meals when they wished, which further reduced risk of behaviours which could be challenging. For example, staff knew which people would not be pleased to be disturbed if they were feeling tired and kept their food back until

they were ready to eat.

As many people on the New Wing were mobile and liked to pick up random items for sensory or destructive purposes staff had found it was safer not to use tablecloths, place mats and condiments although kept these safely available. 'Free' items were kept to a minimum so that those accessible were safe to be 'held' such as 'fiddle muffs' and couldn't be destroyed which further reduced behavioural triggers from staff having to remove them. One health professional said, "People do tend to destroy items unfortunately." Pictures, activity equipment and other homely touches were kept out of immediate reach with safer items such as books and games easily accessible and we saw people looking at these independently. Pictorial signage aimed to indicate bathrooms and rooms was often removed by people so staff were looking at more secure and safe signage methods. Staff encouraged and supported people to maintain their independence and people had their continence well managed, for example, and seemed to independently know where communal bathrooms were or staff recognised signs that people required assistance. One person often put any item in their mouth so staff ensured they had something safe to hold as stated in their risk assessment, which we observed. One person liked to carry items and due to their military background saw the item as a defensive weapon which staff ensured was a safe item. Some people took their shoes on and off and staff ensured these were kept away from people walking. A relative said how challenging it was for staff to constantly monitor people but said they did a good job in keeping the area safe, especially when people preferred to walk in bare feet or socks. Another person sometimes threw their meal, which we observed. Staff were quick to respond in a kind and understanding manner, saying "Don't worry, we can clear it up" sitting with another plate of food ensuring the person ate. The registered manager had assessed how safe people were and applied for additional funding appropriately to enable some people to have constant one to one support from staff. Where funding had not been successful the provider had continued to provide one to one support based on the home's risk assessment for that person, ensuring they were safe and had their own space. For example, when they were resting the staff member gave them space at a discreet distance. They had tried various engagement techniques suggested by the CHEST team and confirmed by a relative but the person rarely made eye contact and only responded to staff company and family when they wanted to. The balance between people's safety and their freedom was well managed.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. People and staff felt there were sufficient staff on duty and available to meet people's needs. Their comments included, "I have a very good response. I don't use [my call bell] very much as the staff are constantly checking to see I am alright", "Absolutely. [Staff] sit down and talk" and "Yes, the staff are very good." Staff said, "Yes we have enough staff and we could go to the registered manager and they would listen to us" and "It's very busy making sure people are safe but we all work well as a team so it works." People who were able to communicate verbally told us they did not have to wait long if they needed help. Throughout the inspection we heard call bells, mainly at The View, being answered quickly and saw people received the care they required in a timely manner. The Court staff were constantly visible and attentive as most people were unable to use a call bell or verbally ask for support.

The Court staff were supported by the registered manager, a clinical lead and a deputy manager with a registered nurse, two senior care workers and two care workers on duty in the day for 18 people on the Old Wing. Staff remained in the communal areas at all times to ensure people's safety and supervision. On the New Wing there were two registered nurses, one often a registered mental health nurse, one senior care worker supported by eight care workers. An additional care worker provided one to one care for a person. This person liked to stay in their room and their care worker discreetly supervised them to ensure they were safe. The registered manager said they were able to easily access temporary agency staff to cover any shift vacancies but they used agency staff who knew the home well and this was not often required.

The deputy manager at The View had recently changed the way this unit was staffed. Staffing was now arranged so that staff worked between the nursing and dementia units to ensure there was a minimum of eight care workers and one registered nurse on duty during the day time. Rotas showed and staff confirmed this was the case. The deputy managers sometimes worked 'on the floor' as an additional member of care staff and registered nurses were also visible and working 'on the floor' with the care team. People also benefitted from the services of an occupational therapist, three afternoons a week and an aromatherapist once a week.

Staffing numbers were determined by using a dependency tool. This tool took into account such needs as behaviours which could be challenging, risks, disturbed night behaviour and levels of need. Staffing numbers were flexible and were increased or changed if people's needs changed, for example if people became particularly unwell or if a person was nearing the end of their life or staff identified their needs as a risk to their safety. Staff were also supported by a maintenance team, housekeeping and domestic, laundry and kitchen team. Staff were seen sitting and engaging with people and their relatives and records showed evidence of care staff having one to one time with people. For example, looking at photos, just being there or holding a hand or chatting. Two people chose to remain in their rooms, staff regularly checked on them. We saw people received care and support in a timely manner and at their own pace.

Medicines were managed well and stored safely including medication which required additional security under legislation known as 'controlled drugs'. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff. Secure medicine fridges were available and monitored for medicines which needed to be stored at a low temperature. Registered nurses gave medicines and were trained and had their competency assessed before they were able to do so. We saw ten medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

Excellent details were given about administration of 'as required' medication, for example, for pain or anxiety. Staff knew what this medication was for and why for individuals. For example, there were clear details of what actions to try first if the person was anxious and medication was seen as a last resort. Information included best interest decision making with external health professionals about 'covert' medication (medication given hidden in foods for example, to ensure people took essential medication). Staff knew how people liked to take their medication such as on a spoon or in their hand and records included recent photographic ID and showed no gaps in administration documentation with medication only signed as given when seen taken by people. We saw medicines being given to people at the correct times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for. The deputy manager carried out medicines audits to ensure people's medicines were stored, recorded and administered correctly. This meant people received the support they required.

Good

Is the service effective?

Our findings

At the last inspection in August 2016, we had concerns about the use of the open plan living areas at The Court and whether this was a noisy environment. During this inspection on both days, we spent time sitting in each area, the quieter lounge, cinema area, during lunch and using the chairs by the patio windows. We saw people choosing to use each area freely, resting easily and no-one displayed negative behaviours. Relatives visiting told us they came most days and had no complaints about the environment or atmosphere. Noise levels had been a possible concern during our last inspection in August 2016. We did not see any people display anxieties that could be caused by noise and we spent time in each of the seating areas and took lunch with people at different ends of the dining room. Staff were vigilant to notice any signs of anxiety and reassured and distracted people which managed a rise in verbal noise well. There were quieter areas with lower lighting which some people were enjoying. Staff enabled people to access outside space freely such as The Court patio. The Old Wing had a small patio area which the registered manager was in the process of making a pleasant area in the warmer weather.

The registered manager and staff team had looked at the Butterfly project, a nationally recognised way of ensuring people with dementia matter and are valued. The provider had another home which was a 'Butterfly' home and the directors were registered mental health nurses. They had adapted some of the environmental ideas such ensuring toilet seats, door surrounds and grab rails were an easily identifiable colour. Where doors could confuse, were locked or did not lead anywhere these had been disguised with attractive pictures such as a book case to minimise frustration if a door did not open for people. This was in line with guidance used by the home called, "Good practice design dementia and sight loss."

People received effective care from skilled and knowledgeable staff. People and their relatives said they thought staff knew what they were doing and were well trained and spoke highly of staff in the home. A relative commented, "[Person's name] is thriving, and staff have kept them infection free. I am well impressed". (They had past poor experiences in another home). Relatives with loved ones at The Court who visited regularly specifically said, "I feel [person's name] is looked after really well. Staff deal with people so well, not patronising and manage potential conflict quietly and quickly", "The home suits [person's name] perfectly. Staff love singing and dancing with them. They know [person's name] does what they want to do, sitting down is not their way so staff just join in with them" and "Staff look after [person's name] and let me know how they are doing. The whole place is very good all the time. Staff are in attendance. I'm most impressed." People able to comment at The View said, "I love it here, I would choose this [home] any time", "They [staff] have done the job a million times. I don't feel they make any mistakes", "Yes, [staff] go off usually, I would say, every 2-3 months and do a training course" and "Yes, I am confident staff are appropriately skilled."

There was a stable staff team at the home who had good knowledge of people's individual needs. Each staff member we spoke with could tell us about individuals' background, likes and dislikes and triggers for behaviour that could be challenging. The activity co-ordinator particularly knew details about people's lives. They said it was not a workplace for everyone and they needed to understand the level of people's needs. Some staff had worked at the service for some years and all enjoyed the challenges of caring for people with

more complex needs. Some registered nurses continued to work part time in acute settings which helped to keep their knowledge and skills up to date. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support and we saw this happening with staff offering short bursts of engagement that matched people's attention span.

New staff underwent a comprehensive corporate induction programme for three months. For care staff this was followed by opportunity to gain a nationally recognised qualification, either the care certificate or continue with national vocational qualifications (NVQ). New staff worked in addition to staffing rota numbers and had a named mentor to support and follow their progress, initially for a week but longer if required to ensure competency. One relative said, "Yesterday when I came in, a new [staff member] was doing one to one [with a person] but being monitored by a permanent staff member." The registered manager said it was important for all new staff whatever their role to understand the complexities of the needs of people at the home before agreeing to take on the job. Potential staff did not pass the probation period if they were not suitable.

Staff received regular supervision in one to one sessions, especially in the first three months, to monitor how they were getting on and any issues or training needs. This gave staff opportunity to discuss all aspects of their role and professional development with their line manager. The deputy manager and senior staff assessed staffs' knowledge by observing their practice. Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. There was a programme to make sure staff training was kept up to date, confirmed by the training matrix record. The registered manager was keen to invite external professionals to run additional training sessions for staff. For example, a relative who was a health professional was booked to deliver some training on oral care and the local hospice.

There was a comprehensive staff training programme in place which included specific training to meet the needs of the people living at Primley Court such as dementia training, challenging behaviour, Mental Capacity Act (MCA) and safeguarding adults. Due to the level of need, all staff undertook training in challenging behaviour. One staff member told us how this training helped them understand people's needs and how to keep people safe. We saw this training and good person centred dementia care being put into practice throughout the inspection. For example, there was no need for any restraint or restrictive measures, other than pressure alarm mats at night, as staff used alternatives to ensure people remained safe in a person centred way, also confirmed by visiting relatives.

One health professional expressed some concerns about staff skill and knowledge with regards to supporting people with mental health issues and suggested staff needed more specific training. They said staff could be reactive rather than proactive but did not give any examples. However, we saw and were told about many examples where the home had been pro-active in reviewing how people were on a day to day basis and whether they needed a referral to a mental health professional for example. This was usually done through the person's GP but was becoming quicker with the Care Home Education and Support Team (CHEST) team input. Daily notes showed where people had been referred and why and any actions needed. For example, one person was referred due to their erratic sleeping pattern relating to increased violent episodes. They were seen the following week before which the staff followed advice about medication timings. Another person was referred by the home with episodic agitation leading to aggression and visual hallucinations. The home then worked with the CHEST team reviewing medication and trying recommendations. Some distraction techniques worked better than others, which staff told us about, new medication effects were monitored and the frequency of episodes had decreased. Staff also monitored possible health reasons such as urine infections which could affect their behaviour. The person now no

longer required constant one to one support to keep them safe.

We looked at staff feedback shared following a recent training course in challenging behaviour. Staff commented on what they had learnt and put into practice and we saw this happening. For example, they said, "The course re-enforced my knowledge that knowing your residents, likes and dislikes and what works better for them not you. Makes you aware of what signs to look out for and you don't need to use break away techniques as much", "I learnt ways to handle challenging behaviour safely and the importance of getting to know people" and one person who had been supporting a person one to one said how they managed a situation by keeping a discreet distance, giving the person space while reassuring them they were available." One staff member commented about their training saying, "In my work I'm always aware of delivering person centred care. Respecting people's wishes, dignity and privacy. Talking to family members is very helpful in understanding the residents." All relatives said staff talked to them about their loved ones likes and dislikes and backgrounds.

The registered nurses told us about the different types of dementia, for example, and how they managed these. One person had an alcohol abuse related condition resulting in short term memory so staff consistently reminded the person what was going on discreetly whilst recognising their past higher education and intellectual experiences. One person walked around looking upwards, staff acknowledged them as they were walking and frequently engaged with them to encourage changing their neck position. Another person displayed survivalist behaviour due to their background. Staff understood their behaviour and were discreet and gentle when approaching them, especially when the person displayed over protection of their belongings.

Care plans were very detailed for people with behavioural needs. They described people's individual behaviours such as continuously undressing, inappropriate toileting, unawareness of risk and spatial awareness and tendencies to enter people's personal space. Many people did not have insight into their mental health conditions. Staff ensured people were prompted to use the toilet regularly, for example. One person was displaying minimal insight and engagement and continual undressing. The registered manager had completed behaviour charts to share with the Care Home Education Support Team (CHEST). The team had made recommendations such as trying to increase focussed activities and promoting sleep at night which were in their care plan. The home were trying to engage with the person using background history, likes and dislikes but from observing them we could see as the care plan stated "[Person's name] does not take part in activities and walks without obvious purpose, having little engagement when approached by staff or walks away." This made it difficult for staff to engage as the person clearly did not want to despite their regular efforts at varying times. However, staff were very attentive and spent time with the person just being with them. We spoke to the person's relative on the telephone. They were so relieved and happy their loved one was at Primley Court. They could not fault the staff, who were kind, friendly and attentive. They felt their loved one was happy, unrestricted and well cared for, shown in recently calling them by their name, which had not happened for some time. As the person had very short attention span and minimal eye contact, even with family, they felt that more focussed activities would not work although staff tried. They said mainly staff spent time with them just 'being' and they were very happy about that.

Another person had complex needs and minimal ability to focus on engagement. As they were very mobile and unaware of risks of people's personal space the provider was supporting them with one to one staffing. This had resulted in reduced incidents as the person was able to move freely without triggering behaviour which could be challenging for other people and engage with the staff member chatting or focussing on a topic for short periods. Activities suggested by the CHEST team and care staff had been tried but staff said some had become further triggers to behaviour which could be challenging. An activity plan included creative, person centred ideas to try such as watering plants and looking at gardening books, encouraging

household tasks, electronic tablet use and animal therapy, which we saw happening although briefly at times due to people's short attention span. Staff were all very knowledgeable about people's individual needs and the world they lived in. Care plans included information about activities that been successful and people had enjoyed. This information was used to support feedback to visiting health professionals about how people were engaged and occupied. For example, another person independently mobile with limited communication had been able to enjoy music, painting cards and animal activities. The registered manager said they encouraged staff also to record activities and engagement however long, which were tried but not so successful to aid feedback with health professionals.

Care plans were detailed about mental health abilities such as 'has little short term memory, repetition and frustration causing aggression at times'. During our inspection one person did not want to stop walking but staff reassured them about a family visit and what day it was and the weather, talking a little about the rain. The person listened for a short while. These smaller interactions were not recorded in the daily records but we could see they happened. The person had also spent time walking a dog around the home and a good reaction was recorded. This showed staff understood people and were able to give effective care, understanding people's limitations and recognising times when people may be more responsive.

Relatives said they were happy with health care input. One relative said they had no worries and their loved one's toe dressing and regular self-removal of the dressing, for example, was managed well. They always received an update if anything had changed. Another relative said, "The staff are wonderful, I'm pleased with everything they do. I'm always included and they ask my opinion. I don't feel guilty leaving [person's name] there at all." Other people and relatives said, "Yes, I get passed any letters that come here, and they phone me on my mobile", "Yes, [I see the] GP. They [staff] tell you they have rung the doctor and they always ring and ask me if it's okay to change the medication. If I say yes, they phone right to the doctor who will prescribe" and "When [person's name] first came in I raised concerns because they were on high levels of medication. The deputy manager called the doctor in and they reduced it. Occasionally they will give her medication to calm her down. [Staff] will always act on what I have asked." Another relative said, "Yes, [staff] initiate [health professionals]. They ring me to keep me informed. They say the optician has been not long ago."

People were able to see a range of health care services when needed, and had regular contact with dentists, opticians, chiropodists and GPs. People's care plans contained details of their appointments and care plans were updated. Where changes to people's health or wellbeing were identified, records showed staff had made referrals to relevant healthcare professionals in a timely manner. For instance, records showed where people had needed specialist referrals such as the dietician and speech and language therapy (SALT); these had been made in a timely manner. Staff reviewed medication and contacted people's GPs to review. For example, they recognised one person had a history of bone fractures and enquired as to the need for a bone protection medication.

The mobile optician was complementary about the care provided saying, "Staff do a good job. We know each other well and staff can make or break a place especially in one as challenging as this. They are good at checking up on referrals, offering confidential space and encourage people to wear their glasses. They know this can help people look at photos or stimulate them to be more aware of their surroundings." People were seeing a mobile dentist during the inspection. One person had refused contact so care staff documented the dentist's recommendations in the care plan, resourced denture fixative and ensured they returned to the person later when they were calmer to fit their new dentures. A visiting health care professional told us staff were very receptive to suggestions they made and were very quick to act on their suggestions and recommendations. This demonstrated the staff were involving outside professionals to make sure people's needs were met.

Some people who lived in the home had the mental capacity to be able to choose what care or treatment they received. They were asked for their consent before staff provided assistance. Comments included, "Yes, [staff] are very careful. They don't strip me off!" and "[Staff] do, yes. They say 'what would you like us to do today?'. I think different carers have different personalities, and some are quicker than others, but most of them take their time and are very good. I don't have any complaints." Another person said, "I get up [when I want], watch TV, often stay in my room. Sometimes I go to the lounge. I have a sketch pad. I do like drawing." Other people said their decisions were respected by staff saying, "[Staff] know I get tired, and when I would like to go to bed" and "Yes, they definitely do. They now call me by my name rather than sweetheart or darling, and that has been adhered to." Most people at The Court had been assessed as not having mental capacity to make particular decisions such as choosing to stay in a care home. However, we heard staff consistently asking people what they would like and offering choices such as relating to drinks and food offered, showing physical options and where people would like to go regardless of their mental capacity and promoting real choice. Staff also ensured those people who could not verbally make choices were able to demonstrate what they wanted for example by enabling them to mobilise freely where they were headed or choose to pick up 'safe' objects. Records also used language which promoted choice such as '[Person's name] allowed me to change her dressing'.

The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Records showed where best interest decisions had been made about the use of pressure alarm mats at night and mattresses on the floor by the bed for people at risk of falling or putting themselves on the floor when independently mobilising. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes such as where people wanted to sit, have meals and who they indicated they preferred to spend time with.

The majority of people required the restriction of needing to be in a care home to keep them safe. The registered manager had made appropriate applications to the local authority to deprive these people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the person's advocate. Records of legal power of attorney were kept. One relative said, "I have just signed a form to say I will act on [person's name]'s behalf. I don't think they are being restricted or being made to do things against their wishes." Staff were aware of the implications for people's care and we saw clear records in care plans about how these measures were carried out and reviewed to provide effective care. Staff gave us examples of restraint such as a locked front door and bed rails that could mean that people's liberty was restricted. They knew that an application might be required to determine if the measures in place were suitable and people who required one had an application in place. The registered manager had been involved in a best interest process for one person who was deemed unable to live at home but was unsettled at Primley View. A decision to move the person to The Court resulted in a more settled experience with more space. The person had funded regular trips out with their spouse because the person required two care workers at times when out in the community. Staff knew the person had always been fairly solitary and acted as advocates to try to promote future trips out.

Staff told us how they supported people to make decisions about their care and support. For instance, supporting people to maintain a balanced healthy diet or by encouraging people to seek advice from healthcare professionals. We saw people were offered choices and their independence promoted. Staff told

us they had received training in this area. The registered manager kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. For example, one family were considering caring for their loved one at home. The registered manager was planning a best interest decision making meeting with relevant health professionals to ensure any decision on place of care focussed on the best interest of the person. They had also followed a best interest decision making process for another person with mental capacity who refused to comment on a particular safety proposition discussed with them.

There were risk assessments in people's care records relating to skin care and mobility. We saw where someone was assessed as being at high risk, appropriate control measures, such as specialist equipment, had been put in place. One person had a leg wound. Staff had liaised with the lower limb clinic to source optimum wound dressings. There were clear instructions for staff, care plan updates and a photo record of the wound showing good management and positive progress. For example, treatment hosiery protection was ordered as the person scratched the area and removed dressings. This meant people's health needs were assessed and met by staff and other health professionals where appropriate.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Those people identified as at risk of losing weight or not eating were monitored with food and fluid input records, highlighted on the staff notice board. Total input was recorded and appropriate action taken. One relative said their loved one had gained weight since being at the home despite constant walking and staff knew what they liked such as small amounts of fruit 'on the go'. Staff told us, and people's care records showed that appropriate professionals, such as the dietician, had been contacted to make sure people received effective treatment. We observed the lunchtime meal in both premises. Staff offered food and drink regularly and took time to ensure people had an adequate diet. People sat in small groups and staff sat with people providing assistance where necessary at eye level. Where people needed assistance, this was provided appropriately and discreetly. Care records highlighted where risks with eating and drinking had been identified. For instance, where people required a soft or pureed diet, this was being provided. Each food item was processed individually to enable people to continue to enjoy the separate flavours of their meals. There was a four weekly seasonal menu which included pureed options.

Due to the nature of people's needs staff managed people's meal experiences individually. Where people were very active staff recognised they would burn off more calories and adjusted dietary intake accordingly. For example, many people required continuous encouragement to eat as they would get up and walk off mid meal. Staff followed people offering appropriate finger food to encourage eating with success. One person would not eat their meal but was eventually gently encouraged to sit down with a bowl of finger food which they finished. Care plans informed staff where people required additional prompting and why and what methods worked best. For example, at The Court lunch times were a long process with staff sitting and encouraging people, offering second helpings and following people around with food. People could see the food which was individually served from a hot trolley so each plate was personalised to the individual. During the inspection people enjoyed beef stew and dumplings or fish fingers and chunky chips followed by apple crumble and custard. If a person did not appear to want one choice, staff tried an alternative. Some people could sit at the table with others but the majority of people ate where they rested, moved places during the meal as they wished or preferred to eat their meals alone.

At The View people were satisfied with the food and drink available to them. People commented, "They have a chef. It's fabulous. After each meal they ask you about the next one, for example 'would you like fish and chips', and that's when you choose. You do get coffee and tea to drink. I get hungry, I have a bag of crisps" and "In the last year to 18 months it has got a whole lot better. Sometimes I have given suggestions,

especially lamb stew, [which I get] and have been doing that ever since. I am not a lover of biscuits or snacks." People were able to have their meals in the lounge or in their own rooms if they wished. People were offered a choice of two meal options and dessert at lunch times with soup, light meal options and assorted sandwiches with dessert for supper. We saw the chef and kitchen assistants were provided with detailed guidance on people's preferences, nutritional needs, and allergies and there was a list of people's dietary requirements in both premises' kitchens. Staff offered people choices during meal times and tea, coffee, and soft drinks were freely available.

The home was well maintained other than in relation to the infection control issues noted in Safe. The provider told us about an adequate allocated budget for on-going maintenance such as the low level, unobtrusive perspex covers for doors, on-going painting and the flat roof which was being repaired during our inspection. There was a team of three maintenance workers on-site and a manager oversaw the four homes in the group. The environment at Primley Court was as homely as it could be in relation to keeping people safe and enabling free movement. Staff did what they could to make the environment attractive and homely while at the same time maintaining safety, for example by hanging pictures slightly higher. Walls were painted rather than wall papered as people tended to pick the paper off and so make an area difficult to maintain so décor was kept simple. People tended to pick up items in communal areas and move them around the home which staff said was fine. Staff noted where things were and tidied them up again. Most areas at The Court were kept free of clutter and rugs as most people were independently mobile with purpose. Flooring was clean laminate and trip hazard free and plain to aid cognition for people living with dementia. If someone wanted a table moved near the window this was done and staff tried to ensure the environment worked for the people using it. Best use was made of the views over the bay. All relatives we spoke to had no concerns about the environment, saying it was a balance between decoration and safety and they thought the home did a good job.

Only one person had more ability to talk to us directly at The Court and we asked them if they minded living in the busier wing with more mobile people with more complex needs than their own. The person said they liked it there as there was lots of space and things going on which they liked to watch. The registered manager said they regularly considered whether any people living at The Court would benefit from a quieter atmosphere including the person above. However, no-one during this inspection was displaying any negative outcomes and those people who wanted a quieter area at The Court used the quiet lounge or the end of the dining room and cinema area. One person had not seemed to settle on their admission to The Court so they had moved to the Old Wing as they were generally not used to large rooms or company. The registered manager was aware that not everyone may enjoy a large open plan space which is why there were smaller areas within it and they reviewed people's needs in relation to the space. One relative said they liked the way the open space was divided with smaller seating areas and we saw their loved one using various areas as they pleased. One relative said their loved one 'was in heaven' in the cinema area as they could watch westerns and war films, enjoying the action rather than the story, which they were doing.

People living at The Court were able to decorate their rooms as they wished. Other than two people who could directly choose, all others were reliant on staff and family to help them. Rooms were made homely with personal belongings and families said they could also bring in furniture or other items. The registered manager told us they were in the process of improving the few rooms that had less homely items belonging to people who had no family or advocates. A room re-decoration programme had already begun. The View had under gone re-decorating and was light and airy. New flooring had been installed throughout. Bedrooms we visited had been personalised to people's tastes. We saw people had family photographs, personal furniture and ornaments to help the room feel more homely. The rooms were clean and tidy. However, we saw that there was no pictorial signage to help people move around or identify rooms such as, doors to toilets and bathrooms. The registered manager said they were in the process of adding these when

they had sourced a method that would better endure wear and tear.

There was plenty of equipment to support people such as grab rails, assisted baths and mobility aids, enough for each floor. There was a lift to assist people with all levels of mobility to access all areas of the home and people had individual walking aids, beds, wheelchairs or adapted seating to support their mobility.

Good

Is the service caring?

Our findings

At the last inspection in August 2016 we found this area required improvement due to people not always receiving consistently kind and compassionate support. At that time some people's dignity and privacy was not maintained as well as it could have been.

At this inspection we did not see or hear about any concerns relating to the above. People were supported by kind and caring staff. Staff talked with us about individuals in the home. They all had good knowledge of each person and spoke about people in a compassionate, caring way. People who could comment directly said the staff were caring. One person said, "Staff are very caring and friendly". Other comments included, "There's love here", "I can't think of anything to improve it here", "I think it's very good", "They definitely care here", "This is definitely the best place" and "Yes the staff care and listen well".

Relatives of people living at The Court told us on the telephone, "They are very caring staff. One carer went on holiday and brought back some pretty locally made tops for [person's name]. Staff are always in attendance and talk. Most impressed", "[Person's name] loves to sing and dance and staff love doing that with them. We all do it together when I visit. They are very friendly and try to give [person's name] things to do but that's not [person's name]'s way. They just let them do what they want to do" and "Staff sit with people. If [person's name] isn't shaved it's because they didn't want to. You can definitely say good things about the home. I had heard negative reports before [person's name] came but staff deal with people so well."

We saw staff displaying caring and respectful attitudes throughout the inspection. Each person was acknowledged as staff moved around the home. One person told us they had a headache. Staff said they had given pain relief but staff then sat and reassured the person that they had had medication and should feel better soon. They helped them to be comfortable and rest in bed. They recognised which people had been particularly active during the night and encouraged them to rest often just sitting with them. One person was particularly mobile and agitated on our arrival and staff were kind and caring as they defused the situation, guiding them to the lounge with chat about the person's home town.

Another relative said the staff second guessed if people needed pain relief. Another relative said, "Staff fall over themselves to help you. Staff do encourage [person's name] to walk, and they walk behind with a wheelchair for when they get tired." Their loved one was now able to go out of the home with family as their mobility had improved, and was going out to lunch with their family to celebrate a birthday during the inspection. We saw where relatives experienced a 'good' visit with their loved one responding and engaging with them more, staff celebrated this with them. For example, when a person said their spouse's name, sang loudly or enjoyed an animal visit. One relative was sat with their loved one having a chat and banter with staff, their loved one was included in the conversation and suddenly said they would like their nails done like their relative. A lively conversation followed with staff noting this as something to try when the person was less active.

Staff respected people's privacy and dignity. One person said, "I have never felt embarrassed" and another

said "Staff are as good as gold". A relative said, "If [person's name] needs the toilet we just ring the bell once and staff come". We saw bathroom doors shut before care was provided and where people undressed in communal areas, staff calmly supported them to a more private area. Where two people looked a little dishevelled staff explained they liked to be self-caring and resisted any assistance. They discreetly adjusted trousers and tops if people allowed them to and left some wipes within one person's reach to wipe some food from their face at a time that suited them.

Relatives said they were involved in the care and updated of any changes. They felt able to leave their loved one at the home and know they were well cared for. Relatives said, "Dad and I came prior to mum's admission, about the facilities and care being offered. It's very family orientated involvement. The staff are very friendly, they stop and have a chat with her. She loves the banter", "They ring me, I have no doubts they are looked after to the best of their ability" and "They keep you informed, and every day when you come in they [the staff] tell you what has happened. If they have a fall they telephone". Visitors were able to spend time with people in the communal areas or their rooms. One relative said, "On a good day [person's name] will join in with activities in the lounge, and the staff interact with him and they will enjoy that but otherwise we spend time in their room and they play music. You only have to say." People were able to see visitors at any time. Relatives told us they felt welcome and were always offered tea and biscuits together at any time. One relative said their loved one loved the food at the home and added that staff also looked after their dad when they visited, also informing them if staff were concerned about him too.

People and/or their advocates could be involved in decisions about the running of the home as well as their own care. The home sometimes had relatives and residents meetings although there had not been one for a while. However, all relatives and people able said they could go to any of the staff at any time. They said they only had to make a suggestion and it was done, such as closing a window, installing an outside tap or including a different meal on the menu.

People were also invited to use the national feedback website www.carehome.co.uk with a link to recent inspection reports. The site had received 19 reviews with a review score of 9.5 out of 10. Recent comments included, "Primley Court put on a fantastic birthday for my nan. Every time I visit the staff are always very caring and helpful. The residents are at ease with the staff and there is a lot of love in there. I can't thank everyone enough for making my nan enjoy the rest of her days here", "The manager and staff are wonderful, so kind and caring all the time, I was amazed how well my husband was treated. It was excellent and I would recommend it to everyone", "There is a warm friendly feel when you arrive. Staff are friendly and helpful, nothing is too much trouble, they go the extra mile. I can't recommend it highly enough" and "This is the fourth care home my father has been in and undoubtedly the best. All the staff were caring to dad and supportive to us. The care and support was outstanding." Staff talked about Primley Court being like a 'family' and all staff said they loved their job, the challenges and rewards. They said they often worked beyond their shifts by choice. For example, the registered manager had just stayed on late to accommodate a family anxious about finding a suitable care home. They had shown them around late evening and said the family were keen for a place. The activity co-ordinator had stayed late with a new admission to help them settle in. The aromatherapist always stayed to have a cup of tea with people after their treatment, staff described them as 'a great healing person'.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. This included who in the community supported them and their needs as a family. There was information which showed the result of health professional discussions with people and/or their advocates about whether they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions and staff were aware. The staff approach was to optimise care for people approaching the end of life, increasing staff numbers and enlisting the advice of the

local hospice team. Relatives had recently sent thank you letters commenting, "The support you gave us over the years has been very much appreciated, especially during their final few days. All those who were involved with their care in those final hours were fantastic", "We have been very blessed in the love and care you gave" and "The last days were traumatic for us but the care they received and the dignity they were shown coupled with the concern for us made that time easier to bear."

Staff from the home often attended people's funerals, sent wreaths and celebrated people's lives with their families. One relative wrote, "I was so touched that some of you [staff] took the time to attend the memorial service, it was very reassuring to hear how much they meant to them and hearing their recollections……it helped to hear they would be missed." People were also welcome to continue visiting the home when their loved one had passed.

Good

Is the service responsive?

Our findings

At the last inspection in August 2016, we found improvements had been made with the introduction of the electronic care planning system but we found that people living with dementia were not engaged in meaningful interaction or activity and there seemed to be little available to aid in reminiscence or sensory stimulation. During this inspection in June 2017, we did not find this to be the case and we found that staff understood people's needs and engaged with them individually throughout the day, especially at The Court.

People received care and support that was responsive to their needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. There was good communication across the staff team about people's needs through handover and care plan records. The registered manager did a round of the home every morning and met with the heads of department and so also had good knowledge about each individual and any changes.

People and relatives also said the service across The Court and The View was very responsive to their loved one's needs. One relative had written to the local paper about Primley Court to say, "Family members were impressed by how much staff knew about Dad. This meant they were able to engage in meaningful conversation with him." Recent comments on the national care home review website stated, "The quality of care is excellent. All residents are treated according to their individual needs and preferences. My husband is unable to communicate but is relaxed and comfortable. The staff have learnt how to get the best response from him, CDs of folk music or birdsong to give him the right atmosphere when in his room and we are made welcome at any time" and "I was worried about my husband going into care. How wrong I was, from our first point of contact staff could not have been more caring and welcoming. The staff are so kind and professional and set an example to the caring profession. My husband has changed from being anxious, depressed and in constant pain to being calm and smiling. He enjoys the special contact with staff. I can sleep at night." One relative told us that staff were responsive saying, "Staff will second guess when they don't think [person's name] is very well. They will give her a couple of paracetamol." Some relatives had experience of using a number of other homes and said Primley Court was the best. One relative said, "We went to about 14 care homes. I would not want [person's name] to be moved from here. She is comfortable and is as good as she can be. She eats well, drinks well, she has her medication – she doesn't argue about that."

On both premises staff were seen to be visible and attentive, chatty with people and there was a lot of banter and humour. They gave attention to detail based on their good knowledge of people's needs and behaviours. For example, noticing people's body language. If someone was fiddling with their clothes they checked if they needed the toilet and they placed cutlery and glasses on the table at the same time as the meal to maintain a safe environment and focus the person on what items were 'theirs'. People said, "Staff… will spend time chatting to me. I like to hear about their life and I think they like to hear about mine. Some are very helpful as well. It keeps me in contact with everything." Another person said, "It's very, very good. It's very upbeat and a lot of activities. You can hear singing in the communal room and they sometimes have sing songs there." They said how they used to play the piano professionally, and were able to continue to

play on a portable keyboard.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone. The registered manager said, "I don't allow admissions in an emergency or on a Friday so we can be sure the placement will work before people come. We make sure we physically assess all possible admissions first and get a good picture of their needs with their families." They also took a care worker or nurse to assist with assessments. They said, "It's important as they will be delivering the care and can advise as to whether we can meet their needs along with other people at the home. I always speak to the nurses on the floor before we admit anyone. They are the ones on the floor and we take their views seriously." The assessment formed the basis of a care plan, which was further developed with the person and their relatives after the person moved in and staff had got to know them.

People, if able, were involved in planning and reviewing their care. We saw people's care plans were discussed with them or their advocate each month and changes were made if necessary. People had signed some of their care records and the record of each monthly review. Where people lacked the capacity to make a decision for themselves staff involved other professionals and family members in writing and reviewing plans of care. All care staff had input into the care plans. They said this meant they felt valued as a team. Daily records were clear and related to the care plan detailing people's experiences and needs.

People's electronic care plans were personalised and provided staff with detailed guidance about each person's specific needs. Staff said they could all access the care records on the computer. Care workers tended to inform registered nurses of shift information so they could stay with people rather than use the computer. Information was provided about what people could continue to do for themselves and how they liked to be supported. Each section of the care plan covered a different area of the person's care needs, for example, personal care, mobility, physical health, continence and skin care, communication and mental health and emotional support. People's care plans were informative, easy to follow, accurately reflected people's needs, and were reviewed monthly or as people's needs changed.

Staff were aware of people's changing needs and risk assessments and provided care in line with care plans and assessments. One person had a high risk assessment in place regarding their skin viability and risk of pressure damage and this was well managed and their skin remained intact. Where people had specific needs relating to living with dementia, guidance was sought from health professionals in how best to support people. For instance, one person had particular sensory needs. The home had sought guidance from the 'sensory team' and occupational therapist to develop a plan for staff to follow to support this person's well-being and minimise the impact this might have. Staff were able to describe how they supported this person. Another person was supported by staff to carry out regular exercises following the occupational therapist advice.

Due to the nature of the people's complex needs many interactions with staff were seen to be adapted to people's short term attention span, mood and responsiveness at any given time. We saw staff sitting chatting with people, singing and dancing and enabling people to help with chores. One person loved the crisp feel of a wipes packet, staff had tried other sensory items but they preferred the packet so staff ensured they had one ready. Their relative confirmed they always had "something to fiddle with" as they liked that and mentioned they particularly liked the packet. These interactions were not always recorded as they were seen as part of the daily care and could be fleeting. As there had been concern about the level of 'activities' in the last inspection in August 2016 we suggested staff try to include these more intimate, individual moments with people but we observed them happening. For example, during a group ball game staff had previously noted one person seemed to engage and focus on the ball. We saw staff trying the ball game

again for a few minutes during our inspection before the person stopped. They said they kept offering a ball game if the person appeared willing and we saw this again on our second day.

Staff interacted with people on an individual basis as the majority of people living with dementia and mental health conditions had specific needs and triggers that could lead to behaviour which could be challenging for staff. All staff were able to give further details about how they provided engagement, stimulation and social interaction with individuals. They were looking forward to a new 'magic table'. This is an electronic activity system offering meaningful games through light animation for people living with dementia. Staff said the table could be moved and also used for people who were restless at night.

When we spoke to relatives, they all commented on how well staff knew their loved one. Staff were able to tell us detailed information about people's backgrounds and life history from information gathered from families and friends. Each person's electronic care plan contained information which covered the person's life history. This gave staff the opportunity to understand a person's past and how it could influence who they were today. Other more focussed or group activities were recorded more thoroughly. The computer system also enabled staff to record how a person had responded to an activity using 'emotion mapping' stating if people were content, happy or pleased. For example, the activity co-coordinator had spent an hour introducing a pet dog to one person who had previously liked dogs. After watching they eventually stroked the dog and made a positive face. Their relative also told us about this. Many people, especially those people who displayed limited engagement, had regular visits from an aromatherapist. They recorded each visit in detail noting people's responses. For example, gentle shoulder massage as sleepy, sat holding their hand for ages, [person's name] enjoyed putting on their own cream, really lovely chat about their family and just listened as [person's name] told me all about their husband. This showed individualised, responsive care.

There was also an activities coordinator who managed regular activities around the home including one to one time with people. There was an advert out for a second full time co-ordinator. The registered manager said there were also a large number of job adverts for this role elsewhere. They were keen to employ the right person to meet people's specific complex needs with the focus on the person not the activity. We took time to discuss 42 individuals living at The Court with the registered manager, deputy, a registered nurse and the activity co-ordinator and then walked around the home to see these people. Throughout the inspection we saw staff interacting appropriately with people based on their responsiveness at the time. Staff said, "We constantly give people choice which is nice", "It's a minute by minute thing" and "It depends on what people want to do when." The activity co-ordinator said, "It's not so much about the group activities which we do but we work on letting the person out of themselves as much as we can. There is no way we are ignoring anyone, it feels like we do the impossible sometimes but we try what we can to connect".

They regularly sent letters to families to tell them how people were doing, especially families living far away. For example, two staff members spoke their native language with people who understood which made the person respond and smile. One person had few reactions but liked singing and would hum if sung to. They liked their leg rubbed like their husband used to do. Staff understood when the person was loud, they were trying to speak so staff responded with the appropriate sounds to show a conversation. One person was very protective of their space but staff knew they appreciated beautiful things. The registered manager had sat looking at their perfume and talked about hair dressing. They loved a long bath. One person played the organ and staff helped them to accompany the weekly church service at the home so they didn't forget their skills. Music was often used and staff noted how positively people reacted, with a tapping foot, just a smile or a sway. Another person with limited sensory communication liked singing for only a short time and not too loud which staff respected and they enjoyed regular foot baths.

People we spoke with who were able to comment said a variety of activities were provided. They could choose to take part, but if they did not want to participate their wishes were respected. The home produced an activities programme, which was displayed within the home, and informed people about upcoming events such as, animal visits, singers and music. We saw there was an activities coordinator employed from Monday to Friday each week. Each person's care plan included a list of their known interests and staff supported people on a daily basis to take part in things they liked to do. People who wished to stay in their rooms were regularly supported by staff in order to avoid them becoming isolated. For example, one person's care plan told staff they enjoyed animals and loved to chat about animals. We saw staff had made sure the 'small animals' expert who visited the home every month, were taken into the person in their room. Another person's daily records described how they had enjoyed a recent quiz and a discussion about travel. Specialist dementia support objects were available such as empathy dolls, 'fiddle muffs' and sensory blankets. For one person, who had specific sensory needs, staff had made them an activity station for them to fiddle with switches and wheel and handles they could touch and move.

People had taken part in art sessions and painting, animal therapy visits, external musical entertainers and other more spontaneous activities. For example, the maintenance manager was also a music therapist and had given a spontaneous 'show' on the Old Wing recently as people were looking more engaged that day. Many people including those with very limited engagement had enjoyed the local air show from the home's prime position on a hill overlooking the bay. The activities co-ordinator had recorded feedback about how people had reacted. Some people had enjoyed being on the patio, others had been able to focus on a plane for a few minutes whilst another person had unusually agreed to leave their room and had a successful afternoon socialising for a short while. The home had participated in a charity dementia coffee morning and were preparing resources for the Alzheimer's Cupcake Day where people would decorate their own cupcakes.

People and relatives said they would not hesitate in speaking with staff if they had any concerns. They said, "There is a lead carer on duty and the nurse and we have had occasion to ask questions and they have always answered them well and they have been more than helpful." Other comments included, "If I had any reservations or anything I did not seem to be happy about I have spoken to the deputy manager and instigated changes. I have been happy with the response I have had from them and the manager" and "There's always [someone to talk to]." People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. No-one told us about any complaints with the service. This was reflected in that the home had no recent formal complaints. We suggested recording day to day informal comments to be able to show their responses and follow any developing patterns for the future. One relative had asked for the room to be decorated which was done in colours the person was very happy with.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2016 we found the provider did not always have efficient systems in place to monitor and improve poor practice. For example, in moving and handling, laundry provision and malodours. We found during this inspection the systems were still not fully effective and needed further improvements.

The quality assurance systems had not been effective in managing and monitoring infection control and cleanliness in particular areas. For example, the New Wing kitchenette, timely replacement of shabby furniture no longer able to be cleaned and some dirty mobility aids. We also found issues relating to poor infection control which could put people at risk and did not promote a homely environment.

Although there were quality assurance systems in place to monitor care and plan on-going improvements, the infection control audit had not been effective and management had failed to have an overview on cleanliness throughout the home, infection control and the housekeeping department.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed this back and physically showed the registered manager and the housekeeper the areas we were concerned about. By the second day of the inspection the registered manager and operations director had carried out a room by room audit again and the areas of concern were cleaned to a good standard. The registered manager said they would now carry out infection control audits in particular related to cleanliness themselves rather than rely on delegation, which clearly had not identified the failures we found in this area.

People and relatives felt the home was well led at The Court and The View. They said, "We haven't come across anything to the contrary. I have met the deputy manager. I met the owner last week", "The manager [The View] is lovely I feel able to discuss anything with her", "It's well managed I think" and "You can definitely say good things about the home and the manager and I'm in all the time." Notice boards contained useful information for people and relatives, for instance, copies of the home's complaint procedure, last inspection report and the home activity programme. Meetings for people and their relatives had been arranged in the past but not well attended. The registered manager thought this could be because they had an open door policy and welcomed feedback from people and relatives at any time. None of the people or relatives we spoke to had any negative issues to raise, although one person said they would like more to do.

Primley Court's ethos was to enhance the quality of life of residents by providing a home for people that had the flexibility to adapt to the needs of individuals. Their brochure highlighted that the service delivered care for people with complex or higher nursing needs. The provider and registered manager valued the staff, speaking highly of their team, considering the high level of complex needs they cared for. They said, "It was all about getting the right people for the job" and the provider had just increased pay levels. During a staff

meeting the registered manager was pleased to announce the appointment of new staff with very good past experience and a new registered nurse with a good clinical background.

Staff all felt well supported and listened to. Staff said there was always a more senior person available for advice and support. During supervision one staff member had requested more senior support for supervisions and this was accommodated. One registered nurse said, "Staff support and help each other. You can't buy loyalty." Any issues including through the company's whistleblowing policy were dealt with appropriately. For example, an anonymous staff member had communicated about poor practice by another staff member. An investigation and witness statements were taken and a conclusion made. There had been no recent complaints so we looked at the last formal complaint in 2016. This had been investigated and responded to sensitively in an understanding way addressing all points in the complaint using the company's complaints policy.

Staff at The View also spoke highly of the management team and told us The View was well managed. Staff described a culture of openness and transparency where people, relatives and staff, were able to provide feedback, raise concerns, and were confident they would be taken seriously. Staff were positive about the support they received and told us they felt valued and worked well as a team. Staff knew whom they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through daily handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns.

There were regular staff meetings, senior care staff and registered nurse meetings. These enabled staff to discuss ideas about improving the home. Meetings included communication about any operational changes such as refurbishment budget and recommendations from external health professionals. There was discussion about what was an incident or an accident and a reminder that 'engaging with residents at all times must be done but if people refused (or were unable) to engage to ensure it was recorded. Further discussion was about how some people found it difficult to engage due to their condition and the registered manager responded by saying to continue encouraging people but not force them and to record refusals. Staff were excited at the prospect of the new 'magic table' electronic activity table, which the provider said they were about to order following a local press release. The registered manager went on to praise senior care workers for their good handovers. Staff had time to raise any other issues and be listened to.

The recent nurses meeting discussed how to complete the forms relating to mental capacity which external health professionals had asked them to do. The registered manager offered help to any staff as the new form was four pages long and had said it was difficult to fill in. The computer care plan system now contained new updates and staff were supported with daily teaching sessions about inputting care plan reviews.

There was a management structure in the home which provided clear lines of responsibility and accountability. A registered manager was in post who had overall responsibility for the home. They were supported by a deputy manager at The Court and The View and senior staff. Some members of the staff team had lead roles such as dignity and wound care champions so they were able to guide staff practice in these areas. The dignity champion said they made sure people were covered, looking well cared for and not upset. Other staff were delegated responsibility for overseeing food and fluid charts and medication. We observed that the management team took an active role in the running of the home and had very good knowledge of the people who used the service and the staff. People appeared very comfortable and relaxed with the management team. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors even if this

was sometimes out of their contracted hours. Relatives felt there was an open door policy and they could speak to the managers or staff at any time.

The registered manager showed great enthusiasm in wanting to provide the best level of care possible. They kept up to date with current good practice by attending training courses and reading professional publications such as David Sheard guidance about the nationally recognised Butterfly Project which ensures people with dementia 'matter' and the University of Stirling Good Practice design dementia and sight loss guidance. All staff had attended training in behaviour which could be challenging and completed feedback on how this had affected their practice. All staff had noted person centred care and knowledge of the person as key. One staff member described how they knew how to use techniques resulting in minimal impact or distress for the person. For example, if the person grabbed their hands tightly and wouldn't let go. The registered manager said restraint was rarely used and we did not see any happening or recorded. They attended company leadership meetings with other managers in the group. One meeting designated a named staff member to ensure staff were up to date with code of conduct and policies. New safer grass flooring and new parasols were ordered for The Court patio and medication updates for registered nurses. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way that they cared for people. One staff member said "We are such a good team, each one of us" and "I'm very proud. I love it here, each day is a challenge and rewarding." Staff were valued and encouraged to continue learning and put that into practice. For example, a care worker had enjoyed training to be able to practically assist the nurses in wound care.

Staff were also well supported in a personal way which the registered manager said helped staff retention and quality of consistent care for people. There was close monitoring of any absences and staff felt able to talk to management. There was a low staff sickness level. The registered manager said they were due to carry out another staff survey. Staff had commented in the last survey 'what we do well' saying 'excellent care of residents, good management and team work, promoting people's independence and meeting needs of people with complex needs'. The registered manager told us how important it was to praise staff and staff agreed. The deputy manager said of the registered manager, "She does everything for staff and everybody." This was reflected in the very stable team with most staff having worked at the home for some years.

Staff enabled people to have community links if they were able. For example, Age UK befrienders had been tried although the person did not engage. The local parish church vicar and a catholic priest attended regularly for those people whose body language showed they enjoyed maintaining religious practice. Links with two local schools resulted in seasonal school choir visits which people responded to. The Salvation Army also visited to offer sing a longs. There were also visits from local 'Dementia Friends', lay people with an understanding of dementia to offer company. The home also embraced local events such as the air show and topical charity events such as Alzheimer's Society projects.

There were audits and checks in place to monitor safety and quality of care which were monitored on an action plan. This was also monitored from the corporate head office with the registered manager sending a monthly clinical audit report every month. This contained audits on people's weights, hydration and nutrition, covert medication authorisations, DOLs application expiry dates and safeguarding. The provider visited regularly and the operations director was based at the home and discussed any issues arising with audit findings. The provider signed off each monthly audit and agreed any actions. They met with the registered manager monthly for a formal one to one manager meeting. Recent minutes showed discussion about how a new training 'Virtual Dementia Experience Roll Out' was going and feedback from staff would be gathered when all the staff team had attended. Staff feedback had previously resulted in a change in training providers for other topics to ensure relevant, good quality training was provided. In addition there were weekly provider and manager meetings. These followed an agenda including regulatory issues such as

safeguarding, training, catering (a visitor snack menu was now on offer), staffing and equipment needs. There were also quarterly group meetings including managers from each of the provider's four homes. Each home gave an overview of their performance and management report and discuss areas for learning. For example, following the last CQC inspection, issues about manual handling were shared and staff attended refresher course with a different provider.

There were no recent safeguarding referrals. Care reviews by health professionals were included and follow up such as recommendations, letters and actions. Falls were recorded monthly and analysed for patterns and possible prevention discussed with actions such as referral to the community physiotherapist. Falls were further categorised into falls from standing, minor, non injury, fall from bed or chair for example. There were no pressure sores. Records were stored securely, when we asked to see any records, management were able to locate them promptly. This demonstrated the home had a culture of monitoring and learning in relation to the quality of care provided.