Barchester Healthcare Homes Limited

Harper Fields

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 21 March 2018. The inspection was unannounced.

Harper Fields is a purpose built home which provides accommodation with personal and nursing care for up to 80 people. There are four separate units within the home. Two are 'memory lane' units for people living with dementia. Another unit is for people with nursing care needs and the fourth is a residential unit. There were 75 people living in the home at the time of our visit.

At our last inspection in May 2017 we rated the service as good overall. However, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 because risks around skin care and wound management had been not been addressed in line with people's care plans. The key question of 'Is the service safe?' was therefore rated as requires improvement. The provider sent us an action plan, setting out the actions they planned to take to improve the quality of the service. At this inspection, we checked whether the actions they had taken were effective.

Since our previous inspection in May 2017 we have reviewed and refined our assessment framework, which was published in October 2017. Under the new framework certain key areas have moved, such as support for people when behaviour challenges, which has moved from effective to safe. Therefore, for this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

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

At this inspection staff told us learning had been taken and shared following the issues previously identified around wound management. The registered manager had implemented procedures and processes to ensure people's skin was regularly assessed and wounds were monitored regularly. Some improvements were still required to documentation, but the registered manager took immediate action to ensure staff had all the information required to check wound treatment plans were effective.

Staff were responsive to changes in people's health needs and sought professional advice and support so people's health was maintained. Overall, people received their medicines safely and as prescribed. However, the provider needed to ensure safe medicines management was consistently followed throughout the home.

People were safe from the risks of harm, because staff understood their responsibilities to protect people, and were encouraged and supported to raise concerns under the provider's safeguarding policies. The registered manager checked staff's suitability to deliver care and support during the recruitment process.

There were enough staff on duty to support people safely. Staff had the necessary skills and experience and received appropriate training and support from the registered manager to provide effective and responsive care.

People's needs were assessed before they moved to Harper Fields so the registered manager could be confident those needs could be met. Risks to people's personal safety had been identified and plans were in place to minimise these risks. Accidents and incidents were investigated and actions taken to minimise the risks of a re-occurrence. The premises and equipment were regularly checked to ensure risks to people's safety were minimised.

Staff had received training in the Mental Capacity Act 2005 and understood about working in accordance with people's best interests and in the least restrictive way. Staff offered people choices and sought their consent before they supported them.

People were supported to eat and drink enough to maintain their health and there was a strong emphasis on people eating well.

People were extremely comfortable in the presence of staff who gave people understanding, affection and physical reassurance when they needed it. Staff took time to get to know people and demonstrated this through their attitude and behaviours towards people. Staff respected people's individuality and understood how past experiences could affect people's responses now.

People were able to take part in a wide range of leisure activities and other pursuits which reflected their choice and interests and promoted their physical, emotional and mental health. Activities were also arranged so people could spend time together and develop friendship groups based on shared interests.

Staff enjoyed working in the home and felt well supported by managers and each other. Staff had confidence in the registered manager who listened to their views and opinions and understood the challenges they faced.

People and their relatives felt able to make suggestions to improve the home, and told us they would raise concerns if necessary.

The registered manager and provider carried out a range of quality audits to ensure people received safe, effective and responsive care that met their individual needs.

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 mostly safe.

Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Overall, people received their medicines safely and as prescribed. However, the provider needed to ensure safe medicines management was consistently followed throughout the home.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Harper Fields

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 21 March 2018 and was unannounced. Two inspectors, a specialist advisor and an expert-by-experience undertook the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a qualified health professional. The specialist advisor who supported this inspection visit had experience in providing nursing care to people with complex medical needs.

The inspection was prompted in part by concerns about how risks to people who were vulnerable to skin damage where managed and the management of wounds within the home. Our specialist advisor looked at how staff cared for people with wounds or sore areas to their skin.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send to us by law. We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The local authority shared information about their most recent monitoring visits they had carried out at the home

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent a significant period of time observing the communal areas and we saw how people were supported to eat and drink at lunch time. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During the inspection visit we spoke with seven people who lived at the home and eight relatives. We spoke with four nurses, seven care staff, an activities co-ordinator, a member of domestic staff and the operational trainer about what it was like to work at the home. We spoke with four new members of staff who were going

through their induction at the time of our visit. We spoke to the registered manager, the regional director and the senior regional director about their management of the home.

We reviewed eight people's care plans and daily records and 29 medicines administration records. We also looked at the management records of the checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2017 we rated this key question as 'requires improvement'. We found the provider had not always ensured identified risks around skin care and wound management had been addressed in line with people's care plans. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found improvements had been made and the provider was no longer in breach of the Regulation, but some improvements were still required.

Staff told us learning had been taken and shared following the issues around wound management. Further training had been introduced for both clinical and care staff so they understood their individual responsibilities. Each person's skin was now monitored closely and a weekly body chart was completed to check the condition of their skin and record any marks, bruises or red areas. Wound care had been addressed in staff meetings and staff had been reminded of the procedure they should follow if they identified any concerns.

A member of clinical staff told us that care staff were trained to routinely check the condition of people's skin when providing personal care. Care staff we spoke with told us they followed their training and reported any concerns to the nurse or senior member of staff on duty. Comments included: "We will notify the nurse and apply the creams. We will work on the repositioning programme to make sure people are being moved off their sensitive areas" and, "When we give personal care, we apply cream. We change their position often and use a slide sheet. If we see a red area, we call a nurse and they will check and take a photo."

One relative told us staff had taken appropriate action to minimise the risks to their family member's skin. They were happy that when their family member complained of a sore lower back, staff had immediately put the person on a pressure relieving mattress to reduce the risks of skin damage to this vulnerable area.

Our specialist nurse advisor checked the care records of five people who had wounds or tissue damage to their skin. Two people had minor skin tears which were being dressed in accordance with their care plan. Two other people had leg ulcers and the district nurse had been contacted to assess and diagnose the correct method of treatment in both these cases. The fifth person had a form of skin cancer. The GP had advised monitoring at this stage which was being done on a weekly basis. The monitoring was supported by photographic evidence which was reviewed by the GP monthly.

Each person had a treatment plan and wound chart and wounds were photographed on a weekly basis to support evaluation of the treatment plan. However, we found these could be improved because where people had more than one wound or area of skin damage, there was only one wound chart so it was difficult to establish the condition of each individual wound. Also, wound charts did not record the location, size, depth and description of the wound so it could be clearly demonstrated if they were deteriorating or improving.

Immediately following our visit the registered manager sent us confirmation of a meeting they had held with all clinical staff and the actions taken to address the issues around record keeping: "Nurses have now

implemented wound charts for all individual wounds which will be updated according to the plan and will be easier for nurses to identify any changes in size and progress. Weekly photos and measurements of wounds will still be taken and wounds progress will now be easier for all staff to monitor. As manager I will still carry out weekly checks on all wounds and also a full monthly audit on documentation and recordings."

Our specialist nursing advisor looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 29 people, speaking to staff and observing how medicines were given to people. We found the MARs were completed accurately and demonstrated that people received their prescribed medicines. Our observations showed that staff supported people to take their medicines in line with safe administration procedures. However, one person told us, "The staff always give me my medicine. They put the pills in a little plastic container and leave me to take them." Staff should observe people take their medicines before signing the medicines administration record (MAR) to confirm they have been taken. This not only ensures people have taken the medicines they need to maintain their health, but also protects against the risk of other people taking medicines that are not prescribed for them. Some medicines needed to be given in the morning 30 to 60 minutes before food and other medication to ensure their effectiveness. There were no arrangements in place to ensure these specific administration instructions were followed.

Some people were prescribed 'as required' medicines. These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. Overall, guidelines for the administration of these medicines had been implemented to make sure they were administered safely and consistently. However, we did identify two such medicines where the protocols were not in place.

We looked at three people who were given their medicines covertly (disguised in food or drink). For two of them there was evidence of a best interests decision made through discussions between the GP, nurse and relatives. However, there was no documentation to support the decision to give the third person their medicines covertly. Care plans for giving medicines in this way did not state the safeguards to ensure all the medicine was taken, and only taken, by the person it was prescribed for. This is essential for people living with dementia as they can easily become distracted and leave their food or drink unfinished which could then be picked up by another person. It is good practice for a copy of the plan to be attached to the MAR.

People felt safe being cared for at Harper Fields. When we asked one person if they felt safe they responded, "Oh yes. I feel safe because I know everybody." One relative told us they were confident their family member was safe in the home which gave them reassurance. They told us, "I'm comfortable when I go, [person] has got people who look after them and who care."

Staff felt people who lived at the home were safe and confirmed they had completed training to safeguard adults. Training included how to raise concerns, and the signs to look for such as unexplained bruising to people's skin, which might indicate they were at risk. Staff knew the signs to look for that might indicate a person was unhappy or concerned and told us, "A change in the person, sadness, agitation, quiet, or if they become withdrawn." Staff understood their responsibilities to keep people safe and told us they were confident to report any concerns to their managers. One staff member explained, ""I would go to the nurse in charge or unit manager so they could find out what the problem is and how they can solve it."

Staff understood the importance of supporting people safely and said they would not hesitate to report any poor practice by other staff such as not using equipment correctly. One staff member explained, "If any skin tears happen or any bruising, it could be down to us not repositioning people correctly."

The provider's recruitment procedures minimised risks to people's safety. Staff confirmed their references

had been requested and checked and their DBS (Disclosure and Barring Service) clearance had been returned and assessed by the management team before they started work. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

There were enough staff on duty to support people safely. Staff had time to spend with people and supported them effectively. Staff told us they felt there were enough of them to support people's needs without rushing.

People mostly felt there were enough staff, because staff came quickly when they rang their bells for assistance. Comments included: "Generally they are very responsive" and, "I press the buzzer and they come quickly." However, one person felt staff were not as responsive at meal times when they were busy assisting people with their meals.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risks identified included moving and handling, falls, malnutrition and skin breakdown. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people safely to mobilise around the home.

We saw staff encouraged people to be as independent as possible but monitored people's abilities to ensure risks were managed. For example, one person was advised to use a wheelchair because of the distance they were going to walk to join an activity.

Where people were at risk of not drinking enough, their fluid intake was recorded, but their output was not always recorded. This is particularly important for people who have catheters as output can be an early indicator of urine retention or infection. This was brought to the attention of the senior nurse who said they would remind staff this needed to be done.

Some people could demonstrate anxiety or agitation because of their diagnosis. Staff told us they felt confident to deal with such situations to keep people safe. One staff member explained, "I back off a little bit and then go in with a different approach. Or I will go and ask the nurse what the best approach is because I don't want to make the person feel uncomfortable." Some people's behaviours were recorded on ABC charts to help staff identify any specific triggers. However, when we checked the ABC charts it did not appear these were being used consistently. For example, the last entry on one person's charts was in February 2018, but the person's daily records described other incidents when the person had become "'aggressive"'. It was also not consistently clear from the daily records in what way the person was being "aggressive". Whilst more information would support staff in developing strategies to support the person, staff spoke consistently of how they responded to this person to maintain their emotional wellbeing.

The provider's policy and procedures were understood and implemented by staff to protect people from the risks of infection. The provider had appointed a champion for infection prevention and control, in line with the Department of Health guidance. The home was clean and tidy and free from odours. A member of domestic staff told us they had a daily schedule of cleaning tasks which ensured every part of the home was regularly cleaned.

Staff had received training in infection control and understood their role and responsibilities in relation to infection control and hygiene. Staff made appropriate use of personal protective equipment (PPE) such as disposable gloves and aprons which were readily available in wall mounted dispensers along the corridors and in communal bathrooms and toilets.

There were cleaning schedules for clinical equipment and records showed the equipment was regularly checked to ensure it was in working order and ready for use. There were appropriate bins for the safe disposal of pharmaceutical and clinical waste.

Equipment used by people was checked by staff and external contractors to make sure it was safe to use. For example, hoists had been checked by an external contractor in February 2018. A maintenance person worked at the home to undertake general repairs and complete safety checks such as weekly fire alarm tests. Staff understood the process for reporting maintenance issues and said they were dealt with promptly.

The provider had procedures to manage risks in the event of an emergency. People's care plans included personal emergency evacuation plans (PEEPS), which described the support they would need to evacuate the building in the event of an emergency. These were kept in a file on reception so they were accessible to the emergency services. Staff understood what to do in the event of a fire because they had received fire safety training. One staff member explained, "We have done fire training. If there is a fire we alert everyone, set the alarm and inform the nurse who will give instruction on what to do."

Good

Is the service effective?

Our findings

At this inspection, we found staff had the same level of skill, experience and support to enable them to meet people's needs as effectively as we found at the previous inspection in May 2017. People continued to have freedom of choice and were supported with their dietary and health needs. The rating continues to be Good.

People and their relatives had confidence in the staff who looked after them and were happy with the standard of care in the home. One relative told us, "[Person] is settled here and the staff are fantastic." Another said, "The staff seem very dedicated."

The needs of people who lived in the home were met by staff who had the right knowledge, skills, experience and attitudes. New staff completed an induction when they started working at Harper Fields which included training in all areas the provider considered essential and a period of working alongside more experienced staff. The provider's induction was also linked to the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

We spoke with four new members of staff who were going through their induction at the time of our visit. They were all extremely positive about the process and felt it would give them the understanding for their new roles. They described it as, "Very good, very informative and essential for the new starter." They told us the induction involved a lot of 'group work' which encouraged them to work as a team so they could effectively meet people's needs.

Staff told us they received regular refresher training and that the registered manager sourced additional training when a need was identified. For example, in response to issues around wound management, nursing staff had attended specialised tissue viability training and care staff were completing a "My Skin" training module. A member of nursing staff was confident this extra knowledge would ensure staff had the skills to provide effective skin and wound care in line with current best practice.

We spoke with the operational trainer who was responsible for ensuring care staff had the skills and knowledge to meet the individual needs of each person who lived in the home. They told us an important aspect of their role was to ensure staff understood their training and effectively implemented it into their everyday practice. At least once a month they worked alongside staff so they could complete observations and identify any areas where staff would benefit from more support or training, either individually or as a group. Records demonstrated that when poor practice had been identified, the operational trainer had taken action and the member of staff involved had been given guidance and support to ensure their practice was safe.

Staff were supported by group and individual [supervision] meetings which took place on a regular basis. Staff found these meetings useful as they were able to discuss any issues relating to people or their own developmental needs to support them to become more effective.

Clinical staff told us that each day they had an opportunity to get together and discuss people's clinical needs, emerging issues and share learning. On the day of our visit their discussions involved concerns about one person's medication and the difficulties faced by another person's family due to a decline in the person's mental health. The conversation was open and nursing staff clearly felt confident to share information in a supportive environment. One member of the clinical staff told us, "I love the nurturing and I feel it supports my practice."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager understood their responsibilities under the Act. Where the registered manager had reason to question a person's capacity to understand information about risks related to different aspects of their care and support, their care plans included a mental capacity assessment. When it was necessary to impose restrictions on people to keep them safe, applications had been made to the local authority to deprive people of their liberty.

Staff told us they had received training in the MCA and understood about working in accordance with people's best interests and in the least restrictive way. They told us that people's rights were not restricted unless a decision had been made in a person's best interests, because they did not have the capacity to understand risks to their wellbeing. For example, one staff member told us about a person who could be very reluctant to receive personal care. They told us, "We have to consider their wellbeing. We have to look after their best interests and how we can keep them clean. We don't restrict their freedom, we talk to them, ask them what they want and check them frequently to make sure they are comfortable and what is best for them. We know they have to be clean." Another staff member confirmed, "We just have to talk to them, reassure them, and tell them it won't take long and keep as calm as possible."

We saw staff offered people choices and sought their consent before they supported them. One staff member explained, "We support them as much as possible to make their own choices. The more you talk to them, the more orientated they become." Staff recognised that some people may be more responsive to certain members of staff. For example, a staff member asked one person if they would like to go to the dining room to eat their lunch. The person declined, but when another staff member approached them five minutes later, they readily accepted the staff member's arm and happily walked to the dining room with them.

Care plans contained pre-admission assessments so people's needs were identified and the registered manager could be confident those needs could be met. This included ensuring the correct equipment was in place to support the person effectively and maintain their health. For example, one person's admission to the home had been delayed by 24 hours so staff could ensure they had the equipment in place to support the person's respiratory needs.

Staff worked with other healthcare teams and organisations to deliver effective care for people. The registered manager told us they regularly met with the GP practice which supported the home to ensure effective communication was maintained. District nurses regularly visited the home to support people who lived on the residential unit and the community nurse from the local clinical commissioning group visited the home on a weekly basis to provide support and guidance to staff.

People's care plans included details about their medical history and their current medical risks and needs, to enable staff to identify any signs of ill health. Records showed people were supported to obtain regular checks with other healthcare professionals, such as chiropodists, dentists and opticians. Where people required the support of other healthcare professionals, staff worked with them to ensure people had the most effective outcomes. For example, one person was experiencing high levels of pain. Clinical staff had worked with the GP, mental health team and McMillan nurses to ensure the pain was managed appropriately. Relatives confirmed they were kept informed about any changes in their family member's health.

There was a strong emphasis on people eating and drinking well. People had a choice of meals and could eat in the dining room or their own bedroom, according to their preference. Meal options were displayed in words and pictures to support people's understanding of what was available. At lunchtime the atmosphere was calm and staff were talking with people and each other. People who needed assistance to eat were supported by staff sitting next to them, and supporting the person at their own pace. Some people had adapted plates to enable them to eat independently and coloured crockery supported people with dementia to recognise what was on their plates.

We asked people and their relatives what they thought of the meals provided. Responses were positive with people saying, "The meals are very varied" and, "I sometimes have lunch here. It's very good." People told us drinks were readily available and staff encouraged them to drink enough to maintain their health.

People's nutritional risks were assessed and their care plans explained the support they needed to maintain a balanced diet and sufficient nutritional intake. Staff were aware of those people with risks associated with their nutrition, for example, swallowing problems, and told us the cook prepared special diets for those that needed them. This included pureed diets and vegetarian choices. They said if anybody was not eating or drinking well, they referred it to the nurse who requested an assessment by the GP.

The premises had been designed and decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were several rooms and areas along each corridor where people could sit and read, rest or watch what was going on around them. Corridors on the memory lane units brought those people who liked to explore back to the main communal areas and there were items along the corridors to engage people's interest and stimulate memories. One member of clinical staff felt this particularly benefited people because, "When they come here they feel they can walk away because there is so much room." The external doors for each unit were number coded, to make sure people who needed support from staff to go outside, could not go out unobserved.

People had photographs and memory boxes outside their bedroom door to enable them to find their room more easily. Directional signs were in large print and included pictures to help people understand the words.

The shared facilities on-site included a hairdressing salon, a large garden area and a 'coffee shop' in the reception area on the ground floor. People and visitors were able to help themselves to drinks and snacks and the tables and chairs were arranged to enable small groups of people to sit and spend time with their visitors, or with other people, away from the main lounges.

Good

Is the service caring?

Our findings

At this inspection, we found people were as happy living at the home as they had been during our previous inspection in May 2017, because they felt staff cared about them. The rating continues to be Good.

Staff told us they enjoyed working in the home, and spending their time with the people who lived there. Staff said they worked as a team to ensure people were supported in a caring environment. One staff member explained, "It is a homely atmosphere. We are one big family. We look after each other and support each other in every way." When we asked another staff member how they demonstrated the caring values of the home, they responded, "My personality, understanding, listening skills, communication skills, and by encouraging independence."

People spoke very well of staff and when describing them used words like, "very nice", "cheerful", "pleasant" and, "helpful". One person said, "They look after you and everybody is nice." This was confirmed by relatives, one of whom told us, "You can see the way staff are with everyone, very professional, but very friendly." When we asked another relative what they thought of the care their family member received, they told us staff were "excellent, professional and caring."

People were extremely comfortable in the presence of staff and when people were approached by staff, they responded with smiles and conversation. Staff acted professionally, but gave people understanding, affection and physical reassurance when they needed it. Staff interacted with people when supporting them, explaining what they were going to do and encouraging people to take an active part. When helping one person to move from one chair to another we heard a member of staff say, "You look fabulous. I love your new haircut and new shoes as well. Do you want to take my hand? On the count of three we are going to stand." This was done in a relaxed and unrushed manner which promoted the person's independence.

Staff took time to get to know people and demonstrated this through their attitude and behaviours towards people. One person told us they felt particularly cared for because staff took time to know them as an individual. They explained, "You get to know everybody and they call me by my name when they come in." This was further demonstrated by another person living with dementia who had started calling out someone's name when they became anxious or agitated. Staff had contacted the person's family to find out who they were calling out for, so they could offer appropriate reassurance and understanding.

During our visit we saw many occasions when staff demonstrated thoughtfulness towards people. For example, when they gave people their drinks, they ensured the handles were turned towards people so they could pick their cups up easily. When one person walked into the lounge with only one slipper on, staff noticed straight away and said they would get the other slipper for them. The person was shown to a chair and offered a drink while they waited.

Care plans contained information about people's personal histories, preferences and interests so staff could consider people's individual needs when delivering their care. Staff respected people's individuality and diversity and understood how people's past experiences could affect their responses now. One member of

staff told us that whilst they were not formally aware of anyone living in the home who identified themselves as being lesbian, gay, bisexual or transgender, all relationships were respected. They told us of one person who had chosen not to discuss their relationships with staff but went on to explain, "They were able to express their character as they wanted to."

People told us, and we observed, staff respected people's privacy and dignity. When doors were closed, staff knocked on the door and identified themselves on entering the room. Staff were discreet when people needed assistance and only provided personal care in the privacy of people's rooms. One relative told us, "The staff are very courteous and treat [person] with real dignity. They seem very dedicated."

Staff understood the need to maintain people's confidentiality and told us, "We have to be careful what we disclose and only if it is their main legal Power of Attorney. We would not disclose it to a friend, we would say go and have a chat with the nurse."

All the relatives we spoke with told us they were able to visit at any time and the atmosphere was warm and welcoming. Relatives were invited to join their family members for meals and to join in activities and trips outside the home. People were encouraged to personalise their bedrooms with their own possessions so they could make it as homely as possible and give them a sense of belonging.

Good

Is the service responsive?

Our findings

At this inspection, we found staff were as responsive to people's needs and concerns as they were during the previous inspection in May 2017. The rating continues to be Good.

People's needs were assessed and plans of care developed to meet those needs in a structured and consistent way. Care plans focussed on the individual needs and wants of each person and contained information about their likes, dislikes and daily routines with clear guidance for staff on now best to support the person. Care plans also contained information about people's communication needs and the best way for staff to communicate with them. This information had been drawn together by staff speaking with the person and their relatives and enabled staff to understand what was important to people. Records showed each person's care plan was regularly reviewed and updated.

Staff we spoke with had a good knowledge of people's physical, emotional and mental health needs and how they affected people. One member of staff described how they always had to assess their responses to people to ensure they met that person's needs at any particular time. They also told us it was vital good communication was maintained and information shared between staff to ensure positive outcomes for people. They explained, "We really support wellbeing and look at the person holistically. Yesterday affects today. It can affect it negatively or positively. You might have tried something yesterday that worked really well although it was not care planned." Staff confirmed the handover between shifts was thorough and they had time to discuss matters relating to the previous shift that might impact on the support people needed that day.

Where people and their relatives wished to plan for how they were cared for if they became very poorly, care plans included their future wishes for end of life care. For example, one person's care plan stated in what circumstances they would wish to be admitted to hospital if their health deteriorated, and when they would prefer to remain at the home. The plans also contained some information about what was important to people at the end of their life, for example, whether they wanted any spiritual support.

Clinical staff had received training in end of life care. One nurse told us they had previously worked as a district nurse and palliative care was a large part of their role within the home. Staff worked with other healthcare professionals to ensure people had a comfortable, dignified and pain free death. Anticipatory medicines were prescribed and stored at the home should people require them.

People were able to choose what activities they took part in and suggest other activities they would like to try. A timetable of activities was displayed in communal areas so people were aware of events that were coming up. We saw people were able to take part in a wide range of leisure activities and other pursuits which reflected their choice and interests and promoted their physical, emotional and mental health. For example people's physical health and balance was promoted through an 'early risers' exercise class, skittles challenge, swimming and a walking club. Weekly Tai Chi, mindfulness and medication classes and religious services supported people's spiritual and emotional wellbeing. Sensory stimulation was provided through pet therapy, pamper sessions and massage therapy and quizzes, and reminiscence sessions encouraged

people to remain mentally alert.

Activities were also arranged so people could spend time together and develop friendship groups based on shared interests. Such activities also enabled people to remain creative which increased their sense of self-worth. For example, some people shared their love of flowers in a floristry workshop and gardening club and other people enjoyed a regular reading group. Others enjoyed a game of dominoes together or the weekly 'knit and natter' club. Some people had requested a 'gentlemen's club' and this was held once a month supported by a male member of staff.

Staff also supported people to maintain their interests and hobbies outside the home. Regular community trips included going to local theatres, visiting houses and gardens of historical interest and boat trips. One of the activity staff explained, "We make sure all our residents have the opportunity to go out of the building." People and children from the local community were also invited into the home to share events such tea parties, open days and a recent 'teddy bear hunt'.

Staff appreciated that people also needed opportunities to achieve things on an individual basis. The activities co-ordinator explained how they were working on a resident's bucket list to enable people to share their wishes. They went on to say, "The bucket list is very individual to the person because we are arranging things around the person. Whatever they want to do, we will arrange for it to be done." For example, one person had a wish to go on a train again and this had been arranged for them.

In collaboration with a local university, the registered manager was introducing the Nameste programme into the home. This is for people who are towards the advanced stages of dementia where communication is far more challenging. It is a programme which is designed to support the use of senses such as smell, touch, sound and feel. Training had been booked and the registered manager was confident this would give staff an extra tool to provide excellent person centred care for those people with complex dementia care needs who were unable to participate in group activities. .

People were encouraged to share their views and raise concerns. The provider had a complaints policy that included information about how to make a complaint and what people could expect if they raised a concern. The policy was displayed within the entrance to the home. Records showed that complaints were recorded and responded to in line with the provider's complaints procedure.

People and relatives told us they would not hesitate to complain if they needed to. One relative told us, "[Registered manager] is very approachable." Staff told us if a person or their relative wished to make a complaint, they would support them to do so and refer it to the registered manager or the senior person in charge.

There were also three 'resident ambassadors' in the home. A member of activities staff explained what the role of the ambassadors was. "I meet with them once a week and ask if they have any problems. It is about finding out what we are doing well and what we could do better."

Good

Is the service well-led?

Our findings

At this inspection, we found the home was as well managed as we had found during the previous inspection in May 2017. The rating continues to be Good.

The home was well-led. People spoke positively about the quality of care in the home. One person had recently made the following comment: "I believe my feelings are taken into consideration. If I ask for something, they listen." A relative told us, "It is excellent, I couldn't be happier." Another relative commented, "I am very pleased with the standard of care now." This relative felt the home had improved under the guidance of the registered manager.

The provider was confident the registered manager had the skills and ability to provide effective leadership within the home and spoke positively about what the registered manager was trying to achieve. They told us, "[Registered manager] is hands on, she is not at a distance from care delivery. She is very proactive and liaises with us if she needs any guidance."

Staff were equally positive about the registered manager. They told us they enjoyed working at the home and felt well supported. Comments included: "The staff and the manager, we just seem to work together as a team which is good. If you have any issues you have a manager who is very approachable which helps immensely" and, "It is good to have a manager who is a nurse because she understands the challenges. We are equal partners."

Staff told us they liked working at the home, because it was rewarding. They told us they felt valued and encouraged in their role because managers recognised their contribution within the home. One staff member told us, "You always get praised if you have done something nice. You get praised a lot."

Staff also spoke about a supportive staff team who worked well together. Comments included: "We are quite a close knit team and we are very good at supporting each other" and, "It is a wonderful place to work, everybody is friendly, staff and people." One care staff member particularly spoke about good communication between care staff and the nurses and said, "You can always go to the nurse and they will give you good advice." Another said, "I feel supported by the nurses and the manager. If we need something, they help us." This was reciprocated by a member of nursing staff who told us, "Staff work really hard, and they are eager to learn and they work well as a team."

Staff attended staff meetings on a regular basis. Records showed the meetings happened regularly, and that staff were advised of developments in policies and any learning that needed to be taken from incidents that had occurred in the home. They also showed staff had the opportunity to discuss people's care and support needs, which ensured staff were involved in service development. One staff member told us, "We can give opinions and make requests. If you know a resident needs something we refer it to the manager and she will make sure it happens. We did say we needed something more for activities, like bringing people from other units so they can mix with other residents, and this has happened. This last meeting the manager told us they are bringing in the Nameste programme. They are coming to train us so we can give more to the

residents."

People and their relatives felt able to make suggestions to improve the home, and told us they would raise concerns if necessary. The provider regularly sought people's views about the home and responded to people's comments. For example, people had been asked about what activities they would like. Some people had asked for more activities that were male orientated and a gentleman's club had been formed. Other people had asked for more activities in the evening and a cinema club had been introduced. This demonstrated that people's suggestions were listened to and action taken.

We asked the registered manager what the main challenges had been in the 12 months prior to our visit. They told us, "Getting stability and improving the standards." They told us that now they had a full staff team, "The whole home is more stable." They told us the provider had been supportive and had recently introduced a staff profit sharing scheme to improve staff retention within the home. There was also an 'employee of the month' to recognise staff who had delivered excellent care standards. .

There had been learning taken from incidents that happened in the home at both service and provider level. Following issues around wound management, the registered manager had introduced a weekly review of all wounds, the nature of them and how the wound was progressing. The provider also planned to recruit a clinical development nurse to support skin care and wound management. The provider's regional director told us the nurse would visit the home on a weekly basis to advise on pressure care management and complete audits around tissue viability.

The registered manager conducted regular audits of the quality of the service. They checked people's care plans were regularly reviewed and up to date, that medicines were administered safely, that the premises and equipment were safe and clean, that any weight loss had been managed effectively and people's nutritional needs were met. They analysed accidents and incidents to ensure action had been taken to minimise the risks of a re-occurrence for the individuals concerned, and to identify any trends at service level. The registered manager made visits to the home outside normal working hours to check people were receiving a quality service.

The provider also completed a range of quality visits. These included monitoring documentation, talking with people and completing observations. We saw that at a recent visit in February 2018, issues had been identified around the mealtime experience within the home. This had been shared with managers and staff and the provider continued to monitor the home to ensure the expected standards were achieved. The regional director told us, "Where we do become concerned about a service, then we have a quality improvement process."

Opportunities for improving and ideas for innovation at the service were discussed at the registered managers' group meetings. The registered manager told us the meetings were used to share ideas, good practice and any learning from incidents that had occurred in any of the provider's other homes.

The registered manager worked in partnership with other agencies such as the local clinical commissioning group and McMillan. They had also established a link with a local university to improve engagement with people with more complex dementia care needs. One of the activities staff had recently been a finalist at the National Association of Care Catering Awards and had received an award from a leading authority on vegan and vegetarian diets for their work in this area.

The registered manager understood the responsibilities of being a registered person. They sent us statutory notifications about important events at the service. We did identify two incidents that occurred in the home

when the registered manager was on annual leave that should have been notified to us. The registered manager immediately submitted the notifications. It is a legal requirement for the provider to display their ratings so that people are able to see these. We found this had been done at the home and was also displayed on the provider's website.