Care Quality Commission

Sunrise Operations V.W. Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Sunrise Operations V.W Limited is a care home providing accommodation and personal care for up to 92 older people, some who may also be living with dementia. There were 68 people living in the home at the time of our inspection. The home is laid out over three floors, with one floor currently closed for refurbishment. The lower ground floor provided specialist support to people living with a dementia type illness.

The inspection took place on 30 November 2016 and was unannounced.

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

The service was last inspected on 4 February 2014, where we identified breaches in the regulations in relation to staffing and record keeping. Following that inspection, the provider wrote to us to tell us the action they had taken to address the concerns raised. This inspection found that the provider had made the improvements they told us they had and the previous requirements were therefore met. No new breaches of Regulations were identified as a result of this inspection.

Sunrise Virginia Water was well-led with good systems in place to provide support that was safe, effective, caring and responsive. The leadership team had fostered a positive and open culture where people, their representatives and staff were encouraged to express their ideas and thoughts. As such, the atmosphere within the service was relaxed, friendly and inclusive.

Each person was appropriately assessed and had an individualised plan of care which outlined how their needs would be met. People were involved at each stage of planning their care to ensure staff provided support in a way that met their needs, preferences and expectations.

There were systems in place to gain consent from people and staff understood the importance of involving people in their care and respecting their wishes. Not all staff however, were able to demonstrate they knew about the principles of the Mental Capacity Act and as the service provides support to a significant number of people living with dementia, this is an important area for the provider to further develop.

The service was well staffed by suitable and well trained individuals who were able to deliver support to people in a safe and effective way. Appropriate checks were undertaken when recruiting new staff to ensure only suitable staff were employed.

The service had overall good systems to identify and manage risks to people and to maintain the safety of the service as a whole. People were further protected from the risk of abuse or avoidable harm, because

staff understood their role in safeguarding them.

Staff worked in partnership with other health care professionals to help keep people healthy and well. There were good systems in place to ensure people received their medicines as prescribed.
The provision of plentiful good quality meals and drinks and the monitoring of people at risk meant that people received appropriate nutrition and hydration. Furthermore, mealtimes were a sociable occasion which people enjoyed.

Staff treated people with dignity and respect. Support was provided with compassion and wherever possible people's independence was promoted. People had choice and control over their lives and staff respected their privacy. Visitors were welcomed into the home at all times and people were encouraged to lead their lives as they wished.

The service offered an extensive range of activities and was constantly striving for new ways of engaging people and providing them with opportunities which were meaningful and interesting to them.

The management team continuously reviewed and monitored the quality and safety of the service and responded openly and proactively to any feedback received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient to safely meet people's needs. Appropriate checks were undertaken to ensure only suitable staff were employed.

People were protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in safeguarding them.

The service had systems in place to manage risks to people and maintain the safety of the service.

There were good systems in place to ensure people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

There were systems in place to gain valid consent from people with regard to their care and treatment.Not all staff however, fully understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff had the skills and knowledge to meet people's needs. Training and supervision were provided to ensure care staff supported people effectively.

People were appropriately supported to maintain adequate hydration and a balanced diet. Mealtimes were a pleasant and sociable occasion that people enjoyed.

Staff worked in partnership with other health care professionals to help keep people healthy and well.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respect. People clearly

had positive relationships with the staff who supported them.

People had choice about their daily routines and were regularly consulted with about their life in the service.

Staff respected people's privacy and dignity and treated them as individuals.

Relatives and visitors were encouraged and welcomed in the home at all times.

Is the service responsive?

Good

The service was responsive.

People received individualised support that was responsive to their changing needs.

People had daily opportunities to engage in a wide range of activities. People were encouraged to maintain their independence and follow their interests and hobbies.

People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated.

Is the service well-led?

Good

The service was well-led.

The leadership team had fostered a positive and open culture where people were regularly encouraged to express their ideas and thoughts.

Quality assurance audits were regularly carried out to maintain quality and the safe running of the service.

There was a high standard of record keeping which provided a clear audit trail in respect of all aspects of care and service delivery.

Care Quality Commission

Sunrise Operations V.W. Limited

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 was 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 30 November 2016 and was unannounced. The inspection team consisted of four inspectors and one expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern at the inspection. We asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke individually with 13 people who lived at the home, four relatives,19 staff, including the registered manager and general manager. We also met with one external healthcare professional who regularly visited the service and agreed for their feedback to be included in this report. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interactions between people and staff during the morning and afternoon on each unit. We joined people in the communal areas across the service at lunchtime to gain a view of the dining experience.

We reviewed a variety of documents which included the care plans for ten people, six staff files, medicines records and various other documentation relevant to the management of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said, "I'm certainly safe with the staff here" and another commented, "There are always people about …. That makes me feel safe." Relatives echoed the same view and expressed confidence that their family members were safe. For example, one relative told us, "Mum and Dad do feel totally safe here without a doubt. I feel they're safe with the carers and I would trust them implicitly." Another relative spoke of their family member no longer being safe in their own home and added, "Here is just right, she feels secure."

People told us that there were sufficient staff to support them safely. One person commented, "I do feel there are sufficient staff here." They went on to describe that, "When I've used my call bell pendent it has usually been answered quickly." Another person reflected, "There's a lot of people around, so they all look after us." Relatives also felt that staffing levels were sufficient. One relative remarked, "I would say that there are sufficient staff here… I've noticed that they do respond quickly to any call bells that are rung."

Staffing levels were sufficient to meet people's needs. Throughout the day we observed that there were enough staff on duty to support people at the times they wanted or needed help. Staff told us that there were enough of them to support people safely and effectively. Staff confirmed that the staffing levels on the inspection day were typical for the service and the rotas confirmed the same. Staffing levels were responsive to people's changing needs. For example, staff told us that the staffing ratio in one area of the home had recently gone up due to the increased needs of some of the people living there. The registered manager told us that agency staff were being used to support this increase whilst permanent staff were being recruited.

We noticed that there was a particularly high staff presence in the specialist dementia unit and this allowed staff the time to sit and spend time in the company of people and not just when care interventions were required. At mealtimes, those people who required support to eat benefitted from the allocation of one-to-one staffing.

In addition to care staff, a number of other housekeeping, catering and reception staff were also on duty to facilitate safe and effective service delivery. The management team and activities coordinators were also supernumerary to the number of care staff allocated to each shift.

Appropriate checks were undertaken before staff began work. Staff files showed that criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) prior to new staff starting work. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people whose situation made them vulnerable. There were also copies of other relevant documentation including references, job descriptions and copies of identification documents, such as passports in staff files. We noted from interview notes in staff files that candidates were asked about issues relevant to the care needs of the people they would be caring for as part of the recruitment process.

People benefitted from a stable and well-established workforce. Of the 98 staff members working at the home, only nine had joined in 2016; with several staff members having worked at the home for 3 years or

more.

People told us that they felt the home offered a safe environment and that they were treated with kindness. One person told us, "I feel safe from the staff, I know they wouldn't abuse me, either physically or verbally." Similarly another person commented, "I feel absolutely safe with the staff… , I'd be off like a shot if anything [unpleasant] ever happened."

People were safeguarded from the risk of abuse. Staff were confident about their role in keeping people safe from avoidable harm. They also demonstrated that they knew what to do if they thought someone was at risk of abuse. Staff confirmed that they had received safeguarding training and were able to describe the different types of abuse and what might indicate that abuse was taking place. One member of staff said, "I would report to a member of the management team or a senior on shift. We are here for the residents and I would definitely report concerns." When asked if staff knew of any external agencies they could report safeguarding concerns to, most staff correctly named the local authority safeguarding team, the police or CQC as being the key contact agencies.

People told us that they felt safer living at the service than they had prior to moving in. For example, one person explained, "I feel safe here. I had lots of falls in my own home, but have had none since moving here." Another person commented, "I'm supported to be independent although they will make sure it's safe for me to do whatever it is I want to do."

Risks to people were identified and managed appropriately. People were supported to take control of their lives in a safe way. Risk assessments were in place that considered any potential risks, but also ensured people's rights to make choices were promoted. These included areas such falls. Risk assessments were reviewed and updated regularly and after incidents occurred. For example, after a fall, one person's needs had changed. This person now required two staff to support them with their mobility. Falls mats had also placed either side of the person's bed to reduce injuries and alert staff if they were to fall again. The person's risk assessment had been updated and reflected these additional support measures and equipment that had been put in place.

Risk assessments were also in place that considered the specific needs of people living with dementia. For example, one person had a risk assessment for agitation in the mornings when offered assistance to wash and dress. This gave clear information about triggers and steps that staff should take to reduce agitation; such as respecting the person's preference to sleep until 10am and positioning the showerhead so that it did not direct water on to their face. Staff that we spoke with were able to explain the support given to this person and this corresponded with the contents of their care plan.

We did however find that the risk assessments for the use of profiling beds were generic and not specific to the individual person who used the bed. These generic assessments stated that all beds should be positioned away from walls and we observed this to be reflected in rooms that we viewed. We did note that some people had sensor mats on the floor next to their beds to alert staff in the event of falling. Some people had two sensor mats either side of their bed but others did not. We highlighted this to the management team who agreed to review these assessments.

Each person had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation. These contained information about the mobility needs of people and assistance people would require to move safely if there was a fire. Staff knew where to find this information and what was expected of them in the event of an emergency.

The provider had an emergency plan which included how the service would safely continue in the event of an emergency situation. It contained clear and concise information and instructions concerning the management of emergencies such as fire, flood, gas leaks and adverse weather. There were contact details available for emergency accommodation and transport, in addition to the contact details of contractors and emergency services.

Incidents and accidents were reviewed on an individual basis in order that actions were taken to reduce risks to people. For example, in one case, there had been an incident between two people. It was recorded that staff had checked their vital signs, called 111 for advice and notified the on-call manager. Increased checks of both people had been carried out and all relevant parties notified. As both people involved lived with dementia arrangements were made for a CPN to visit them. Larger visual identification had also been placed on their room doors in order to help them orientate better in the future. Since then there had been no further incidents involving these two people.
People told us they received appropriate support with their medicines. One person said, "I'm on quite a lot of medication, staff watch me take them down, just to make sure." A relative also talked to us about how the management of their family member's medicines had improved since they moved to the service.
Medicines were managed safely and there were processes in place to ensure people received their medicines appropriately. Staff told us that they had received regular training in medicines management and the training records confirmed this. We were shown evidence that a system to ensure all staff dispensing medicines underwent a process of regularly checking their competency to do so was in place.
The administration of medicines followed guidance from the Royal Pharmaceutical Society. Medicines trollies were locked when left unattended. Staff did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. One person was receiving continuous oxygen therapy. We saw precautions and risk assessments were in place to safely manage this. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with MAR charts. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. Staff were knowledgeable about the medicines they were giving.
All medicines were delivered and disposed of by an external provider. The management of this was safe and effective. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in lockable cabinets. There were lockable rooms for the storage of medicines. Medicines requiring refrigeration were stored in fridges, which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored daily to ensure the safety of medicines.

Eight people living at the home managed their medicines independently. The care plans for these people included appropriate risk assessments to ensure they were capable of managing their medicines. Secure storage facilities were available for these people to keep their own medicines in.

One person received medicines covertly, that is without their knowledge or permission. Their care records evidenced that a mental capacity assessment had been completed. This had identified the person could not understand or consent to their medicines being crushed before administration, as prescribed by the person's GP. There had been a best interests meeting held, with input from the person's representatives, their GP and staff at the home. They had also been referred for DoLS authorisation. This was consistent with the provider's policy and the law.

The provider undertook regular audits to ensure the safe and effective management of medicines. These

included checking medicines had been signed for when dispensed and that medicines were safely stored and disposed of. There were also regular external audits, undertaken by the provider's assigned pharmacy.

Good

Is the service effective?

Our findings

People who had capacity to make decisions for themselves, told us that they were free to do so and that the choices they made were respected. For example, one person said, "There are no restrictions on where I go. I tell them and they don't interfere. I can go outside, I just take it carefully." Similarly, another person commented, "I am very mobile and I'm allowed to do what I want." They went on to describe, "If we want to go out, we sign out and sign in when we return. As long as they know you're gone, there's no problem." The dementia specialist unit was secured by way of a coded entry system and each person living there had been assessed as needing this level of security. People who lived in this part of the service appeared happy with the care and support they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for all the people who lived in the dementia specialist unit as they lacked capacity and were unable to leave the service freely. As part of this process mental capacity assessments had been completed along with evidence of best interest meetings having taken place involving people's relatives. Staff recognised the restrictions in place were for people's safety and supported people to have as much choice and control as possible.

Consent forms were in place for areas that included opening mail and sharing of information. Where people had capacity, these had been signed by the person. For four people these had been signed by a family member. Mental capacity assessments and best interest meetings had been completed as people lacked capacity to consent in these areas. Three of the four relatives involved in making decisions had a Lasting Power of Attorney (LPO) for property and financial affairs. There was no evidence of them having LPO for health and welfare issued by the Office of the Public guardian to ensure people had the legal right to act on behalf of individuals. The registered manager said that she would look into this and take steps as necessary.

Restrictions to people's movement were appropriately considered. For example, one person had an alarmed falls mat next to their bed that alerted staff to their movements. A detailed and informative mental capacity assessment and best interest decision record was in place that considered all the required areas as detailed in the MCA 2005 Code of Practice.

All care staff understood the importance of gaining consent from people, but some were not familiar with the principles of the MCA. For example, one member of staff explained that the MCA, "Is about if a person cannot decide for themselves and we guide in the best interest of the person. Some other staff however said

that they had completed eLearning on MCA and DoLS but could not explain what either of these meant or give any details of the course contents. This was highlighted to the registered manager who said they would take steps to improve staff knowledge in this area.

People told us that they thought staff were well trained and knew what they were doing. One person said, "I certainly think they're well trained to look after us all." Another also commented, "The staff are well trained here, they give you confidence in that way." Relatives also echoed the view that staff were competent and confident in their roles.

New staff undertook an induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. Those staff who had been recently recruited confirmed that they had been given appropriate support when they started work at the service, including the opportunity to shadow more experienced staff. They told us that their induction had helped provide them with the necessary skills and knowledge to support people effectively.

Training and support were provided to ensure care staff undertook their roles and responsibilities in line with best practice. Staff told us that they had received training in areas such as safeguarding, moving and handling, infection control and fire safety. In addition to mandatory training, we also found that staff had the opportunity to undertake more specialised training in order to meet the needs of the people they cared for. For example, a number of staff had completed a diploma in dementia care.

Staff said that they received sufficient support to fulfil their roles and responsibilities. One said, "My induction included training, understanding Sunrise policies and procedures and records. It lasted six weeks; it was helpful to me as I had not worked in care before. I also did e-learning in dementia, moving and handling, fire and first aid."

Staff were well supported. Staff told us that felt supported by the management team and were confident that they could raise any issues with them. Staff received regular supervision. A supervision is a 1-1 meeting between a staff member and their line manager to discuss practice and training requirements. We saw the minutes for some of these meetings which identified that development and practice issues were continually discussed. One member of staff told us, "We have an appraisal every year where they ask about us and our development plans for the next year. It also includes self-reflection and improvement and we discuss future training."

People were complimentary about the food and told us they had lots of choice and flexibility in respect of their meals. For example, one person said, "I do like the food; it's quite tasty and nutritious with plenty of choice. If you make a choice which you don't like they'd change it for you, no problem." Another person commented, "I'm never hungry here and never thirsty. There's plenty to drink and they are always pleased to get one for you if you ask. That's really any time you want something, they'll get it for you." Relatives echoed the positive comments about mealtimes, telling us, "There is plenty of choice and they are very accommodating. They assist mum with her feeding too." Another relative told us that their family member was "Eating better than they did before" they moved to the service.

People had enough to eat and drink throughout the day. Mealtimes were flexible and offered extensive choice. The chef told us, "In terms of everything, the residents come first." People's likes and dislikes as well as information on whether they had specific needs were also recorded. This ensured people were provided with food they liked and for those who could not tell them verbally what they wanted, with food they were known to enjoy. Staff were aware which people were at risk of dehydration or weight loss and were

proactive in the monitoring of people's food and fluid intakes.

In the main dining area, individual tables were laid and people were free to take lunch when and with whom they chose. We saw that the mealtime was a social occasion with people chatting and laughing with each other and staff. Menus were displayed and the food in both units looked appetising and portion sizes were good. A range of drinks were on offer, including alcoholic refreshments for those who wanted them. There was also a private dining room which could be booked for family gatherings and that their family had frequently used this facility to dine together.

A new dining experience had recently been introduced in the specialist dementia unit in order to give people with higher needs, a more fulfilling dining experience. This included consideration of food textures, smells and colours. Staff levels had also been increased to support the new dining experience. The general manager said of this, "It includes thinking about the whole dining atmosphere, tastes, smells. It's made a massive difference, creating a very respectful experience for people." We observed the lunchtime period in the garden unit and saw this to be a positive experience for people. People were served a range of food items that they could try and consideration had been given to colour, texture and taste that reflected the general manager's comments. There was a high staff presence which benefitted people who were given encouragement and time to enjoy their meal. There was lots of conversation between everyone and it was evident that people really enjoyed this time of day.

People were supported to maintain good health and access external healthcare support as necessary. Staff ensured people had access to other healthcare professionals and people had choice about the health care support that they received. People told us, "They will arrange a doctor for you or an optician if you need one." Care records showed that people had been appropriately referred to other health service including; palliative care teams, speech and language therapist and the community mental health team. We spoke with one healthcare professional who had regular involvement with the service and they spoke highly of the service. They told us that staff had a good knowledge of people, were prompt in reporting concerns and overall people received "Good medical care."

The management team were continually looking at ways to improve the design and layout of the service to meet people's needs. As a result, the specialist dementia unit had been totally refurbished with consideration for people who lived with dementia. This included neutral colour schemes and flooring and a central kitchen with open access for people who lived on the unit. Memory boxes were next to bedroom doors that helped people who lived with dementia to orientate to their individual rooms. Newspaper articles from the 1950s and 1960s had been framed and placed on walls as reminiscence aids for people who lived with dementia.

Good

Is the service caring?

Our findings

People told us that staff treated them well and praised the support they received. For example, one person said, "The staff here are very good indeed, extremely good!!" Similarly, another person told us, "I'm really happy here. Lovely staff, couldn't find better." Relatives also talked to us about the kind and caring nature of staff. For example, one relative commented, "The care here for Mum is absolutely excellent and is definitely given with affection. They're very attached to her, I know that."

Staff treated people with kindness and compassion. We saw that staff spent time engaging with people in a meaningful way and interacting with them in a way that was endearing. For example one person was holding the hand of a member of staff while eating at the dinner table. Similarly, when a person sneezed, a member of staff walking passed automatically said "Bless you." People's birthdays were celebrated, including a special private meal each month for all those with a birthday.
People had positive relationships with the staff who supported them. On many occasions staff were observed giving reassurance by holding peoples' hands, smiling and giving hugs. People responded positively to this. People were observed smiling and their body language indicated they were relaxed and happy in their surroundings. We noticed staff sitting with people and spending time with them in a way that was not just task based.

People's privacy and dignity were promoted. People confirmed that staff routinely respected their personal space and knocked before entering their rooms. One person told us, "When they want to come in, they knock and wait for me to respond before they enter." Staff spoke to people with respect. For example, we noticed that staff asked people's permission to sit with them. As people moved around the home, we saw that they were always acknowledged by staff with a smile and conversation.

Peoples care plans included information about their personal care requirements, preferences, the assistance they required and what they could do for themselves. This helped ensure staff had information to provide care with respect for people who may not be able to always verbalise their preferences. For example, one person's plan stated, 'I am generally a sociable person and like to be where things are going on. When I feel overwhelmed I can be frustrated and shout.' The care plan went on to describe how the person could be supported effectively to minimise their frustration.

Systems were in place to support people to make decisions about their care. Information was appropriately displayed throughout the building that informed people of events and activities. Staff regularly sought people's opinions and where appropriate, gave people choices with the support of visual aids. One member of staff explained, "We give choices, it's important to give people choices for when they get up, what they eat and drink, what they wear and all of their daily routines." Regular residents' meetings enabled people to be involved in the running of the home. For example, one person told us, "I go to the resident's meetings and they do respond and address any issues that we might raise."

People's bedrooms were personalised with items of furniture and personal affects that included photographs and ornaments. People had a choice of rooms that included rooms with individual

rooms and lounge areas. Good attention to people's personal appearance had been given. Everyone wore clean colour coordinated clothes, men were freshly shaved, people wore clean glasses and some ladies wore items of jewellery that complimented their outfits.

People's religious preferences were known and respected. Representatives from the local Church of England visited the service three times each week and a priest provided Communion to those who wished to receive it. Staff told us were people to follow other religions, then other appropriate worships arrangements would be made.

Good

Is the service responsive?

Our findings

Care was personalised to people and responsive to their needs. People told us that they had been consulted with and involved in the care planning process. For example, one person commented, "The care plan was done with myself and my daughter. I do know that they update it on a regular basis." Relatives also echoed that they had been involved in the care planning of their family member. One relative informed us, "The care plan was sorted with myself and mum when she first came here." They went on to describe how it was regularly updated.

People's needs were assessed and regularly reviewed to ensure they received appropriate support. Prior to admission, the person and/or their representative were asked to complete an assessment form which provided key information about their medical needs and social preferences. The first month of residency at the home was then considered an ongoing assessment period. Following the assessment stage, an individualised plan of care in place was devised that included information about the person's communication, mood and behaviour, socialisation, memory and cognition and safety.

People had a document titled 'My life story' in place. These gave staff information about people who were important to the person, their past memories, hobbies and interests, and preferences. They also included information about people's current preferences in relation to daily routines, which included times of rising and retiring and bathing. Staff told us that the information within these helped them to understand the whole person, especially for those people who now lived with dementia.

People received a responsive service. Staff completed daily records for each person and where necessary we saw that these were used to trigger changes in the person's overall plan of care.
For example, we found that a referral to a community psychiatric nurse (CPN) had been made for one person after staff noticing a change in their behaviour. The person's behaviour continued to be monitored and professional advice included in their care plan. Staff were able to tell us of the contents of the care plan and daily records evidenced the care plan was being followed.

Another person's care plan identified that the person had experienced difficulty with swallowing. The person had been appropriately referred to the speech and language team (SALT) who identified that the person's dementia was the reason for the risk. As such, the person's care plan had been updated to provide the person with 1-1 support at mealtimes in order to encourage effective chewing and swallowing and reduce the risk of choking. Our observations on the day confirmed this to be the case.

Support was provided flexibly and promoted people's right to remain as independent as possible. We observed one person finding it difficult to mobilise and a staff member reassured them and offered to use the hoist. Staff later went on to explain to us that the person had good and bad days as such the support provided was always tailored to how they were at the time. Another person told us that they liked to manage their own personal care. They went on to say, "I know I'm slow, but staff respect that and allow me to get ready in my own time."

People had daily opportunities to engage in a wide range of activities. People spoke positively about the activities on offer. For example, one person told us, "There is always something going on that I enjoy." On the morning of the inspection, a keep fit class was taking place. We observed the co-ordinator inviting people to join the session, but there was no pressure for people to do so. One person remarked to us, "There are lots of activities going on, but there's no pressure to take part. I enjoy the scrabble and quizzes."

Activities were personalised to people. The service operated a 'Wish Book' where people were encouraged to write down their wishes about things they wanted to do and achieve. As a result of this, one person had been supported to go to the theatre. One of the activities assistants told us that it was important for them to "Engage each person" in whatever activity was going on. They went on to describe how during a recent art appreciation session one person had expressed an interest in visiting an art gallery and this was currently being explored. In the meantime, we saw that a piece of art work that the person had found meaningful had been given to them and framed for their bedroom.

The service operated two activity timetables, one for people who were more independent and another for those living with dementia. Multiple activities were scheduled and taking place on a daily basis. Activities ranged from physical exercise classes, to art, musical entertainment and flower arranging sessions. Each activity was evaluated at the end to assess it success for both individuals and appeal to the wider group.

There was a calm but lively atmosphere across the service with a variety of activities offered during the inspection. Activity staff were really enthusiastic and attempted to involve and interact with everyone. Many people joined in the activities. Those who did not actively participate still responded positively. For example, one person was observed smiling with their eyes closed and moving their head to the sound of music and singing that was taking place. Another person was seen singing to themselves.

People felt happy to raise concerns with the management and have confidence they would be acted on. For example, one person told us, "The managers are very good. I had a grumble about towels this week and they sorted it out very quickly." Another said, "I've never complained, but if necessary, I would go and see the manager who I'm sure would sort it for me."

People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated. Copies of the home's complaints procedure were clearly displayed, along with comment cards and suggestion sheets for people to use if they chose. Records confirmed that complaints received were documented investigated and responded to. The manager demonstrated a positive approach to complaints and had held face to face meeting with people and relatives to resolve issues.

Good

Is the service well-led?

Our findings

People and relatives expressed confidence in the management of the service. For example, one person told us, "I believe this place is quite well managed …. I was recommended and have never regretted it. I would most certainly recommend it on to somebody else." Similarly another person commented, "I would recommend it to anyone as it's totally excellent!! It does feel like home to me, I don't want to go!" The most recent family and residents' satisfaction survey found that 80% of participants would recommend the service to others.

Staff also reported that they felt that the home was managed well and that they felt valued and respected by the management team. For example, one staff member told us, "I love it here and the managers definitely respect the staff." Another staff member described the managers as being "Supportive and always available." Staff said that they were recognised for the work that they did. One explained, "Yearly they give recognition awards, called heart and soul awards. You get a plaque, a free meal and appear in the company magazine."

The leadership team had fostered a positive and open culture where people were regularly encouraged to express their ideas and thoughts. There were good communication systems across the service. These included a full handover at the start of every shift and a communication book to remind staff about important changes or appointments. There were also monthly staff meeting led by the general manager. Staff described these as useful meetings where they received feedback about what was going on and were invited to share their own ideas about the way the service could be improved. A team feedback day where staff were involved in a critical evaluation of the service had also recently been held. This had resulted in an action to further improve practices across the evening and weekend periods.

Quality assurance audits were regularly carried out to maintain quality and the safe running of the service. For example, monthly internal audits were completed across a wide range of areas including, care plans, wound management, call bell response and weight loss. Action plans to address any identified issues were included in the audit reports. We saw how learning from audits had changed practice and improved care provision at the service. For example, the root cause analysis of every fall and incident had led to comprehensive risk management strategies being put in place to reduce the risk of reoccurrence. The provider had also commissioned a number of external audits to provide an independent assessment of the service.

People were routinely encouraged to be involved in the running of the service and invited to make comments and suggestions about how things could be improved. In addition to regular residents and relatives meetings, people were actively involved in discussions about menu planning, outings and the refurbishment of the service.

There was a high standard of record keeping which provided a clear audit trail in respect of all aspects of care and service delivery. Information was stored securely and in accordance with data protection. The registered manager was aware of her legal responsibilities in respect of documentation and the need to

report significant events. Notifications have been submitted to the Commission in a timely and transparent way. Through the completion of the provider information return (PIR) the registered manager demonstrated a good overview of the service and how it can meet and exceed the required standards.

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The management team demonstrated understanding of the policy and reflected an open and transparent demeanor throughout our inspection. Complaint records included evidence that the principles of Duty of Candour had been applied. For example, people had received a written apology as part of the response to concerns raised.