Sonnet Care Homes (Essex) Limited

St Mary's Court

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?	Outstanding

Summary of findings

Overall summary

This inspection took place on 24 February 2016 and was unannounced. There was a breach of the regulations in force at the time of the last inspection on 6, 7 and 8 January 2015. Therefore we followed up Regulation 17 Good governance. And found no on-going breach relating to the maintenance of accurate records.

St Marys Court is registered to provide accommodation, personal care and nursing for up to 90 people. At this inspection we found 75 people residing at the service. There is a passenger shaft lift to assist people to the upper and lower floor and the service is set in pleasant extensive grounds. The accommodation was purpose built, light and airy for people to enjoy. The outdoor spaces are developed with people at the service and made safe spaces with lawns, attractive raised beds, outdoors seating and wheelchair accessible. These add interest and provide a pleasant aspect.

The home had a registered manager in place. 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.

People at this service were keen to tell us of their positive experiences. People felt involved in the development of their care and support and were consulted on matters that affected them. Staff knew people well, but had up t date person centred care plans to guide them with risks mitigated where possible. People and their families told us that staff were caring, compassionate and acted with kindness. We observed a staff group that worked well with people and ensured peoples comfort with all their interactions. Staff were mindful of privacy and dignity and diversity of people and therefore treated people as individuals and respectfully.

The staff group truly understood and practiced the values of this organisation of Kindness, Comfort and Respect. The leadership was visible and led by example. Staff felt valued in their contribution. There were robust systems in place to recruit, induct, train and support staff to ensure there was a staff group who were effectively prepared to meet the needs of individuals in their care.

People were able to have a varied and interesting life that was supported by sufficient staff for them to access the community and a host of social activities that were widely advertised. People experienced the pleasure of good food that suited their needs, with people who needed a soft diet having food that was presented using moulds so that different foods were separate and looked like real food was intended to. People were supported to maintain good health and if their needs changed they were promptly referred and seen by medical practitioners. Qualified nurses had the skills to meet the nursing needs of people at this service. Medicines were managed so people got medicine as intended by the prescriber, but where possible people were supported to be independent and manage their own medicines.

The was a strong quality assurance system throughout the service that truly enabled a 'floor to board' approach with the provider seeking out new ways to understand the experience of people using the service and listening to what it was like to use the service. Managers were listening and were flexible in their thinking to take on suggestions made by staff, other professionals and people at the service. Managers and the provider responded to people if they made suggestions or made complaint to show how they had acted responsibly.

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.

Staff had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting and monitoring allegations of abuse and worked with health and social care professionals.

Potential risks to people were assessed and measures put into place to mitigate risks. Where incidents occur these were analysed and used as a learning tool to reduce future risks.

People's needs were met and they were supported and cared for by staff from a range of disciplines that had the appropriate skills and knowledge.

People were supported by staff in all aspects related to their medicine, which included the use of equipment where required to ensure people received their medicines.

Is the service effective?

Good

The service was effective.

People received support and care from a staff team who were trained to meet their needs. Training was well managed by a dedicated team within the service. We found staff were encouraged to develop their knowledge and skills.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu, which included a range of specialist drinks for those with a reduced appetite.

People's health needs were carefully monitored and appropriate referrals made to other professionals, where required.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff treated them with kindness, care, dignity and respect at all times. Staff were highly pro-active in their approach to care. They demonstrated compassion and preserved peoples privacy in every aspect of their work to make people feel valued and supported.

There was an emphasis respect for choices, self determination and independence that valued every aspect of the person and gave opportunities to develop and enjoy their time. People were consulted and involved. Staff were culturally sensitive. Relatives were warmly welcomed.

Is the service responsive?

Good

The service was responsive to people's needs.

People received individualised and personalised care which had been discussed and planned with them. Staff provided tailored support which met individual needs and preferences.

Staff worked very hard to ensure people's lives were as fulfilling as possible. People's views were listened to and acted upon by staff.

Is the service well-led?

Outstanding

The service was well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service and their relatives to comment and influence the quality of the service provided.

The provider and managers provided strong, effective leadership and provided a clear strategy for the long term development of the service. Everyone knew and worked towards the same values that were well known and 'live'. People felt valued by the service. Staff were recognised for their achievements both with financial incentive and participating in industry awards.

The management team was pro-active in introducing new ways to meet the needs of people and promote good practice. There were effective and responsive systems in place to monitor the quality and drive improvement within this service.

The provider developed initiatives and welcomed innovation to develop and influence care for people.

St Mary's Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 24 February 2016 and was unannounced.

We gathered and reviewed information before the inspection. This included information from the local authority, 'Tell us your experience' information gathered through our website and from people who had contact with the service. We reviewed the information that the provider had sent to us which included statutory notifications of significant events that affect the health and safety of people who used the service. These are significant events that the manager must legally notify us about.

The inspection was carried out by four inspectors. One of whom took the lead role of speaking with people and visitors of the service to seek their views. We spoke with 18 people who used the service and three relatives who were visiting.

We spoke with the registered manager, the Nominated Individual, a number of managers with differing responsibility for areas within the service, which included clinical staff, training, and housekeeping. We spoke with 15 staff, which included, nurses.

During our inspection we observed how the staff interacted with people who used the service, including during lunch. Some people were unable to speak with us directly because of communication needs relating to dementia. We used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed nine people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We also looked at the recruitment files of four members of staff, a range of policies and procedures, staffing rosters, call bell use, quality assurance and clinical audits, the minutes of meetings and other records related to the running of the

service.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and abuse. People told us they felt safe living St Marys Court. One person said, "It's fine for me here. I am safe living here and others are safe around me. The staff are very good with me. I never have any problems. If I had a problem – I would let you know. It's okay here."

Staff were aware of how to raise concerns and agencies outside of the organisation to contact if necessary. Staff spoken with were clear about the processes to report and expressed confidence that they would be listened to. Staff were clear about whistleblowing and described having an independent phone line they could use to raise concerns.

One member of staff told us. "If I had any safeguarding concerns I would speak to [named the person in charge and the registered manager]. If I wasn't able to talk to them or they were not dealing with it effectively – I would whistle blow." We found that there were appropriate policies, procedures and systems in place for dealing with safeguarding adults from abuse. Staff had received training in recognising and responding to concerns where vulnerable people were suspected of being at risk of abuse.

Risks to individuals were managed with people's freedom supported and protected. One person explained to us what that meant to them. They said, "The staff come quickly when I use the call bell. It can be set as an emergency so that staff come quicker but I don't need that. The night staff check on me at night. I have got bed rails on my bed and I keep thinking why do I have these but I am happy to have them as I could roll out." Another person told us that they felt safe when being hoisted. We looked at risk assessments in place for individuals. Moving and handling plans were in place and where people required hoisting, the assessment included sling type, size and colour that they needed. We checked for one person and this was corresponded. The sling was labelled with the individual's name. The hoist seen had been serviced within the last 12 months. Staff confirmed they had received training in using the equipment and moving and handling techniques. We observed people being supported with moving and handling. We saw two staff support a person to stand from a chair. The staff members gave the person lots of verbal prompts and told the person what they were going to do. We saw that the person was offered a choice of which room they wanted to sit in. We observed staff using the hoist to lift one person off the floor. Senior staff checked the individual for injury before moving them. Staff were confident and worked together well to move the person into a chair.

Care plans included up to date and reviewed risk assessments on the use of bed rails, moving and handling, and advice for staff on managing anxious behaviour where needed. Waterlow risk assessments were in place for pressure care. These documented the setting for the mattress and when we checked this for two individuals this corresponded. Records said that individuals should be repositioned and a chart was used to regularly record this.

There were risk assessments in place for people at risk of falls. People who were identified as high risk had pressure mats in place to alert staff to people getting up from their bed. Risk assessment took account of peoples understanding, hearing, medication and stability to assess several factors. One individual had been

reviewed by the falls clinic and had seen by a physiotherapist to further guide staff.

Staff were observed to be following the risk management plan, for example one person was at risk of aspiration and we saw staff making sure that their drink was thickened. They followed what was documented in the care plan. For a different individual we saw risk assessments for the person to eat independently in their room.
In the wider context of managing risk to people we saw that in the event of a fire there were individualised evacuation plans in place for people.

We checked a number of windows and restrictors were in place and functioning to avoid people falling from heights. People who were in bed or sitting out of bed in chairs had call bells within reach. Some people had pendant alarms around their necks to more easily call staff when they we mobile. Each person had a personal emergency evacuation plan [PEEP] in their plan of care. This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency.

There were suitable staff in sufficient quantities employed. During the day of our visit we saw people going out for a walk locally, visiting a local garden centre and strolling in the grounds accompanied by staff. One visitor told us, "I am quite pleased. They are looking after my relative and look after her well and keep her clean. Staff are always helpful. They all came to introduce themselves and they all acknowledge you in the corridor. I have no concerns." A different relative said, "The staff are fantastic. The place where my relative was before caused her to deteriorate. My relative has picked up a lot since she has been here – much more settled here. I have no concerns at all. My relative is being treated very well and we couldn't wish for better. My relative is more settled each time we come. My relative is more independent now and helps herself to a drink whereas she would never do that before. There are always staff around. It is unbelievably different from when it was on TV. I wish they (the TV) would come back and see how good it is now." A person using the service told us, "People come quickly; not like in the hospital. And they stay with you which is nice. They don't rush off and tell you oh I have to go and help so and so."

One person told us that they felt that staff did not always come quickly especially at night. Therefore we requested a copy of the call bell print out for that person s room to see for ourselves. We found that staff answered the call bell for this person consistently within a few minutes each time they called for the time we examined. We spoke to staff who told us that they felt there were sufficient staff on duty to meet people's needs. Staff said they had a good team approach, describing the team as friendly. One new member of staff said that they had helped her fit in.

We observed that staff responded quickly to call bells. For example one person rang their pendant alarm for assistance and staff were there to assist within two minutes.
We spoke to the manager about how they determined staffing numbers and found that they used a staffing guide tool that allowed them to determine staff numbers by calculating people needs as well as the numbers of people resident. This was kept under frequent review. The manager explained they recruited and staffed each unit as if it were fully occupied. This meant a ratio of one staff member to four people using the service during the day and one to eight at night. The manager said she monitored this carefully to ensure it did not fall below this minimum.

We examined the rosters for each of the units. On Cedar unit, which is a nursing unit and accommodates up to 30 people. We found a unit manager, a matron [who also adviser elsewhere on the site], and a qualified nurse along with a senior carer. During the day the service had on occasion two nurses and intended to make this the norm once a newly recruited nurse started shortly.

Managers on the units told us they were able to request agency staff if the need arises. In this case they tried to use the same agency. We looked at the profile of agency staff supplied and saw that it contained a profile that contained a photograph and the date and type of training undertaken and that they were suitably recruited including the reference for their Disclosure and Barring Service [DBS]. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We also examined the recruitment records for staff employed by the service and found these to be robust. We examined three files and saw that staff filled in an application form that showed previous employment and experience, as well as staff being given the opportunity of declaring their suitability. This was also followed up with two references and a DBS that was in place before staff started work. In order that managers could ascertain if people had the suitable values that they sought not only did they interview staff but also asked them to complete a screening test on their decision making called a judgement index. This enabled managers to check if people had the correct motivation to care for people.

Medicine on the whole was well managed and people received medicine as it was intended as per their prescription with people enabled to be independent where appropriate. One person told us, "I have tablet. The staff are good. They have a way of talking with you while you take the tablets which helps as I wasn't used to tablets and the staff are quite encouraging. They [the staff] tell you what the tablets are for. It is very easy to panic but the staff crack jokes which is great and the tablets go down." A different person told us, "If I need medication, I ask the staff."

We found that care plans included information about how people liked to take their medication. Photos were in place to enable people to be correctly identified. Allergies were listed in the care plan and had been transferred across to the medication notes. We identified one person who self-administered their own medication and checked this was accessible but secure. It was kept in locked in a draw in their own room.

Medicine was appropriately stored and kept secure. There was good sized storage with locked medicine trolleys and a separate locked controlled drug cupboard. Storage was at an appropriate recorded temperature. We checked the records relating to controlled drugs and found these to be appropriately kept and matched the numbers of medicines kept by the service.

We checked some high risk medicines such as warfarin, insulin, Aldronic acid and antibiotics. We found that these were administered correctly and noted that changes in blood sugars, warfarin were recorded and a copy of the change was on file. Care plans included details of warfarin and side effects such as Cranberry juice.

We checked to see if the stock of medicine matched the records. Medicine in monitored dose blister packs matched with what was recorded on the medication administration records [MAR]. If people refused medication this was recorded on the back of the MARS charts. At the end of our inspection we fed back that some medicine that required to be carried forward did not have an accurate record. For example two people had been prescribed Paracetamol, neither of their MAR charts had a record of the stock carried forward from the previous cycle and both cases the stock level in the boxes did not match the MARS record. This meant we, nor the service could accurate check to see if these medicines had been accurately administered and recorded. We found that an external audit completed by the supplying pharmacy had taken place in December 2015 and had also identified the above problems. We learnt the manager was aware and was in the process of putting plans in place to address it. The service had appointed a new member of staff as medication champion to re-stock the medication trolleys and include carry over of medicines on the MAR charts.

We also examined where individuals were prescribed 'as and when required' medicines known as PRN.

There was a plan in place and staff spoken to knew the individual well and could describe their anxious behaviour and said that they don't give the medicine during the day unless they needed to, because the person was at high risk of falls but would give at night. We fed back that more detail on strategies to support, understand behaviour and potential distraction and diversionary methods would clarify more for supporting staff as part of the plan before administering this mood altering medicine.

Medicine rounds were completed in a timely way. Staff had access to a copy of British National Formulary. This is an authoritative and practical information on the selection and clinical use of medicines. They also had patient information leaflets and quick reference medication guides to support them.
We saw that any unused medicines were recorded and disposed of by the supplying pharmacist. If there were any medicine errors these were recorded via incident reports and escalated up through the system for managers to take action to prevent a reoccurrence.

Good

Is the service effective?

Our findings

People received care that was based upon best practice that was from staff who were appropriately trained and skilled to meet their needs. Staff told us that they received the training they needed for their role. Our observation of practice was that staff were knowledgeable about the needs of older people, people living with dementia and those people who needed nursing interventions.

One staff member told us, "The training we had on dementia really helps. The training involved the basic experience of how it feels to have dementia. Each person we support is different – it is not one size fits all. We ensure that care is provided in a human way and it is not all about paperwork. We make the time for people and are very aware of people's rights and the Mental Capacity Act." A different staff member said, "I like the way that all staff including kitchen and housekeeping staff have to do dementia awareness." Staff told us that face to face training was provided. A timetable of all mandatory training requirements was available in the offices and was updated on a monthly basis. It listed the available training, when training was completed and when updates were needed. We received a copy of this and saw that the vast majority of completed up to date training was in the higher 90% bracket, showing us the wide range and depth of training for the staff group as a whole.

We spoke to spoke the training manager at the service who said that as well as delivering training to staff they walked around the service and observed practice and liked to be 'hands on'. They told us, "It is important that there was a connection between what is taught on the training and practice". An example was that once they had delivered moving and handling training, this was followed up with a competency assessment to ensure the staff member had understood and was able to demonstrate their learning with the practical application. We were told that is also happened with medicine training. The matron observed staff whilst administering medicines to deem them competent and confident to manage medicine at the service.

Staff told us that they were supported to attend training and were able to request training in specific conditions if someone entered the service with a condition that they were unfamiliar with. The training matrix showed key subjects such as moving and handling, continence management and infection control etc. were covered as well as person specific subjects such as Multiple Sclerosis, Huntington's Awareness and strokes. A staff member said, "They will source whatever we need."

Five members of staff were attending Prosper training. This was with Essex County Council and the Health Foundation, who were developing ways to reduce the number of emergency hospital admissions as a result of falls, pressure ulcers and Catheter & urine infections. The service had therefore gone on to develop Champions in certain areas. These covered areas such as Tissue viability, Infection control, Moving and Handling, Nutrition and Hydration and Key workers. Some of these roles were linked directly to the Prosper initiative. These Champions were attending extended training in these areas and developing initiatives within the service to benefit the individuals living at St Marys Court.

We looked at the specific training of the nurses and the updates that they received. All the nurses employed

were aware of the new processes around revalidation with the Nursing and Midwifery Council [NMC]. Nurses told us they had access to training and updates as they needed. Because there had been an increased number of people requiring end of life care, they had therefore requested an update on training in this area and this was in the process of being arranged for them. Over half [67%] of the nurses employed had training in syringe drivers. This is a method of delivering medicine effectively when people are in pain at the end of their lives. One nurse told us they were confident and competent to use the equipment. All nurses had training in managing diabetes and warfarin management. One nurse explained they had recently had a teaching session on male catheterisation and would perform the next one required with supervision to deem them competent going forward. In addition the service took student nurses and offered a mentorship program to student nurses and had staff appropriately qualified and supported through Anglia Ruskin.

New staff told us they had received appropriate induction to the service. Two new members of staff both told us that they had a four day induction and had completed two shadow shifts before they were put onto the roster. Shadow shifts were completed irrespective of grade, this included nursing staff. Staff were also required to completed mandatory training before being put onto the roster and thereby ensuring they were competent to do the role expected of them. One person said, "I have been here two months. I worked with the agency prior to working here. I have had a DBS check, two references and an induction. I have had manual handling and dementia training. The training was over a three or four day period and I did two shifts of shadowing. There is lots of support. I am completing an induction booklet. I have a weekly meeting with my manager and have had an observation of personal care. I am enjoying it." Another person showed us their training folder which they had competed with their line manager. The service has started to implement the new care certificate.

Staff confirmed that they had appropriate support and supervision for their role. One person told us this was with their team leader. We saw evidence that new members of staff had weekly supervision for the first 12 weeks. Thereafter this was on a quarterly basis with supervision, appraisal or a care competency review completed. Managers told us that regular staff meetings were held. A member of care staff said, "Staff meetings are held monthly." Minutes were kept for other staff not in attendance to read.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place. Some of these had expired and the local authority had been notified and the service was awaiting a response. They told us that those people who they assessed as under constant supervision and who would be prevented from leaving the service if they attempted to do so had been referred to the local authority.

Consent to care and support was always sought and all staff knew and understood how they should act and respond to peoples decisions and choices. People using the service told us that their choices were respected and that they were involved in decision making. The principles of the MCA were known by staff and we found them even displayed in the laundry. Housekeeping staff told us about what this meant for them in their role. The head housekeeper told us, "We have weekly team meetings. Housekeepers are assigned an area each so that the housekeeper can speak to each person and know what time is best to clean their rooms and what their preferences are."

Records showed that 92% of all staff employed had undertaken MCA training. One person told us about face to face training with quiz at the end of the session to ensure people have understood what they have been taught. One unit manager said that the MCA was discussed along with Duty of Candour during supervision sessions with staff. Also that this included what and where to go if they have any concerns.

Care plans clearly showed staff peoples individual ability to make decisions and the choices they had made. This included different aspects of daily living including personal care, manual handling, use of a lap belt in a wheelchair and bed rails. These were up to date and regularly reviewed. A best interest decision was in place in relation to one person in receipt of covert medication. The care plan, contained information to place crushed tablets in yoghurt. Appropriate professionals had been consulted to make the best decision and one that was safe for the individual. In this case a DoLS had also been submitted to the local authority.

The vast majority of people were supported to have sufficient to eat and drink. One person said, "The food is good – no problems. I choose what I eat. I like meat sandwiches." A different person said, "We have fruit and tea and cakes. I get a choice. It's not vast but we get two choices for lunch or sandwiches. We have a main course at lunchtime but they [the staff] don't make a big deal of it and will give you a main course in the evening if you prefer."

We did an observation in all four dining rooms at lunchtime and three of these were very positive. There were issues with the deployment of staff at lunchtime on Oak unit as a significant number of individuals needed support with eating. There were ten people in the dining room and four in their private rooms. In the dining room six people needed to be supported to eat and others needed prompting which was undertaken by the kitchen assistant.

At least one member of staff was supporting people who needed help in their private rooms. Staff were very caring and supported people appropriately however there was a staffing impact as one person took nearly 45 minutes to eat their lunch. Another person was supported for about 30 minutes. Both individuals were at high risk of aspiration and in specialist chairs. Staff took time to meet these people's needs. This meant that two people in the dining room and one in their bedroom had to wait for almost an hour to be supported. One person had by then fallen asleep and declined. We fed this aspect back at the end of our inspection and the management team were keen to address this and immediately came up with potential solutions.

One person told us, "The food is brilliant. Better than my wife's! It is edible! I have put weight on since being here. I get a choice and get asked what I would like each morning." The meals looked appetising and so did the pureed meals. These were moulded into what they were and looked attractive. For example as carrot or chicken to enable the person to easily recognise what they were about to eat, but ensuring the correct consistency to avoid choking. Diabetic meals were offered as appropriate. Some people were supported with choices with picture menus of the main course. Staff members were patient while explaining the choices. One person who was asked what they would like for lunch became anxious. The staff member noticed this and withdrew which reduced the person's anxiety. Another person did not engage with a staff member supporting them. The staff member approached a different staff member and asked them to try instead. This worked and the person began to eat, but slowly. People were supported in a caring way and the support was well paced to suit the individual with staff paying attention to the person and task at hand. Most people who were supported ate well and we observed some people being offered extras and eating more. We saw there was lots of laughter during the conversations and people were relaxed and enjoyed the mealtime experience.

People told us that hot and cold drinks and snacks were available throughout the day if they wanted them. We observed people being offered regular hot drinks throughout the day. We saw that people had jugs of cold drinks in their bedrooms. While we were speaking to one person, a staff member came in, offered the person a choice of drinks and topped up the juice. Where food and fluid charts were in place these were totalled up each day to ensure the person had sufficient to drink and eat each day.

Care plans examined contained Malnutrition Universal Screening Tools [MUST] scores and people were

weighed regularly to ensure intervention if they were consistently loosing unplanned weight. Where these nutritional assessments had been undertaken and people identified as being at risk they were being weighted as per the plan. Those at high risk were weighed weekly. Referrals had been made to the dieticians when individuals continued to lose weight. In one case staff had spoken to the GP whilst waiting for the outcome of referral to the dietician and had been prescribed fruisbin, a build-up drink.

We examined care plans for people with diabetes and saw that there was a care plan in place which set out signs that staff should look out for. There were specific food including cakes for individuals with diabetes. One person's care plan advised that they required assistance and encouragement to eat and drink. We saw that staff put this into practice at lunch time in the dining room. People were seen as individuals in terms of their eating and drinking and staff knew their needs. Staff had received training in food hygiene. Records showed that 97% of staff had undertaken the food hygiene certificate within the last year. Each unit had a person appointed as a nutrition and hydration champion. Their role was to raise the profile of eating and drinking and the benefits to people's all round health and wellbeing in relation to reducing the number of urine infections and how nutrition can impact on people's health.

People were supported to maintain good health and had access to a range of health professionals. One person told us, "The doctors are good. You are treated with respect."

We saw that staff were given a verbal handover of people's needs at shift change and key information such as if any GP's were due to visit was handed over. Staff took active steps to meet people's health care needs. Records demonstrated that staff called the GP and sought advice appropriately. The documentation was clear and made notes of discussions with the GP and the advice given by GP was also recorded for staff to follow.

In care plans we saw evidence of referral to and input from the Community Mental Health Team in relation to advice on managing a person with anxious behaviour. Other health professionals consulted and advise sought included Tissue Viability Nurse [TVN] and a Neurologist. We tracked a person with a grade 2 pressure sore. The correct equipment was in place – such as an airflow mattress for their bed and a high specification cushion for their chair. The staff report showed regular re-positioning and reduced time in their armchair until the sore had healed. The plan stated that the Referral to TVN would be consulted if the wound did not improve.

People were referred to the physiotherapist where appropriate. One person told us that they used to complete a programme of exercises with the care staff. However the member of staff had since changed roles and then the exercises had not been completed consistently. We looked into this and found staff were aware of this and had plans in place to involve the activity team so these exercises could be provided at a consistent time suitable for the individual concerned.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring and that they were usually cared for by people that they knew. One person who had recently moved into the service told us, "It's perfect here." They went on to tell us that before they moved into the service they had felt, "All out of sorts," and couldn't manage to do the things that they enjoyed such as reading a newspaper. But now they feel settled and know that the staff are available to care for them and they were having a daily newspaper delivered.
Staff were caring and compassionate. They knew the needs of the people they were caring for and their approach was person centred. A staff member was sitting with a person looking through the paper and talking about football teams, results and about dogs.

We saw some lovely interaction between people. Staff spontaneously giving people cuddles and touching them gently as they went past. We observed staff put an arm around an individual to reassure them when they started to cough. We observed staff truly caring for people whilst undertaking a variety of personal care. We saw staff making sure that an individual was warm enough and had a blanket over their knees, gently stroking an individual's arm as they sat beside them, whilst helping someone to drink from a straw, staff ensured this was done at a good pace suitable for the person and finally when trying to wake up a resident for lunch we saw this was undertaken gently by stroking their face and speaking quietly.

We spoke with a nurse and they told us, "I've been around the houses and I know what good care looks like and the people are well looked after by staff here."
We saw that staff were being patient and communicating at each person's pace. One person was anxious and tearful during our visit and rang the call bell numerous times. Staff responded each time promptly and patiently. Staff provided reassurance and spent time sitting with this person talking through how they were feeling. When staff walked past this person's room because they were helping someone else, they told the person that they would return and they did what they said they would do.

Care plans contained information about people's life history this meant that staff knew about people's life story. For example one member of staff told us about a person who had a professional career in music and still enjoyed singing. Later in the day we saw the staff member singing with the person. Staff knew what people liked and disliked at meal times. For example staff knew that one person did not like cold drinks with their meal so made them a hot drink instead.

People had names on the door of their private rooms. Some had memory boxes outside with meaningful objects and photographs. We saw that the peoples rooms were personalised with people's possessions, photos and own furniture.

People were listened to and actively involved in their care and support. One person told us, "Staff ask my permission before helping me and tell me which when to lean when supporting me to move. I am really happy." Another person said, "I think they (the staff) are excellent and brilliant at their job. I couldn't ask for any better. They all do their job 100% plus. They are caring. [Named person] is my keyworker and if there is anything wrong, I will tell her and she will sort it out." Another person told us in detail about how new staff

were introduced to them and trained in meeting their individual needs, "The staff ask me for permission before they help me. An example is that a nurse was showing two new people around. The nurse told them what to do [to care for me] by talking to them and making sure that they thought about how I felt."
One person told us that staff had recently changed how they assisted them out of bed in the morning. They felt that they had not been consulted on the change and they were unhappy with the new technique. When this was discussed with staff we were informed that the persons function had deteriorated and that in order for staff to continue to assist them safely to get out of bed a hoist was now required. They were aware that the person was not happy with the change and had made a referral to the Community Occupational Therapist for further advice. This person's view had been acted upon. One person told us that they liked to get up early in the morning. Care staff were aware of this and made sure that this happened by either the night staff assisting them with personal care or a member of staff started their shift early to accommodate this.

We found many examples of people being listened to and their views acted upon. In Ash unit there was a London theme mural on the wall that was chosen by people in that unit. A person told us, "I go outside and walk and listen to the birds. If I tell staff that I want to go outside, then they help me to do that." A different person said, "The manager [of the unit] tries to talk to me. He comes on the ward and he will go around and say 'Good Morning' or 'Good Afternoon'. He asks if I need anything. I do like him."

We observed the lunchtime experience for people in four different areas of the service. There was choice, control and independence being promoted effectively in three of these areas. There was a systematic approach to serving the meals to ensure that everyone received a meal. The meal time experience in Oak unit could be further enhanced and we have commented in more detail previously in the report.

People were able to choose what they wanted to eat from the menu, if needed staff supported them to make this decision, using picture menus. Staff were showing each person two pictures of food to allow them to make a choice. People were offered a choice of drinks and were able to ask for more if they wanted it. Staff asked people if they wanted to wear clothes protectors. Respecting people's views, when one lady refused a clothing protector. Some people had specialist seating and dining equipment to promote independence. One staff member noted and fed back to other staff that a plate guard used for one person appeared to hinder them rather than support them. We saw that finger food such as pizza and scampi was available so those who could feed themselves were encouraged by food that was easily held. One staff member placed tomato sauce on a persons plate to encourage them to eat with their fingers and dip their food. This worked for this individual.

During the meal time there were numerous examples of positive interactions between staff and people eating their meals. Staff sat next to people who required assistance with their meals, spoke to them about what was on the plate and did not rush them. The dining room was animated and pleasant with people laughing and talking to each other and staff about a variety of topics.

We heard one person say, "Very nice, very very tasty." There was music playing quietly during lunchtime. It was very relaxed and people were not rushed. There was one staff member floating between tables checking if people needed help or wanted anything else. People were talking to each other and staff were engaging in conversation with people. We saw people laughing and enjoying their food. Staff helped two people to eat their meal. The staff member would check after each mouthful if the person was ready for another mouthful. We saw staff encouraging people to eat and drink. The interactions were positive and respectful.

People were consulted on developments. We saw that the thoughts and ideas of people on Ash had been sought in relation to the development of the garden. Ideas such as water features, weathervanes and

butterflies had been recorded. We saw the minutes of a recent relatives meeting held in January 2016. Eleven relatives had attended. They were given information on developments such as keeping people healthy and staff appointments. Management were open about challenges and sought views. People were able to express their view and seek answers. The next meeting was due three months later with minutes kept. Everyone living at the service was given information about an independent advocacy service that they could contact. This formed part of the service user handbook that set out people's rights and information in connection with living at St Marys Court.

People's privacy and dignity was promoted. Across each unit, we saw that there were 'personal care in progress' signs on people's bedrooms doors asking others not to enter. We observed that staff consistently knocked on people's bedroom doors before being invited to enter. We saw that staff were respectful in their interactions with people and were thoughtful in how they worked alongside people. We saw a staff member gently wiping people's mouths to protect their dignity. Staff were assisting a person to eat and moved them so they could look out of the window as they ate and in another case staff were assisting a person to eat a biscuit. Staff were heard to give a commentary so the person knew when it was coming.

People told us that there were no restrictions on when they visited and were made warmly welcomed by staff, including an offer of refreshments. One person told us, "My family visit and the staff support this. My little boy comes to see me once a month and staff make it nice when he comes to visit."

Staff were culturally sensitive. A staff member told us, "We support a Turkish lady and it can be difficult to communicate with her. We use flash cards which has the Turkish word written on the back." When we asked how the staff engage with that person, the staff member told us, "We tell her what we are going to do so that she is aware." A different person was keen to be involved with catering and therefore staff enabled them to remain independent and encouraged them to clear tables after lunch and help out in the kitchen with dishes.

Good

Is the service responsive?

Our findings

People were involved with the planning and review of their care and support. One person told us, "I have a personal care plan." Another person said, "Every four weeks I go through my care plan with my keyworker. I did suggest more board games but everything is good." People told us that staff knew the needs of the people they were supporting.

Care plans were informative and up to date. We saw that they had been updated when people's needs had changed. Records included a lot of information about the individual's life and interests. Care plans listed, 'Things that are important to me' and included details about how to promote a calm atmosphere and respond to individuals distressed behaviours. One plan stated 'make me safe and leave me alone' and 'then return'. Plans also outlined when and why they sometimes needed two staff instead of one. This showed a flexible approach to peoples changing needs.

Staff were kept informed of peoples care and support needs. We sat in on two handovers. Senior staff went through each individual with new staff who were coming on duty. The handover was informative and updated staff on any changes.

Care staff recorded in daily records and maintain a series of charts to monitor care. The senior staff also had a central folder which the seniors used to communicate with each other. This was written in on a daily basis and served as an ongoing review of individuals' conditions and care needs.

We saw a list on an office wall of who was designated for Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] We checked this against a sample of care plans and noted that it was up to date and records appropriately completed. We also saw that staff took this key documentation with them on trips out along with medicine to thicken drink. This showed us that care and support was consistent even when not at the care service.

People were supported to follow interests and offered appropriate stimulation both within the service and the community. There was many opportunities given to people to attend socially stimulating events. One person had been supported to attend a local café to meet a friend for a meal. This was a regular occurrence for this person and was important for them. One person told us, "I am going out for lunch at the garden centre. I like doing that. I went the week before last as well". A different person said, "I am going out on the mini bus this afternoon. I like to help around the house. I played table tennis and pool." People told us that they were informed of what activities were taking place by staff, we also saw that there were weekly activity planners visible on each unit to inform people of op coming events.

The Activities Manager told us, "There are three activities co-ordinators on each floor during the week and two at weekends. One co-ordinator was doing sensory/relaxing sessions and hand massage with people. The co-ordinators move between the floors depending on what people want to do." We were told that there was up to four trips out each week. That afternoon people were going to a garden centre and the evening before several people had gone to the cinema to see the film 'Dads Army'. Also that afternoon we saw that

people from Cedar Unit were supported to listen to an external singer who was playing on Ash.

People told us that there was a wide variety of activities organised, that there was the opportunity to go on trips. People spoke of a recent trip to a local museum and Duxford. A senior carer who told us that one person had one to one support for some time during the week and was using this to access the local gym and had been supported to apply for a gym membership. Staff were taking photos of the activities that this person took part in to add to their care plan.

On Ash, we saw that people were watching an Elvis film in the lounge, one person was having some beauty treatments and one person was at the hairdressers. Whereas in Oak, unit music was playing. The TV was subsequently put on and people given choice as to what they would like to watch. On Oak there were lots to look at including pictures, magazines and cuddly toys. One person was appropriately given a doll to cuddle.

The service listened to people's experiences and concerns and responded appropriately. People told us that they felt able to raise issues with staff and felt listened to. One person said, "If I wasn't happy I would talk to them [the staff] about it. I don't have any serious concerns." We spoke to the manager about how people would know who to complain to if they had a concern. The manager explained that the procedures were displayed for staff in the office and were on display in the public toilet and in reception. The complaints procedure was in the handbooks given to people living at St Marys and on the website. The procedure set out the five different ways people could raise matters and be listened to: Talking to any staff member, asking to speak to a senior staff member, using the comment boxes located around the service, attending one of the regular resident or relatives meetings or contacting the independent whistle blowing line 'safecall'. These varied and different avenues available to people enabled the service to be open to suggestions and ideas for change.

We had been aware of one concern a person at the service had and looked into this on the day of our visit. The service was responding to the concerns raised and had a plan in place and needed to monitor this to see if it was effective in resolving the concerns raised. We saw that this matter had been escalated up to the clinical governance board and was discussed and known about by the provider of the service. This showed us that complaints were taken seriously and discussed transparently to improve the service and learn from matters raised.

Outstanding ☆

Is the service well-led?

Our findings

The service has been working hard to promote a positive culture that is person centre, open and inclusive. We were told about the values of the service of; Kindness, Comfort and Respect.[KCR] These were well publicised throughout the service and were part of most literature we saw. All staff we spoke with were aware of these values and gave many examples of what that meant to them in their role. One member of care staff said, "The aim of St Mary's was the total holistic care of the resident and ensuring that they were not in pain. It is about kindness, consideration and communicating with residents. We spend time in people's rooms frequently so people do not feel isolated as many people are bed bound. We ensure that they are safe and we pay attention to the small things. We don't rush and take our time. I try to ensure peoples comfort like turning the pillow if it is too hot or providing a cool duvet. It is about providing reassurance each and every time." A different member of care staff said, "The management support has improved tremendously in the last year. The values are kindness, comfort and respect. We are like a little family." We found that all staff employed knew and subscribed to the values including housekeeping staff. One of the housekeepers told us, "It is really lovely and nice here. I come from working in hotels but working here allows you to give love and kindness. I am well supported by management. The values are kindness, comfort and respect. When I hold a staff meeting, I ask my team for an example of how they live the values. We have the Kindness, Comfort and Respect [KCR] stars. During the last nominations, three of these were housekeeping staff." Staff were clear about the values of the organisation and how to put them in to action. Morale among staff was good. The KCR stars that staff told us about was an innovative scheme run by the service for staff to be nominated and publically and financially recognised when demonstrating the values of the organisation. Staff appreciated this acknowledgement of their contribution. Even new staff were able to tell us, "The values are kindness, comfort and respect. The values were covered in induction a lot."

Staff told us that they found the management to be approachable and supportive. One member of staff said, "We have come such a long way. Things have trickled down." They spoke about kindness comfort and respect and what that meant to them and then said, "Our owners have a new way of thinking. They are good. We feel fully supported." Another staff member said, "We have updates every three months and think about what is good and what we can improve - what is our responsibility." They went on to say it was now much better and organisation was open to new ideas.

There was evidence that the organisation listened to their staff and encouraged them to come forward with ideas. A staff member showed us the comment box which they said that people could put in comments and they were discussed at the end of the week and then receive an answer. Staff members were able to give examples of how things had changed as a result of suggestions made. The newsletter we saw also showed these suggestions and actions taken. For example a window seat and a padded seat for a bench had been purchased for Oak Unit. There were systems in place to protect staff around whistle blowing and a external number for staff to call and report any concerns they had should they not feel able to speak up in the service. There was also a free employee assist service to support, advise and counsel staff if they needed this external to the service.

People were listened to through a variety of opportunities in place for people. This varied from one to one

meetings such as the keyworker system in operation; resident meetings looking at the developments around the garden and wall art recently installed based upon feedback from people; regular relatives meetings; suggestion boxes placed around the service; the annual resident and relative survey [last completed in May 2015] and the more formal systems such as the comment and complaint procedure. This layered approach in different methods allowed people to be heard. In each case we were able to see that the service listened and made known to people the action they took in response to any matter raised with them.

A relative said there was now, "Greater consistency in staffing," Even when there had been a problem last weekend as an agency staff had not turned up ,they had been able to talk to the manager about this and understood that they had been let down. They felt the manager was approachable and all in all thought the service was "Going in the right way." We followed this up with the manager and found that there was honest communication about the events of the weekend and action that was taken to ensure staffing was safe for everyone.

We had been forwarded the findings of the local authority and clinical commission group following their last visit to check on the service in December 2015. Their finds were all positive and demonstrated that the managers and service had been working with other key professionals on developments for the benefit of people living at the service.

There was good visible leadership at all levels. The provider representative who we have registered as the nominated individual was regularly at the service, approximately three days a week. One nurse told us that they knew who this person was. They said, "I have seen her seven or eight times in the last two months. They are frequently in the service. It makes me feel part of it all." They were at the service on the day of our inspection and told us, "There is now a manager on each floor which was put in place last year. I didn't think the management structure was as effective as needed. I feel the new structure is working well." This showed us that the provider took time to evaluate effectiveness of the management structure and was willing to be flexible and responsive to what they found. People using the service did relate to this layer of managers who were in charge of each unit and told us so. One person using the service said they appreciated that managers were visible and told us, "The manager has come to see me in the past – he has just had a couple of weeks off. He is all good."

Between the nominated individual and these unit manager was the registered manager. Staff described the registered manager as excellent. One person said, "She is really approachable, encouraging and I feel wanted as part of the team. We have good team work". The registered manager described her management style to us as, "All cogs in a wheel. We are not top down. We want to listen". The manager was able to show us a structural chart of who was in which position within the organisational structure. This clearly showed levels of responsibility in terms of line management. The registered manager related well to CQC and gave us all information we required including statutory notifications in a prompt and timely manner.

There were systems in place to monitor the service at all levels and feed up to the clinical governance board so that the provider was truly aware of the events and day to day happenings at the service. Seniors collected information which feeds into a report presented monthly by the registered manager to the board. We saw information collected by seniors such as falls, infections, weight monitoring and any pressure sores. These are all key indicators of health and wellbeing in older people. The manager collated these findings along with information on complaints, safeguarding's and staffing matters and presented as a report at the monthly clinical governance board meeting. We attended part of this meeting as it coincided with our visit and found that this was chaired by an independent person who reported their findings to the board. As part of reporting to the provider this independent chair also received reports from Human Resources [HR] on all

staffing matters including levels of supervision given to all staff but importantly took time to speak with people who used the service, interviewed relatives, staff and walked around the premises. Therefore they truly could evaluate and understand on behalf of the provider [from floor to board] the service that was being delivered and experienced by people.

One aspect that the registered manager demonstrated impressive development with was the development within the staff group and striving to ensure that the correct numbers of suitable staff were in place. We saw that there were robust recruitment processes in place, including the testing of values and decision making as part of the recruitment process to understand peoples motivation for employment in this care home. There was an overall recruitment tracker accessible to appropriate levels of staff within the organisation so managers could see at a glance the progress of staff recruitment in the pipeline. Information such as staff lists of employment where readily available and this listed hours worked and usual unit of work. This was able to be monitored for sickness, leave and vacancies. This then linked to the staffing tool [that calculated the numbers and dependency of people at the service] was kept under regular review. We saw the training tracker system that was colour coded for ease of use that showed what skills and updates were required. All these well maintained systems enabled the manager to marked knowledge about her staff group to ensure they were 'fit for purpose'. The bonus of this close monitoring showed a reduction in use of agency staff for the benefit of people at the service.

A positive initiative to further develop the staff group the service had locally enrolled five staff members on Prosper training. This was with Essex County Council and the Health Foundation, who were developing ways to reduce the number of emergency hospital admissions as a result of falls, pressure ulcers and Catheter & urine infections. Champions within the service in each of these areas were being developed to benefit the health and wellbeing of people at the service.

The provider had also brought in another layer of quality assurance with consultation from a professional with experience and knowledge of regulating registered services through a consultant. They had listened and acted upon the advice given to drive improvement of the service. A key action was to prepare for a CQC inspection and be able to present information quickly and appropriately for the inspection team. This was well executed on the day of our visit.

As well as systems in place to monitor and improve care and support to people at the service there was a drive for improvement through innovation and seeking out new opportunities. The service is known and has good links within the local community. We saw that the service is looking at additional ways of working with local school children and children of people at the service living with dementia. There were plans to raise awareness and provide child friendly training on dementia awareness.

The provider felt they had improved and sustained development and wanted the service and staff recognised and therefore had entered a number of schemes and award ceremonies to evaluate their care services against others both locally and nationally. This had proved to be fruitful as they had received positive feedback. They were nominated for national finalists for Management and Leadership at Skills for Care Accolades. They were nominated national finalist at The National Care Awards care leader Award and were asked to facilitate a workshop on the change in culture and values at the National Conference for Skills for Care. In addition they made the East of England Finalist for great British Care Awards Care Training Award.