Barton Place Limited

Barton Place Nursing & Residential Home

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

This inspection took place on 20 October 2017 and was unannounced. At the previous inspection of the home on 19, 23 and 27 September 2016 we found one breach of Regulation 11; Need for consent and we rated the service as Requires Improvement overall. At this inspection we found improvements had been made and the service was fully compliant. We found people were receiving a good service.

Barton Place Nursing and Residential Home is registered to provide accommodation for up to 42 people who require nursing and personal care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection there were a total of 34 people living there.

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

People told us they felt safe. A relative told us they would not hesitate to report any concerns to the registered manager or deputy manager and said "I feel confident with them". The service protected people from the risk of abuse through appropriate policies, procedures and staff training. All staff had received training and updates on how to recognise and report any suspicions of abuse. Checks and references had been taken up before staff began working at the home. The provider told us new staff were not confirmed in post until they had checked the records to ensure all required evidence was in place and they were satisfied the applicants were entirely suitable.

People and relatives told us there were enough staff employed to meet people's needs safely. Staff rotas showed there were sufficient staff on duty at all times of the day and night. In the last year the number of permanently employed staff had increased, and the number of agency staff had reduced. This meant people were receiving a more consistent service from staff who knew them well and understood their needs.

Risks to people's health and safety had been assessed and regularly reviewed. The home used an electronic care planning system that showed risk assessments had been carried out on all potential areas of risk, for example nutrition, hydration, moving and handling, choking, falls and continence. Staff had a very good understanding of each person's needs and provided care that took account of individual needs and wishes. Staff were able to describe each person's interests, personality, likes and dislikes. They understood people's daily routines and we saw the care plans reflected the care people received throughout the day, which was in line with their care plan.

Medicines were stored and administered safely. People living in the home and their relatives told us they were confident their medicines were looked after and administered safely. Staff were well trained and

followed safe procedures when administering medicines. Records of prescribed tablets and liquid medicines were signed for each time they were administered. Medicines were regularly audited to ensure safe procedures were followed.

The home was well maintained, clean and hygienic. Comments from people living in the home and relatives included, "Fantastic. His room is spotless. They didn't know we were coming in today", "Cleanliness seems to be very good. Its clean here, they seem proactive with hygiene." Equipment such as gas, electrical equipment, hoists, life and fire safety equipment were regularly checked and serviced.

The provider and registered manager had taken actions to ensure people's legal rights were protected. Where people lacked the capacity to make important decisions about their lives mental capacity assessments had been completed. The provider told us in their Provider Information return (PIR) "Staff receive training in managing violence, aggression and dignified breakaway. Staff have training and an understanding of the Mental Capacity Act 2005, deprivation and liberty is included in their training and the use of restraint."

People received care from staff who understood their needs and communicated well with them. Staff had the skills, experience and knowledge to meet people's needs effectively. Training records showed that staff had received a range of training, regular updates, and qualifications to provide them with the knowledge and skills to meet people's needs. Staff were supervised regularly and well supported.

People's nutritional and hydration needs were met, and care was taken to ensure all special dietary needs were catered for. People and relatives told us they were happy with the quality and range of foods offered. Comments included, "I had a lovely dinner, breakfast. Lots of drinks", "I've got allergies to some things such as strawberries and different things. Home know that" and "Very good. [Person's name] can't feed himself, they're doing it fine. The thing is not to hurry him. He's eating well".

People continued to receive care from staff who were kind, respectful and understanding. Staff were attentive, and chatted to each person frequently throughout the day. Comments from people living in the home and their relatives included, "They are always talking to him", and "Yes they come here and sit and talk to her when they have tea breaks." Staff respected each person as an individual and understood their diverse backgrounds and needs. Staff treated people as unique individuals with their own personality and interests. People could be confident they would receive compassionate care at the end of their lives that had been planned and agreed with them.

Each person's social needs had been assessed and agreed with them. Staff understood the things people enjoyed doing, their past lives, employment and achievements. Two activities organisers were employed on a full time basis providing people with a wide range of group or individual activities throughout the week. There were also visits to the home from a range of professionals such as musical entertainers, music therapists, and dance therapists.

People and their families could be confident any complaints would be listened to, taken seriously and actions taken to prevent similar problems happening again. Complaints procedures were displayed prominently around the home. People's views and comments on the home were sought, listened to and addressed.

The home was well managed. The provider has systems in place to monitor the quality of the service and make continuous improvements. Staff told us they felt well supported by the registered manager and deputy manager. Staff had developed links and close working relationships with external health and social

care professionals, including the local mental health team and community nurses. People were encouraged to maintain close links with the local community.

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.

People had been protected from the risk of harm or abuse by the home's recruitment procedures.

Medicines were administered safely and stored securely.

People were supported by sufficient numbers of staff to safely meet their needs.

Risks of abuse to people were minimised because staff knew how to recognise and report abuse.

People lived in a home that was clean, free from any odours, safe and well maintained.

Is the service effective?

Good

The service was effective.

People received care and support from staff who had the skills and knowledge to meet their needs.

People's legal rights were protected because their capacity to make informed decisions about their care and treatment had been assessed in accordance with the Mental Capacity Act 2005.

People had access to healthcare professionals according to their specific needs.

Food was served in accordance with people's dietary needs and preferences.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and caring, and who knew each person well. .

Staff respected people's privacy and dignity.

People received compassionate care at the end of their lives that was in line with their wishes.

Is the service responsive?

Good

The service was responsive.

People received personalised care that had been planned and reviewed with them and/or their relatives and representatives.

People's wellbeing benefited positively as they were offered a wide range of activities either individually or in small groups.

People and/or their relatives knew how to make a complaint and could be confident their complaint would be listened to and acted upon.

Is the service well-led?

Good

The service was well led.

There were effective quality assurance systems in place to make sure any areas for improvement were identified and addressed.

There were clear lines of accountability and responsibility within the management team.

The management team were visible and accessible and ensured the service was monitored make sure it met people's individual needs effectively.

Barton Place Nursing & Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 and 20 October 2017. The first day of the inspection was unannounced.

The first day of the inspection was carried out by one inspector, one special advisor with expertise in nursing care, and one 'Expert by Experience'. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in caring for an older family member who uses care services.

Before the inspection we looked at the information we had received about the service since the last inspection. This included notifications we received from the service about deaths and any significant incidents or accidents. Before this inspection the provider submitted a Provider Information Return (PIR). This is a document that gives a range of information about the service and how it is managed.

Many of the people living at Barton Place had dementia or illnesses that limited their ability to communicate and tell us about their experience of living there. Therefore we observed how staff interacted and looked after people and we looked around the premises. We spoke with the registered manager, deputy manager, two providers, the chef, and three members of the staff team. We spoke with two people living in the home, ten relatives and we looked at six care plans and tracked the care given to four people in depth. We observed medicines being given to people during a midday medicines round and also looked at the storage and recording of medicines. We looked a range of records including staff recruitment , staff rotas, staff training and supervision records, menus, activities records, and records relating to the maintenance and management of the service.

Good

Is the service safe?

Our findings

At the last inspection of the service in September 2016 we rated this domain as 'requires improvement' because robust recruitment processes had not always been followed before new staff began working in the home. At this inspection we found recruitment procedures had improved and checks and references had been carried out on all new staff. The provider told us new staff were not confirmed in post until they had checked the records to ensure all required evidence was in place and they were satisfied the applicants were entirely suitable.

The service protected people from the risk of abuse through appropriate policies, procedures and staff training. All staff had received training and updates on how to recognise and report any suspicions of abuse. Where concerns had been raised with the management team these had been taken seriously, and appropriate actions taken. The registered manager had liaised with the local safeguarding team and followed advice to ensure any concerns were investigated fully and actions taken where necessary.

People and relatives told us there were enough staff employed to meet people's needs safely. Staff rotas showed there were sufficient staff on duty at all times of the day and night. In the last year the number of permanently employed staff had increased, and the number of agency staff had reduced. This meant people were receiving a more consistent service from staff who knew them well and understood their needs. One person told us, "I think they do their best. There's always a couple or more I can call upon". We asked one relative if they thought there were sufficient staff employed and they said, 'I think so, there is always someone in the lounge. He's always clean. I've got no query with the staff at all. They are very, very good." Another relative told us, "The carers are very good, usually there's a nurse in charge. They work in two's all the time".

A relative told us, "There was a time (before the last inspection) when I wasn't very happy. Shortage of staff. I knew things weren't right. Since [registered manager's name] is back it's a blessing. Things are alright now", They went on to say, "The seniors get together and work out who is going to be with [person's name] today".

Call bells were answered promptly during our inspection. A relative told us, "They are fairly prompt with answering the bell and treating [person's name]". The registered manager told us they were planning to improve the call bell system by linking it to the computers in the near future. This will enable the management team to have better oversight of response times and will be an additional tool to help them monitor care and to ensure staffing levels are sufficient to meet people's needs.

People told us they felt safe. A relative told us they would not hesitate to report any concerns to the registered manager or deputy manager and said "I feel confident with them". All staff had received training and updates on safeguarding procedures at the start of their employment. This ensured they knew how to protect people from the risks of abuse, and knew how to speak out and report any concerns. The home did not hold any money on behalf of people and instead relatives or people who held responsibility for dealing with people's finances were billed for any items or services (such as hairdressing or toiletries) purchased on

their behalf. When people moved into the home all jewellery and items that may be easily lost, for example glasses, were photographed to help staff locate them and return them to their correct owner.

Risks to people's health and safety had been assessed and regularly reviewed. The home used an electronic care planning system that showed risk assessments had been carried out on all potential areas of risk, for example nutrition, hydration, moving and handling, choking, falls and continence. The plans explained the actions staff must follow to reduce the risks where possible. Allergies were documented in the care plan, medicines administration records (MAR) and all food allergies were also clearly recorded on a wipe board in the kitchen. Risks associated with diabetes were clearly recorded and we saw evidence of staff supporting people to manage their diabetes to remain safe.

Staff knew those people who were at risk of falls. Falls were monitored closely and actions were taken to reduce the risk of falls where possible. Staff were vigilant and observant. During our inspection a person who was able to move independently without assistance got up from the dining table to leave the room, stumbled and then fell. Four staff attended the person immediately, checked the person carefully, and provided support, reassurance and treatment immediately.

Where people were at risk of developing pressure sores, assessments had been completed and care plans explained the actions staff must take. Equipment such as pressure relieving mattresses and cushions were in place. All but one of the airflow mattresses we checked were at the right setting for the person's weight. However, one mattress was incorrectly set. The registered manager and carer were aware of problems with the knob regulating the settings on the motor of the airflow mattresses, and staff knew the correct setting. We were assured all mattress settings were checked daily. A relative told us, "He's restless in bed. They turn him three times a night preventing him having sores". Another relative said, "She's been nursed in bed since September 2013 and hasn't had any problem with bed sores. She has a special bed in place".

Where people were at risk of problems relating to feeding, nutrition and hydration, the risks had been assessed, and advice from specialist health professionals had been obtained and followed where necessary. For example, where people were at risk of choking, advice from the Speech and Language Therapy team (SALT) had been obtained and staff had access to the advice and knew how to keep people safe. During our inspection a member of staff noticed a person showed signs of choking on their food. The staff immediately took action to seek advice from the SALT team, and ensured the person received a softened diet and was carefully monitored in the meantime. The care plans included an eating and drinking checklist to help staff identify the risk of choking. Where people received their food through a tube into their stomach (known as percutaneous endoscopic gastrostomy or PEG) the care plans contained clear instructions and evidence of advice received from a dietitian.

Where people sometimes became agitated or displayed anger, risk assessments had been carried out and plans were in place explaining how staff should support them. The plans explained how to avoid situations where the person may become upset, to recognise signs of agitation, and how to divert the person's attention by offering an activity they enjoyed. For example, the plans contained suggestions for topics the person enjoyed talking about. Staff gave examples of how they offered some people 'rummage boxes' when they showed signs of agitation and how people had enjoyed looking through the boxes and using the contents, for example wooden jig saws, packs of cards, model trains and tactile items. During our inspection we saw people using the boxes and they were smiling and relaxed. A relative told us their loved one had become much happier and calmer since moving into the home. The person had previously displayed behaviours such as aggression and continence issues, but this was no longer a problem because staff at Barton Place knew how to support the person. The relative told us, "Staff say he's a lovely man, that goes a long way for me".

People living in the home and their relatives told us they were confident that all medicines were stored and administered safely. Comments included, "Marvellous", "Yes, I'm sure that's done very well", "I would think so yes. Staff here are very competent" and "Yes, I know when she's having morphine they have two staff to sign for it. They look after her medication very well".

Medicines were stored in a large, well lit room which was kept locked when not in use. There were safe systems in place to ensure keys to the room, trolleys and cupboards were held safely. Medicines that required refrigeration were stored securely and temperatures of the refrigerator were monitored daily. Medicines that required additional security were stored safely, and recorded accurately.

The home used a monitored dosage system supplied by the pharmacy. Amounts of medicines received into the home were recorded, and any medicines held at the end of each four week period were checked and the amounts carried forward. This showed there were systems in place to monitor the medicines administered and check the stocks were correct and tallied with the amounts administered. Creams, lotions and liquids such as eye drops were dated when opened.

Staff followed safe procedures when administering medicines. Records of prescribed tablets and liquid medicines were signed for each time they were administered. Staff had been given information on all medicines prescribed on an 'as required' basis to ensure people only received these medicines when they were needed.

Where we noted some minor issues during our inspection the registered manager took prompt actions to address the problems. For example, medications for one person had not been signed for on one day. We brought this to the registered manager's attention and by the second day they assured us they had addressed the matter with the member of staff responsible who would not be allowed to administer medicines again until they had received retraining and their competence checked. We were satisfied the staff administering the medicines at the time of this inspection had a good understanding of each person's medicines, and the registered manager assured us they would take prompt action to ensure all MAR records were correct.

Care plans explained the creams and lotions each person had been prescribed, how and when these should be applied. However, this was not always evident from the daily records completed by staff. There were no people suffering from pressure sores at the time of this inspection, and this indicated the prescriber's instructions had been followed. After the inspection the registered manager told us they had reminded staff of the correct recording procedure for all prescribed creams. They had carried out regular checks and found the records were much improved. They also planned to provide further training for staff to ensure they were competent with the recording systems.

The home was well maintained, clean and hygienic. Comments from people living in the home and relatives included, "Fantastic. His room is spotless. They didn't know we were coming in today", "Cleanliness seems to be very good. Its clean here, they seem proactive with hygiene. They encourage visitors to use the hand gel and asked me to use it" and "The cleaner gets on her hands and knees to do the cleaning, she does everything very well". There was a clean smell around the home. Where we noted a few bedrooms with low odours we were assured of the reasons for this and we saw that staff had carried out regular and thorough cleaning, airing and de-odourising to keep the odours to a minimum. New floorings had been provided in areas where odours had previously been difficult to overcome. Supplies of disposable aprons and gloves were available around the home and we saw staff using these where appropriate.

The laundry room was modern, well equipped, bright, clean and spacious. There were safe systems in place

for dealing with soiled laundry. Care was taken to ensure personal items were returned to the correct owner, clean and in good order. Bedding and towels were checked carefully to ensure they were free from stains and of a good standard, and ironed if necessary.

Equipment such as gas, electrical equipment, hoists, life and fire safety equipment were regularly checked and serviced. At the last inspection carried out by the local environmental health department the kitchen safety standard was rated as 'requires improvement'. The registered manager told us that records had not been properly maintained, but these were now in order and they were awaiting a further inspection to confirm satisfactory standards were now in place. Staff had access to information on each person's individual support needs in the case of an emergency such as fire (this information is known as personal emergency evacuation plans, or PEEPs). All doors were locked to the stairs to promote safety to residents, and could be opened using either an electronic key fob or a switch linked to the fire alarms to ensure safe exit in case of a fire.

Good

Is the service effective?

Our findings

At the last inspection of the service in September 2016 we rated this domain as 'requires improvement' because people's capacity to make informed decisions about their care and treatment had not been fully assessed in accordance with the Mental Capacity Act 2005 (MCA). At this inspection we found mental capacity assessments had been completed for those people who were not able to make informed decisions for themselves. The provider told us in their Provider Information return (PIR) "Staff receive training in managing violence, aggression and dignified breakaway. Staff have training and an understanding of the Mental Capacity Act 2005, deprivation and liberty is included in their training and the use of restraint." They also told us they planned to provide further training for staff in MCA in the near future.

On the first day of our inspection we noted that photographs had been taken of an area of one person's body which was affected by a skin condition. The photographs had been shared with the tissue viability service in order to seek their advice on the best possible treatment for the skin condition. We discussed this with the registered manager and deputy manager. We were assured that the photographs had been taken in the person's best interest and ensured the person received the best possible treatment. However, we noted that there was no evidence that the person or their representatives had been consulted or their consent gained. By the second day of our inspection we saw that actions had been taken to seek and record people's consent where needed, for example where photographs were taken.

The 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. During the inspection we saw staff offered people choices and sought their agreement when offering any care or activities. The care plans provided information on each person's mental capacity in sufficient detail to ensure staff understood where people could make decisions for themselves. The deputy manager told us they had good links with the local mental health team and if they had any queries about a person's mental capacity they would not hesitate to seek advice.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had liaised with appropriate professionals and made DoLS applications for people who required this level of support to keep them safe. Where relatives or representatives held legal responsibility for decisions about a person's health or finances we saw evidence of the power of attorney agreement in their care files.

People received care from staff who understood their needs and communicated well with them. At the last inspection we found some staff who had been recruited from other countries did not always have good English language skills and were not always able to communicate effectively with people. At this inspection we found staff were able to communicate well with people. Where people were unable to communicate

verbally due to their health, staff looked for non-verbal responses and body language to ensure the person understood what they were saying. Staff also knew how to look for non-verbal signs of pain or distress, and the actions to take, for example by offering pain relief medicine.

People received care from staff who had the skills, experience and knowledge to meet their needs effectively. New staff received induction training at the beginning of their employment. Training records showed that staff had received a range of training and regular updates on topics such as health and safety, infection control, dementia, dignity and respect, diet, fire safety and tissue viability. Staff were expected to complete the Care Certificate (a nationally recognised training course for staff new to care) as part of their induction and training. Staff were also supported to complete further qualifications such as diplomas. At the time of this inspection there were 46 staff employed. 19 staff held a relevant formal qualification and they planned to encourage more staff to achieve a qualification in the near future. There were systems in place to make sure staff did not miss any required training updates. People and relatives we spoke with told us they felt the staff were well trained. A relative gave us an example of how staff used distraction techniques to change a person's negative behaviour. They told us, "They are very good". Other comments included, "I think so, they are careful", "With new staff they now get appropriate training with senior staff" and "Yes, I'd say they do (get appropriate training). Senior carers and nurses are very, very nice".

Staff records showed staff had received supervision in a variety of ways including 'ad hoc' supervisions when issues arose, and also group supervisions. The registered manager told us they aimed to provide supervisions to every member of staff on average every two months.

People and their relatives were confident health needs were met by knowledgeable and competent staff. Advice and treatment from health and social care professionals had been sought promptly and appropriately when necessary. Care plans were well documented and contained evidence of appointments and visits from health professionals. Any advice received or change of treatment had been recorded. Care records also contained evidence of discharge letters from hospitals, and records of any future appointment or further monitoring needed, for example blood tests. Where people received their food through a tube into their stomach (PEG) the staff had a good understanding of the person's feeding regime and care of the tube. They had communicated well with the specialist gastro nurse. Comments from people and relatives we spoke with included, "He's had the chiropodist, they come here", "The doctor does know, they've been liaising with the doctor regarding his (illness) and he's had his flu jab", and "They get regular instruction for PEG. Dieticians come, doctor comes. They keep up to date with medication changes if necessary'.

At the last inspection we found some care plans did not contain instructions to staff on oral care needs. At this inspection we found the care plans included a section on oral care needs which gave clear and concise instructions to staff on the assistance the person needed with their teeth and oral care needs.

The needs of people living with dementia had been considered in the decoration and design of the home. Bathroom and toilet doors, including en-suite rooms, had been painted an attractive green colour to help people see them easily, with large signs on the doors. In some areas hand rails had been painted red to help people recognise and use them. Recordings of natural sounds such as bird song were played quietly in the background in some areas. The registered manager told us they had found this helped to calm some people. We noted the signs on bedroom doors were small and people may not be able to recognise their own bedrooms easily. The registered manager told us they hoped to look at more ways of making the environment 'dementia friendly'. There were plans in place to make further improvements in the next year to further help orientate people and enable them to find their own bedrooms more easily. They told us they were a member of the Exeter Dementia Action Alliance which was a source of good practice advice.

People's nutritional and hydration needs were met, and care was taken to ensure all special dietary needs were catered for. Each person was weighed regularly to ensure they were receiving a diet that met their needs. The care planning system included graphs of people's weigh which provided a useful visual tool to help staff recognise any changes in people's weights and seek medical guidance where necessary. We saw evidence of communication with doctors when staff noted any concerns in weight loss and fortified foods and drinks were introduced.

The chef had information on each person's individual dietary needs, likes and dislikes. Staff told them promptly of any changes to their dietary needs, or if a person had lost weight. They used high calorie food such as cream and milk shakes to increase people's calorie intake where necessary. Staff had access to the kitchen at all times of the day and could offer people a cooked meal, snacks and drinks at any time day or night. People were able to choose from a wide range of alternatives.

Staff encouraged people to eat independently wherever possible. Where people experienced difficulty using knives and forks they were offered foods they could pick up with their fingers. This included fish and chips, fried bread and bacon. People were offered snacks such as sandwiches, cakes, biscuits and sliced fruit. During warmer weather people were offered ice creams and ice lollies to cool them down, which also helped some people maintain a healthy weight.

During our inspection we saw people were encouraged to eat their meals the dining rooms if they wished and were able. The dining tables were attractively laid and there was a friendly and welcoming atmosphere. Staff were attentive and showed a good understanding of each person's needs and preferences. If people needed assistance they received individual attention from staff. Staff were patient, observant, and offered gentle encouragement. There were explanations given of what was happening and what staff were doing. For example, a member of staff chatted with a person while they offered food on a teaspoon, asking "Is that nice?" and "Are you enjoying that?" Another member of staff was encouraging and kind, saying "A little more?", "Do you like it? And "Hold my hand, I'll help you". We saw people were enjoying their meals and ate well. People were offered a range of hot or cold drinks regularly throughout the day. Drinks were available at all times in lounge areas and bedrooms.

People and relatives told us they were happy with the quality and range of foods offered. Comments included, "I had a lovely dinner, breakfast. Lots of drinks", "I've got allergies to some things such as strawberries and different things. Home know that" and "Very good. [Person's name] can't feed himself, they're doing it fine. The thing is not to hurry him. He's eating well".

Good

Is the service caring?

Our findings

People continued to receive care from staff who were kind, respectful and understanding. There was a calm, relaxed atmosphere around the home and staff demonstrated a caring manner at all times. Staff were attentive, and chatted to each person frequently throughout the day. Comments from people living in the home and their relatives included, "They are always talking to him", "He gets agitated on his feet, they move him the way he finds it easiest" and "Yes they come here and sit and talk to her when they have tea breaks. [Member of staff] reads to her, family stuff and does her finger nails. Nurses sit and chat to her. They always make sure she is ok".

The provider told us in their PIR, "Staff are trained to understand dignity and respect, we observe that they are putting their learning into practice." During our inspection we observed staff were observant, attentive, and constantly checked that each person was happy and comfortable. Staff respected people's dignity at all times, and had a good understanding of each person's individual needs and preferences.

Staff respected each person as an individual and understood their diverse backgrounds and needs. Staff treated people as unique individuals with their own personality and interests. Staff knew how to communicate with people and encourage meaningful conversations. For example, a member of staff noticed we were speaking with a person with communication difficulties. The member of staff went to the person's room and returned with pictures of the person's family to enable them to have a meaningful conversation with us about them. We also saw a person was singing and a member of staff prompted them to talk about their musical expertise and artistic talents. They also pointing to a picture on the wall the person had painted, and this enabled the person to engage in meaningful conversation. Rooms had been personalised by families with photographs and personal belonging to help people feel settled and comfortable.

The provider gave us some examples of how their staff understood individual needs. They told us, "One of our residents always becomes agitated in the afternoon, staff know her well and will take her for a walk as a distraction". During our inspection we saw photographs and heard evidence of staff escorting a number of people for walks in the local area. Staff understood how people's health needs fluctuated at different times of the day, and the times they may become agitated. One person enjoyed activities such as stacking chairs, and we heard how staff supported the person to do the activities they enjoyed, while at the same time monitoring them to keep them and others safe.

Relatives, friends and visitors were encouraged, welcomed and involved. Family meetings were held and relatives were invited and encouraged to be involved in planning and reviewing people's care. A relative told us a senior member of staff "made herself known to me as soon as I came in, another member of staff took me to her. Staff knew the name of my Nan and bent down to interact with her".

Staff respected people's privacy and dignity. People living in the home and their relatives told us, "They cover you up" and "They did say 'do you mind if a female carer bathe him or a male?' I said it didn't matter as long as he's clean and tidy. It's very nice they keep him good". Staff had taken care to ensure people were

neatly dressed, hair attractively styled and men had been shaved. Staff knew how people liked to be dressed and ensured their wishes were followed.

People could be confident they would receive compassionate care at the end of their lives that had been planned and agreed with them. An end of life care plan was in place for each person. Staff sought input, treatment and guidance from external professionals where needed, for example community nurses who supported the nurses in the home to set up and monitor syringe pumps to ensure people received effective pain relief at the end of their lives. People and their relatives told us, "Yes (they have discussed end of life plans with me). ", "Yes and I've talked to the family. When the final stages come we want them to keep him here" and "Yes, do not resuscitate either of us. We've talked before and have arranged our funerals they know this".

Before our inspection a relative contacted us to raise a concern about contact from the home following a person's death. During this inspection the registered manager told us they had taken immediate action to improve their end of life procedures. They had ensured that contact details for all relatives and friends who were important to the person were clearly recorded and kept updated. They also reviewed their policy on death and dying to ensure staff understood the procedures to be followed following a death.

Good

Is the service responsive?

Our findings

People continued to receive a service that was responsive to any changes in their needs. People we spoke with and relatives told us their needs were assessed before they moved in, and they were involved and updated in regular reviews. A relative told us, "Yes, they keep me very well informed. Weight and treatment, they are very good at that". Another relative told us, "I don't think she'd find much better".

Staff had a very good understanding of each person's needs and provided care that took account of individual needs and wishes. Staff were able to describe each person's interests, personality, likes and dislikes. They understood people's daily routines and we saw the care plans reflected the care people received throughout the day, which was in line with their care plan. There was an electronic care planning system in place which gave staff information on all aspects of each person's health, personal care and social needs. Staff had access to each care plan at all times through the use of hand held devices, and they were able to update daily notes throughout the day using these devices. Care plans and risk assessments were regularly updated. A relative told us they had received "Updates last month. If there are any changes they tell me what they intend to do". Staff had responded to a relative's requests by providing access to documents so that they could check how often the person received care, for example repositioning.

Where people displayed anxiety or agitation that may place themselves or others at risk, staff had a clear understanding of how to support them to remain calm and happy. Staff had developed good communication and trust with each person. Where people wanted to go out on their own, risk assessments had been carried out, and agreements reached to ensure they remained safe. This included putting in place arrangements to ensure people received essential medications when needed. Where people displayed behaviours that may upset other living in the home, staff had looked for possible causes and put in place measures to divert or distract behaviours, and also to keep others safe. Staff were respectful of people's privacy and dignity and explained how they ensured people's wishes were upheld. Staff displayed understanding and compassion where people displayed behaviours such as aggression that may cause offence. This had enabled people to feel more settled living in the home.

Where people had at times entered other people's bedrooms, causing distress to the occupant of the room they had entered by mistake, staff had taken actions to reduce the likelihood of this happening again. A relative told us the person in the room next to their loved one "has a habit of coming in. He can be quite belligerent. It's the only thing I've been unhappy about". They told us they had spoken with the staff about this. We asked the registered manager about the actions they had taken to address the problem. They told us they had made sure a door in the corridor between the two rooms was kept closed, and they had found this had improved the situation. They also told us people were able to lock their bedroom doors when they were in their rooms if they wished, and this was also a way of preventing other people entering their rooms by mistake. They also planned to improve the signage in the home to help people living with dementia locate their rooms more easily.

Each person's social needs had been assessed and a goal plan had been drawn up and agreed with them. People were given the support they needed to enable them to lead active and fulfilling lives and achieve

their agreed goals. Staff understood the things people enjoyed doing, their past lives, employment and achievements. They understood the activities that may calm people, and divert their behaviours. For example, where people at times displayed agitation that may lead to aggression they offered an activity such as dancing, singing, or helping with daily routines such as sweeping or cleaning shoes that they knew the person enjoyed. During our inspection we saw people enjoying 'rummage boxes' containing items that kept them busy such as puzzles.

Two activities organiser were employed on a full time basis providing people with a wide range of group or individual activities throughout the week. There were also visits to the home from a range of professionals such as musical entertainers, music therapists, and dance therapists. During our inspection there was a lively, happy and stimulating atmosphere throughout the home. We saw people engaged in group exercise activities such as balloon play and dance therapy. We also saw staff sitting and talking with people. Pets visited the home on a regular basis including a tortoise, and we saw photographs of people enjoying interaction with the animals. Where people remained in their rooms, staff spent time with them to ensure they did not feel isolated. A relative told us, "They will come to talk to her, read to her and do her nails".

Where people's care plans detailed people's interests and hobbies, we saw photographs and records showing how staff had supported people to regularly participate in these activities. For example one person's care plan said they loved walking and gardening and we saw photographs of them going for a walk, and they were smiling and happy. Where people were interested in hobbies such as gardening, the staff had encouraged and supported them to continue their hobbies, for example there was a group called the 'garden gang'. There were baking sessions, shopping trips, and art groups. People were supported to attend religious services and events, local clubs and groups. There were posters displayed around the home letting people and visitors know the activities planned. People were also supported to sit outside in the garden during warmer weather, or to go for walks in the surrounding area. The gardens were attractive with easy access, sitting areas and raised beds. People and relatives expressed satisfaction with the activities provided. Comments included, "Always on the board. They took him to the Memory Club last week", "He joins in as far as I know, singing, old time music going on. He likes all that'.

People and their families could be confident any complaints would be listened to, taken seriously and actions taken to prevent similar problems happening again. Complaints procedures were displayed prominently around the home. Comments from people and relatives included, "I have no complaints. If I see him untidy I would tell them" and "No complaints. I'd go to [registered manager]. The staff are extremely welcoming to me". Where people and relatives had complained to the home, or to CQC, we saw their complaints had been taken seriously, investigated and acted upon. A relative told us they had recently raised a complaint and they were completely satisfied with the response and actions taken. They went on to say "I changed my view due to the improvements". They were aware of the complaints procedure and showed us where it was displayed in the person's bedroom.

Good

Is the service well-led?

Our findings

At our last inspection of the home in September 2016 we found the service was not fully well-led. The provider had failed to ensure their governance of the home was robust and identified problems and issues promptly. At this inspection we found the provider had taken action to improve their governance and oversight of the home. They had made a number of changes and had plans in place to make further improvements in the future.

At the last inspection the home had experienced a high staff turnover and to fill vacancies they had recruited some staff from overseas. A small number of staff had a very limited understanding of English and were unable to communicate with people effectively. At this inspection we found that permanent new staff had been appointed to vacant posts and the use of agency staff had reduced. All staff present on the day of the inspection had a good understanding of English and were able to communicate well with people.

A new deputy manager who held a Registered Mental Nurse (RMN) qualification had been recruited a few months before this inspection and they told us they worked well with the registered manager to provide clear lines of accountability and support for the staff. They described how the nursing qualifications and experience of the manager, deputy manager and qualified nurse team ensured people received care from a staff team with a wide range of knowledge and experience.

Staff told us they felt well supported by the registered manager and deputy manager. For example, a registered nurse told us they felt safe to practice as a nurse in the home. They told us the manager was supportive, approachable and listened to staff. We heard there were good working relationships among the staff team. Another member of staff told us "We are all here for the best of each resident." Experienced staff encouraged and reminded new staff to uphold values of respect and caring at all times. Training needs were planned, regular updates provided, and staff were prompted to ensure their learning was embedded in practice.

Staff had developed links and close working relationships with external health and social care professionals, including the local mental health team and community nurses. People were encouraged to maintain close links with the local community.

The provider told us in their PIR "Our induction training reflects our values such as safety, respect, equality, honesty, compassion & dignity, new care staff shadow more experiences carers and must be signed off by the manager and carer before undertaking care duties alone." The views of people living in the home and their families were sought through relatives' and residents' meetings, and through periodic questionnaires Their quality assurance system included a system of monthly audits covering areas such as care plans, medications, health and safety and maintenance.

People and their relatives told us they felt the home was well managed. Comments included, "I think so. I have no complaints whatsoever if I did I would ask to see the manageress", "I think it's alright" and "I just feel it's a caring place". People's views had been sought in a variety of ways including questionnaires and

relatives' meetings. Relatives told us, "Yes there is a meeting every six months where more practical things are discussed" and "I think so. I talk to [staff name] more than anyone else. I'm just very glad he's here. I'm very grateful, they make me very welcome".

Since our last inspection the provider had improved their systems to monitor the service. They visited the home at least once a week and they had access to the home's care planning systems and other computer records at all times to enable them to monitor all management and care tasks closely. They were aware of all issues and problems and made sure actions were taken promptly where necessary to address issues. The provider told us they sought guidance from specialist health and safety matters such as fire safety and risk management to ensure the home continued to be safe, met current legislation, and followed best practice.

To the best of our knowledge, the registered manager has notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities. The provider and the registered manager promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. The provider told us in their PIR, "We encourage staff to be open about the errors they make and to understand that covering up mistakes can lead to unforeseen and serious consequences. We have a medication errors reporting form that states 'to err is human' 'to cover up is unforgiveable' 'to fail to learn is inexcusable'". This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.