

Colten Care Limited

St Catherine's View

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 the 12, 13 and 14 October 2016 and was unannounced. St. Catherine's View is registered to provide accommodation for people who require nursing or personal care and the treatment of disease disorder or injury for up to 56 people. At the time of the inspection there were 54 people living there. The home was purpose built to meet the needs of people living with dementia. Accommodation is provided in single en suite rooms over three floors and organised into five smaller house groups based around people's needs.

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

People told us they felt safe at St Catherine's View and people's relatives confirmed staff provided safe care and kept them informed of any concerns. There were procedures in place to protect people from the risk of abuse. The registered manager acted on safeguarding concerns promptly and appropriately and staff had the knowledge and confidence to identify and report safeguarding concerns. Risks to people's health and well-being had been assessed and plans were in place to minimise these risks. We found staff were aware of people's risks and acted to support them safely.

We received mixed feedback about the staffing levels in the home. Staffing levels had been calculated using people's individual needs as a guide. Some staff told us that changes in staffing levels and the way that staff were deployed in the home had resulted in them having less time to spend with people but people's care needs were met. However, people and their relatives told us they thought there were sufficient staff to meet people's needs. The provider's operational managers were aware of the need to embed and monitor the changes to staffing arrangements and were keeping this under review. Overall it appeared there were sufficient staff to meet people's needs safely.

Staff were recruited safely, the provider carried out all the required pre-employment checks to protect people from the employment of unsuitable staff.

People's medicines were managed safely. Arrangements were in place to receive, store and dispose of medicines safely. Staff who administered people's medicines were trained and had their competency assessed at regular intervals.

People and their relatives spoke positively about the staff in the home. Staff completed training to enable them to meet people's needs effectively and to achieve professional development in their role. Systems were in place to provide support and supervision for staff. Staff had not always received the level of one to one supervision in line with the provider's policy. The registered manager was taking action to address this at the time of our inspection.

Decisions about people's care when they lacked mental capacity were guided by the principles of the Mental Capacity Act 2005 (MCA). People's care plans evidenced specific decisions had been made in their best interests when they lacked the capacity to make these. When it was deemed to be in people's best interest to restrict their freedom to keep them safe their rights were protected by an application for a Deprivation of Liberty (DoLS) safeguard. We observed people being offered choices and people and their relatives told us their decisions were respected.

People were supported with their dietary, nutritional and hydration needs. People and their relatives told us the food was good and drinks were encouraged and available. We saw people were supported to eat and drink when they required assistance and were offered choice. Particular attention had been given to supporting the needs of people living with dementia by creating appetising smells to stimulate their appetite, offering choice at the point of food being served and providing snacks to enable people to eat when they were hungry. This was important because people living with dementia may lose interest, ability and desire in eating and drinking sufficiently to maintain good nutrition and hydration.

People's healthcare needs were met by on-site nurses and access to a range of healthcare professionals. People's healthcare needs were monitored and detailed guidance was in place to enable staff to provide effective care and treatment.

People and their relatives spoke highly about the caring nature of staff and the positive relationships they enjoyed with staff. People told us their decisions about their day to day care needs were respected by staff and we found staff were aware of people's individual preferences. People's relatives had given positive feedback about the care their loved ones had received at the end of their lives. Where people had expressed decisions about their care and treatment at the end of their life these were recorded and known by staff to ensure they received the care they wanted.

People's needs were assessed prior to their admission, their care plans were personalised and contained information about the care and nursing actions required to meet their needs. Care plans included information about people's personal histories and their preferred daily routines. We saw staff communicated effectively about people's changed needs and care was planned and delivered to meet these.

Staff completed training in supporting people living with dementia and demonstrated they understood how to meet people's communication and support needs. People's relatives told us the dementia care was good and spoke highly about the design and facilities of the home that created a 'dementia friendly' environment. People had access to a range of activities to provide a stimulating and meaningful use of time. The provider had employed specialist dementia staff to lead on ensuring dementia care was based on and delivered in line with best practice guidance.

People's concerns and complaints were investigated and responded to in line with the provider's procedures. People and their relatives told us they felt confident to raise any concerns with staff.

An effective quality assurance system was in place which enabled the provider and registered manager to assess, monitor and improve the quality and safety of the service people received. Information from accidents and incidents was collated and used to identify trends and monitor the preventative actions in place. People and their relatives were asked for their feedback about the quality of care they experienced and this was acted on.

The registered manager provided visible leadership in the home and kept the day to day running of the

home under review. They conducted daily meetings that included clinical staff, senior care staff and department heads. Information from this meeting was disseminated to all staff in the home.

The provider's values were to provide friendly, kind, individual, reassuring and honest care for people. Staff were aware of the values and we observed these were evident in the observations we made of staff practice in the home.

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 were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to safeguarding and the registered manager acted on concerns to promote people's safety.

Risks to people had been identified and actions were taken to ensure their safety. Risk management plans were in place to ensure people received safe and appropriate care.

Overall people were supported by sufficient and suitably skilled staff to meet their needs safely.

People's medicines were managed safely.

Is the service effective?

Good ●

The service was effective

Staff received an induction into their role; on-going relevant training and professional development opportunities. People received their care from staff that were appropriately trained in their role.

People rights under the Mental Capacity Act (2005) were protected. Procedures were in place and acted on to protect the rights of people who lacked the mental capacity to make their own decisions or agree to restrictions in their care and treatment.

People enjoyed a nutritious diet which reflected their preferences and dietary needs. People living with dementia were pro-actively supported to maintain good nutrition and hydration.

People's healthcare needs were met by on-site nursing staff and access to a range of health care services as required.

Is the service caring?

Good ●

The service was caring

People were cared for by kind and compassionate staff who knew them well.

People were given choices and involved in decisions about their day to day care and these were respected by staff.

People's privacy and dignity were respected by staff.

People's wishes and decisions for their end of life care were recorded and available to guide staff. People and their families received the support they needed at this time.

Is the service responsive?

Good ●

The service was responsive

People's care and treatment plans were person centred and reflected their preferences and decisions. Staff communicated effectively about people's needs and care was planned and delivered to meet these.

People living with dementia received responsive care from staff who understood their needs. The environment and facilities' promoted meaningful interaction and well-being for people living with dementia.

Events, activities and resources were provided to encourage a stimulating and meaningful use of time to meet people's individual needs.

A system was in place for people to raise their complaints and concerns and these were acted on.

Is the service well-led?

Good ●

The service was well-led

There were processes in place to enable the provider and registered manager to assess and monitor the service and make improvements. Information from audits, incidents and feedback from people and their relatives was used to drive continuous improvement to the service.

The registered manager provided visible and effective leadership in the home. They were supported by other managers and senior staff to organise and deliver a good quality service for the people they supported.

There was a positive and open culture in the home that was underpinned by the values of providing; friendly, kind, individual, reassuring and honest care for people.

St Catherine's View

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 12, 13 and 14 October 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience on day one and one inspector for the remaining two days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience as a family carer of a person with dementia who used regulated services.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 10 people, six people's relatives, and a visiting healthcare professional. We spoke with 12 staff including; nursing, care and senior care staff, an activities coordinator, a member of housekeeping staff and the chef. In addition we spoke with the registered manager, the care coordinator, the clinical, operations and quality managers and the Admiral nurse recently appointed as the provider's dementia care consultant.

We reviewed care records and risk assessments for six people. We also reviewed training records for all staff and personnel files for five staff. In addition we reviewed fifteen people's Medicine administration (MAR) records and other records relevant to the management of the service such as staffing rotas for the period 12 September 2016 to 9 October 2016, quality assurance audits and resulting action plans.

The service was last inspected in 2013 and no concerns were identified.

Is the service safe?

Our findings

People were protected from the risk of abuse and told us they felt safe living at St Catherine's View. A person said "I have a feeling of being safe and never thought any different". A person's relative told us their relative was cared for "Incredibly safely" and went on to say "I have found the home to be very communicative about the smallest things that had gone wrong, his safety is exemplary and they (staff) have been very good at keeping us informed".

Staff had completed training in safeguarding and had knowledge of the types of abuse people could experience such as physical, sexual, emotional or financial abuse. Staff were aware of signs of possible abuse, such as a previously sociable person becoming withdrawn or unexplained bruises and skin injuries. Staff were aware of their responsibility to report any concerns promptly and told us they were confident if they were to raise any concerns these would be taken seriously.

The registered manager had raised and responded to any safeguarding concerns in accordance with the local authority safeguarding's procedures. Records showed the registered manager took appropriate and timely action to investigate concerns. Where it was identified that additional actions were required to monitor and support people safely this information was recorded in people's care plans for staff to follow.

People's care plans contained assessments of their risks and support needs in relation to their health and well-being. Assessments included moving and handling, skin integrity and risk of pressure ulcers, maintaining a safe environment, nutritional needs and risk of falls. Risk assessments gave staff guidance on how to protect people from their individually identified risks whilst enabling the person to make choices about their care. For example, a person at high risk of falls preferred at times to be on the floor to enable them to move independently which was facilitated by staff. We reviewed the care of a person at risk of developing pressure ulcers. Records showed that repositioning for the person had been carried out regularly and that their pressure relieving mattress had been checked daily to ensure the setting and functioning were correct. This was in line with the actions detailed in their risk assessment to protect their skin integrity. We observed staff were updated on risks to people during handover and staff we spoke with understood people's individual risks and took the appropriate actions to keep them safe.

We received mixed feedback about the staffing levels in the home. Management staff told us they were assured there were sufficient staff but this was not a view wholly supported by all nursing and care staff. Staff confirmed people's care needs were met but they did not always feel they had the additional time to spend with people to fully meet their emotional and social interaction needs. However, people and their relatives told us there were sufficient staff available to meet their needs. For example; A person said "There always seems to be enough staff" and people's relatives said "There is a good staff ratio and when we call the bell someone comes quickly" and "Very adequate they are very good."

The quality manager told us the staffing level calculation was based on an individual needs assessment. The assessment used determined whether the person required residential, assisted care or nursing care and was used as a guide to identify the appropriate staffing levels. The service was organised in house groups

according to people's level of care needs. Although staff were allocated to each house group the registered manager said they had introduced a more flexible staffing system whereby staff could provide support to people across the house groups and as required for example in response to a call bell request for assistance. Following a management review of people's needs in May 2016 the care staffing level had been reduced and the provider had introduced a senior care lead post to support nursing staff with aspects of people's care such as medicines management. Staff rotas we reviewed showed there was the agreed number of staff on duty in line with the provider's calculation to meet people's needs.

During our inspection we noted there were short periods of time when staff were not always available in communal areas with people. On one occasion an incident occurred between two people that began to escalate into an argument and no staff were immediately able to assist. We had to find a member of staff to intervene to ensure the argument did not continue to escalate. We gave this feedback to the registered manager on the first day of inspection and during the remainder of the inspection no similar incidents were observed. Following the changes to staffing levels and arrangements the quality manager had identified the deployment of staff required "Greater supervision and management support" to embed the changes as to how staff were deployed in the home. This was being provided by the registered manager and care coordinator to ensure staff were effectively deployed to meet people's needs. From our observations overall during the three days of our inspection it appeared there were sufficient staff available to meet people's needs and that staffing arrangements were subject to regular review.

Staff recruitment files contained evidence of all the required checks to ensure staff were safely recruited. This included; criminal records check, a full employment history, satisfactory references from previous employers and photographic proof of identification. Checks were completed for nursing staff regarding their registration status with the Nursing and Midwifery Council (NMC). This was to ensure they had no restrictions on their registration to practice.

Nurses and trained senior care staff administered people's medicines. These staff had completed safe medicine administration training and had their competency regularly assessed to support people safely with their medicines. Arrangements were in place to receive, store and dispose of medicines safely. There was system for checking that medication had been given as prescribed and was signed for. Prior to our inspection the registered manager had identified that topical medicines which are medicines applied directly to skin such as creams and lotions, were not always recorded when applied. They had taken action to address this with staff however, during our inspection we found some examples where topical medicines had not been recorded as applied. We were assured that staff had administered the creams but had failed to record this. Following our inspection the registered manager introduced a more robust monitoring system to ensure topical medicines records were checked during each shift.

Information was kept with people's Medicines Administration Record (MAR) on their individual needs in relation to their medicines. For example; when people required their medicines to be given covertly this was recorded and showed an appropriate decision making process had been followed. People's need for pain relief was monitored through the use of a pain scale assessment tool. This meant when people were unable to verbalise their need for pain relief this could be assessed using indicators such as facial expression and body language. We observed a staff member administering medicines and saw they checked if people required medicines to manage their pain.

We noted the use of anti-psychotic medicines was monitored. These medicines can be used to control the behaviours of people living with dementia. The care coordinator told us a strategy was in place to minimise the use of these medicines and they were "Not to medicate for people's unique personality traits". When people were prescribed these medicines they were reviewed at three monthly intervals to ensure they

remained appropriately prescribed. This meant people were supported to manage their behaviours without the inappropriate use of medicines. People's medicines were managed safely.

Is the service effective?

Our findings

People and their relatives spoke positively about staff. People's comments included: "Very good they (staff) make sure I have everything I need. They always have the answer to anything I ask them". "Very good the staff I have come in contact with are good" and a person's relative said "(staff are) Very attentive, very concerned and strike the right balance if they should call me or not. They seem to be very patient and family orientated".

People were cared for by staff who had received the training they required to meet people's needs. New staff had completed an induction programme that met the requirements of the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which staff need to meet before they can safely work unsupervised. Staff told us they had support from a mentor and shadowed experienced staff before they worked unsupervised to ensure they understood how to support people effectively.

Staff were complementary of the training opportunities provided. Their comments included "The training is very good, all the categories are covered and within timescales". Staff told us they were well prepared for their roles and there were opportunities to pursue development qualifications in health and social care. For example a care staff member told us how they had completed their QCF [Qualifications Credit Framework] level two in health and social care. All staff including ancillary staff completed the provider's mandatory training which included; moving and handling, safeguarding, infection control, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and basic food hygiene. Elements of the provider's core training was also completed by all staff and this included; dementia awareness training, a warm welcome and treating customers with dignity, equality and diversity and understanding behaviour.

The quality manager told us that nurses training included "Mandatory, core and developmental" components. Records showed nurses had completed training in clinical care such as; skin integrity, syringe driver training, falls and dysphagia. Nurses were supported with revalidation by the provider's clinical manager. Revalidation is the process for ensuring that nurses demonstrate development and is required by the NMC to renew nursing registration.

Staff we spoke with said they received support and guidance from the registered manager and senior staff when they needed it. Records showed there were a range of strategies in use to support staff such as; group supervision sessions, reflective practice accounts following incidents and performance management meetings. However, staff had not always received regular one to one supervision meetings in line with the provider's policy and some staff told us supervision meetings had been "Infrequent". The registered manager was aware of this and a plan was in place to ensure staff consistently received regular supervision meetings to receive feedback on their performance and discuss their development needs.

Some people living in the home did not have the mental capacity to independently make decisions about their care arrangements. Staff had undertaken training on the MCA. 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. Staff showed a good understanding of this legislation and were able to tell us about the principles of the MCA such as; the importance of making decisions in a person's best interests when they lacked capacity. A staff member told us how they supported people to make every day choices such as what to wear, what to eat or drink and whether to take part in activities offered.

Staff showed a good understanding of consent and we observed them seeking consent and explaining the tasks they were about to carry out, for example when asking people if they wanted any medicines in relation to the management of their pain. A person's relative said "His decisions are highly respected; for example (person) didn't want the flu jab", whilst the home felt it would have been in this person's best interests they did not pursue the administration of the flu jab as the person had the capacity to make this choice for themselves which was respected.

Where people lacked the mental capacity to consent to specific decisions, a mental capacity assessment and best interest decision was recorded in their care plan. For example; for the use of bed rails. Where people had appointed a representative we saw this was evidenced to ensure decisions were made with people's legally appointed decision makers such as those with a Power of Attorney for people's health and welfare.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff we spoke with were aware of the DoLS accompanying the MCA. Records showed a process had been followed prior to the DoLS application being made that included a mental capacity assessment and best interest decision to determine whether a DoLS application was appropriate. This meant people's rights under the MCA were upheld.

People spoke positively about the quality of food available to them in St Catherine's View. People's comments included: "It is pretty good. Everything you get is always hot and tastes nice" and the chef "Does a lovely curry". A person's relative said "I've eaten here twice and been quite impressed. We have had a conversation with the chef and talked about my relative's diet. He has put on weight which is positive and he is getting lots of vegetables".

We observed the experience of people during a lunch-time in all house groups and saw staff provided a welcoming and pleasant atmosphere for people. People were supported to make choices about what they ate. For example; people were shown plated meals to enable them to indicate their choice. This is important for people living with dementia who may not be able to remember their choice if they are asked for their meal choice in advance. When a person couldn't decide the member of staff said "Try the chicken and I will keep this one for you if you don't like it". When a person communicated their choice using a language staff were unable to understand staff brought a communication diary containing pictures, including food and drink to them. This enabled the person to indicate what they wanted. Subsequently, we saw the person was enjoying the items they had requested.

People's individual dietary needs were catered for; this included documenting their preferences, allergies and specific dietary requirements such as whether they required a pureed consistency of food or any other specialised diet. The kitchen was clean and well organised and the chef had accessible information about people's nutritional needs. The chef told us they regularly checked what people had enjoyed and ensured

this remained on the menu when it was reviewed. We observed the chef talking with people to check their satisfaction with their meal. Snack food was available on the house groups to enable staff to respond to people's preferred times to eat and a bread maker was used to create the smell of fresh bread to stimulate people's appetite. The availability of snack food and the appetising bread smell were used to encourage people to eat well. This was important because people living with dementia may lose interest, ability and desire to eat and drink sufficiently to maintain their nutritional needs. .

We saw people had access to fluids and were encouraged to drink regularly and offered a choice of drinks. A staff member asked a person about their choice of drink and when the person did not understand the choices the staff member showed them both drinks and asked which they would prefer enabling the person to make a choice. We saw that staff responded effectively to non-verbal communication, for example when a person showed a staff member their empty tea cup. Staff understood the person was indicating they wished to have another drink which was promptly provided. A person's relative said "I had the idea that if we presented her drink in a wine glass and served it as wine she may drink more and it worked". We saw the person used a wine glass for their drink during lunch. Another relative said "Staff are always checking and asking would he like another drink".

People were supported to maintain good health through access to a range of health professionals. This included on-site nurses as well as other professionals who were involved in assessing, planning, implementing and evaluating people's care and treatment. During the inspection we spoke with a visiting Speech and Language Therapist (SALT). A SALT provides treatment, support and care for people who have difficulties with communication, or with eating, drinking and swallowing. They told us "They (staff) seem to make a real effort to meet the needs of residents. I always get an excellent handover from staff. They follow up on my recommendations and are good at asking for support or advice. They always know what people like and they (staff) spend time with me". We saw that fluid and food thickener such as 'Thick and easy' was stored safely and used correctly. Thickeners may be prescribed for people with a swallowing difficulty following assessment by a SALT to ensure they could drink fluids safely.

We observed a staff handover and saw that staff communicated effectively about people's health care needs. Records showed that people with complex health needs had been supported by a range of healthcare professionals to provide a multi-disciplinary approach to their care and treatment. For example; a person's care plan had been developed with input from; falls prevention team, a consultant neurologist, the older people's mental health team the GP and a Parkinson's nurse. People who had a wound had detailed treatment plans in place to monitor and evaluate their progress and treatment. We saw a person's wound was improving through treatment. Where people experienced changes in their health staff completed short term clinical observations records to monitor their progress and treatment. A person's relative said "it's very good they are very good if mum is ill or falls and they have gone to hospital with her". People received the support they needed to maintain their health and wellbeing.

Is the service caring?

Our findings

People and their relatives had positive views on the caring nature of the staff. People's comments included: "(staff are) Most helpful, if I wanted them I can guarantee they will help me, they always talk to me nicely and respectfully. They call me by my Christian name and it's rather nice, makes you feel at home". Another person told us "(staff are) Very caring, whenever I am sad they will talk to me and cheer me up. From what I've seen very caring". A person's relative said "They are attuned to dad when he is low and help him do things. They check up on him and make sure he's ok. He is up in the morning and smartly dressed".

People enjoyed positive relationships with staff. The atmosphere was friendly and relaxed in communal areas with staff engaging with people in a respectful manner. We observed many warm and friendly interactions. Staff engaged with people by listening and talking, and by using non-verbal communication including touch when appropriate. Staff clearly understood people's needs well and had a good rapport with them. A person's relative said "Staff show sensitivity, empathy and caring, I have nothing but the highest praise for the way they have treated my relative and us"

People were cared for by staff who were attentive to their needs and wishes. For example, staff knew what was important to people and supported them with their day to day needs and preferences. Staff spoke confidently about people and what was important to them. A staff member told us about one person and said "(person) loves chocolate; they like tea, coffee and a chat. They love a bath and the hairdressers she is a very happy lady who loves colour and wearing broaches she likes flowers". We saw the person had fresh flowers on their table in front of them and when they woke from a nap they were offered chocolate buttons.

Staff spoke positively about the time they spent with people. Their comments included: "We try to give people what they want and to meet their needs as they come up". Another care staff member told us that people were "Well loved" and a nurse told us that "Everyone does their best" to meet people's needs. We observed a care staff member reported a person's 'red eyes' to the senior care lead and a nurse came to see them within three minutes. We saw staff using notes to communicate with a person who could not hear them to enable them to participate in conversation and choices. We saw staff made people comfortable and engaged people in conversation with humour. A person's relative said "It's not a bit like my idea of a '(residential) home', it's a godsend. I'm here most days I stay and help mum have her lunch. I called the manager to say how impressed I was at lunch with the care and the atmosphere. However busy they (staff) are I have never seen them give the impression there are others they are looking after. I don't think we could do better. I can't speak highly enough of it here".

People were involved in making decisions about things that affected them. For example, people told us they made choices and these were respected. A person said "I can choose when to get up. I go to bed when I am ready and If someone asks to change the (TV) channel they will do it for you". Another person said "No one makes you do anything you don't want to do. I can choose whatever I like". People's care plans included information about their choices such as; when they would like to get up, where they would like to eat and the activities and pastimes that were of interest to them. A person's relative said "I'm sure he can make decisions on what he likes and doesn't like and when I come in they ask me questions".

People told us their dignity was respected by staff at the home. The language heard and recorded in care records was appropriate and respectful. Staff used touch to support people to understand instructions, we saw this was done appropriately and people seemed comfortable and reassured through physical contact with staff. During our inspection, we saw staff supported people's privacy and dignity. When people required support with personal care tasks this was done discreetly, behind closed doors to ensure people's dignity was maintained. Staff we spoke with told us they would explain the care to be given and seek the person's consent before supporting people. A person told us "They (staff) call me by my first name, I like that, and they talk to me as a normal person". Another person said "The staff dress me and make me look smart. I can use the hairdresser whenever I want. They also do little things like close the door, and knock before coming in".

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, equipment and medicines were provided as and when needed to enable people to be as pain free and comfortable as possible. People's wishes and decisions were recorded and available to guide staff. This included where people had made an advance decision to refuse medical treatment, who people would like present and where and how they preferred to spend their last days. The registered manager told us they paid attention to detail such as making the person's room "Lovely with lights". The relative of a person who was nearing the end of their life said "They (staff) tell us we are here to support you and your father, it's like his family here". We saw examples where relatives had written to thank the staff for the care their loved ones had received at the end of their life. People's views regarding the end of life care they wished to receive was documented, respected and known and demonstrated by staff.

Is the service responsive?

Our findings

Each person's care needs had been assessed and were used to develop a personalised care plan which reflected people's needs and preferences. This included an assessment of the person's needs before they were admitted to the home. Care plans included the objectives of the person's care and the nursing and care actions required to meet their needs. The registered manager told us the provider had introduced new care plan documents and these were "A work in progress" and were currently being evaluated and refined to ensure guidance was clear for staff.

Relatives told us they were kept informed if people became unwell or their needs changed. They told us they had been given an opportunity to provide information that people might not have been able to share. Such as their preferences and personal history. A staff member said "We get a lot (of information) from families and sometimes things might change like taste" and a nurse told us that there is "Always something that we can improve". This indicated a positive, reflective approach to meeting people's changing needs.

Personal information was available for each person, which included details of the person's early life; education, teenage life, adult life, and the places they had lived, their and career and work. This enabled staff to know about the person and build a relationship. Other information about the person's preferences guided staff to know how to plan and deliver care. For example; a person's daily life plan stated 'I would like to wake up naturally I would like to dine in the lounge/diner. I enjoy pet therapy and musical entertainments.' Night staff confirmed they supported people to get up when they chose to in sync "With their body clock" and records showed the person had attended the activities they enjoyed.

Care plans included information on how staff were to support people to meet their emotional needs. Care plans were in place for people whose behaviour might put themselves or others at risk so staff would know how people preferred to be supported when they became anxious. For example; whether to support with medicine, what the person liked to do one to one with staff in order to engage and distract them and whether regular observations were required. One person's care plan stated 'a calm confident and friendly approach works, repeating yourself doesn't'.

We saw that staff intervened calmly and with reassurance when a person became upset. The newly appointed dementia lead told us they planned to work with staff to develop recording information about effective and non-effective interventions "So someone else doesn't do something that doesn't work". Staff were also supported to care for people appropriately by the provider's clinical manager who reviewed the care of people when incidents had occurred to see if any preventative actions could be put in place to minimise the risk of a recurrence.

Most people resident at St Catherine's View lived with a diagnosis of dementia and staff had received training to assist them to understand how to support people living with dementia. We saw good communication skills and dementia friendly practices were evident when staff supported people. This included, encouraging and reassuring people and supporting people to make choices. The provider had appointed an 'Admiral nurse' who is a specialist dementia nurse able to give expert practical, clinical and emotional guidance to staff on supporting people living with dementia. The Admiral nurse told us they had

noted that staff were good with structured activities and using the 'Butterfly Approach' which includes having items and activities readily available to draw people's eye and engage their interest. The registered manager was ensuring that all staff engaged in this strategy including housekeeping staff who involved people in tasks such as folding laundry and pushing the trolley. For example, we saw a person helping staff to lay table for lunch. These homely types of activities can help people living with dementia retain an emotional and familiar reassuring link with their personal life before they moved to a home. Objects of interest were available to people in the corridors and lounges such as a range of hats on a hat stand, a sewing machine, a board with a selection of locks and switches and a camera and photos. People were engaged with objects of personal interest such as a wind-up musical toy and a baby doll and there were tactile blankets and soft toys available for people to use in communal areas. A person relative said "I would recommend the dementia care I can't fault them and my relative says it's the best place they have ever been in."

Structured activities were available for people every day and they were able to choose whether they wished to participate. Celebratory events were held throughout the year and relatives were encouraged to take part in activities and events at the home. During our inspection people participated in a sing-along with a visiting entertainer and a breakfast club which was held regularly for people to meet together in the on-site café. We observed a craft based activity session facilitated by staff including the service gardener and that people were engaged in this. Some people went out on trips to a garden centre and the New Forest to see the scarecrows and a scarecrow competition was being held at the home. People appeared to enjoy the activities available and a range of activities were also planned to meet people's diverse needs. For example; a gentlemen's club had been established to engage men in activities of interest to them and people's faith needs were respected with spiritual events and regular Christian service and communion. This meant people were given the opportunity to participate in stimulating and meaningful activities.

Family and friends were encouraged to visit whenever they wanted and staff supported people, who wanted to have regular and frequent contact with relatives.

The registered manager told us the home had been designed "Around people's journey with dementia". House groups were arranged according to people's level of needs and the environment was designed to promote meaningful interaction between the people living there. For example; there was a lounge and diner on each house group as well as smaller and quieter areas for people to sit alone or with relatives and friends. Contrast in colour in the environment and objects can be helpful for people living with dementia when they experience orientation and perception difficulties. There was a good use of colour throughout the home and all areas were well lit to support people with sensory difficulties. There were themed rooms such as the 'Music Room' and 'The Hide' these rooms had objects of interest and provided a stimulating environment for people to enjoy. Each floor had access to the garden or a roof garden and these spaces were designed to provide sensory experiences for people which can help people living with dementia relieve stress and promote positive feelings. A relative had provided some feedback to the home which included "The thought that has gone in to the layout of the home is terrific. Whoever you have as a dementia advisor in this regard is doing an outstanding job. Recessed, automatically lit areas for the ugly but necessary equipment, genius! A variety of sitting rooms to be alone, with other residents or family, brilliant! The sensory garden, the large clear photos on the walls, the use of bold colour, the visitors café, I could go on and on". People living with dementia were supported in an environment designed to meet their specific needs.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. A person said "I tell the person I see most often and they will sort it out. If they can't then I will talk to whoever the manager is". One relative told us "Everyday concerns I would talk to the nurse. I would go to any member of staff if needed. Medical concerns I would talk to the clinic led and organisational things to the house manager". The provider's complaints process was available to people and their representatives. This set out

how people could make a complaint and how their complaint would be dealt with. We reviewed the record of complaints and saw they were logged, investigated and responded to and this included the actions taken and the level of satisfaction of the complainant.

Is the service well-led?

Our findings

The provider had effective quality assurance systems including routine checks and audits to continually evaluate the quality of care provided to people in the home. The registered manager was supported by the provider's senior management team which included; quality, clinical and operational managers who advised on and monitored the improvements plans in place.

Regular audits were completed by the registered manager and other managers in a number of key areas including; care plan reviews, infection control practices, medicines management, tissue viability and infections and health and safety checks. Senior managers audited the service against the five key questions we ask of providers; is the service safe, effective, caring, responsive and well-led. The results from these audits were used to drive continuous improvements to the quality of care people received. We saw that improvement actions were monitored through to completion and improvements had been made. For example; staff training completion rates and medicines management concerns had improved from the previous quality audit and the registered manager told us "We are moving in the right direction".

Information from accidents and incidents was collated and used to identify trends and monitor the preventative actions in place. The registered manager had developed a mapping system across the home to further identify issues by house groups. They planned to use this information to inform focused discussions with staff on people's individual care needs in order to "Drive more person centred care with nurses and care staff". We saw evidence that the registered manager had used the learning from incidents to promote positive changes in practices in the home. For example; they had identified the learning outcomes from 'significant falls' and this had included involving the falls clinic nurse to review the care of people at risk of falls and provide training for staff to promote people's safety and wellbeing.

We attended the daily morning meeting which was attended by the registered manager, care coordinator, nurses, senior care leads and department heads. The meeting was used to discuss people's care for example; the 'resident of the day', the progress of people who had returned from hospital and those who had experienced a deterioration in their health. Updates were given on discharge, admissions, referrals and any staff sickness, staff training and meetings. Complaints and compliments were discussed along with planned activities and any maintenance needs. The notes from the meeting were displayed in the staff room to enable all staff to be aware of this information. This meant there was a good level of management communication and oversight of the day to day running of the home and people's needs.

Records showed staff meetings had taken place and the minutes of these described how staff were supported to be aware of their roles and responsibilities. Topics covered at meetings included; the importance of record keeping, infection control practices and medication management. When staff performance fell below the expected standards action was taken to address the concerns and support staff to improve and develop their performance. For example; staff had been asked to complete a reflective practice account to evidence learning from incidents and where appropriate formal disciplinary action was taken. Comments received from staff included that the registered manager was "Approachable" "Accommodating" and "The manager is very nice and helpful".

An annual service satisfaction survey was completed to provide an opportunity for people and their relatives to provide feedback across all the provider's homes. The results of the May 2016 survey indicated the people who responded felt the quality of care provided was either excellent or good. We saw the results for St Catherine's View had been discussed with relatives at a quarterly meeting and the registered manager had reported the home had been rated overall as 'good' by the respondents. Improvement actions identified were incorporated into the home's action plan and the manager had invited relatives to discuss any particular concerns with them. The registered manager told us they encouraged feedback from people and their relatives by having an 'open door' approach and added "I am open and transparent and once I am aware of something I cannot ignore it". Duty of candour forms part of a regulation that states providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. We saw records which showed a system was in place and had been used to meet this requirement.

The provider had a dementia strategy aimed at providing best practice to 'Support people and their families to overcome the challenges associated with dementia'. To support this initiative the provider held an annual Dementia Utopia day to enable staff to share good practice and improvements in dementia care. Staff across all departments were invited to attend as well as expert guest speakers. At this year's event St Catherine's View had been invited to share their practice on activities for people living with dementia. Other actions to embed good dementia care practices had also been taken such as the appointment of a specialist dementia care nurse and a programme of training to achieve 80% of all staff becoming 'Dementia Friends'. A Dementia Friend is someone who has been given a specific understanding of what it is like to live with dementia and provides an appreciation of how the actions they undertake can both affect and support people appropriately.

The provider's values were to provide friendly, kind, individual, reassuring and honest care for people. The values had been developed through a process whereby staff had thought about what would be important for their loved ones when receiving care. Staff completed an induction that included the provider's values and these were reinforced through staff supervisions and company events. A book containing photographs and compliments was kept at reception and this was used to demonstrate how the values had been incorporated in people's care. Staff we spoke with were able to tell us about the values and how these informed their work with people. For example staff told us about being honest with people and their relatives and how they provided reassurance to both families and people during difficult times. We observed these values in action during our inspection and found staff did provide, friendly reassuring and individual care. A person's relative said "I've never seen poor care they treat people warmly and with a smile and they have a nice way of diffusing the situation and that says to me they have a good culture".