Willowbrook Healthcare Limited

Knowle Gate Care 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

The inspection took place on 15 June 2017 and was unannounced.

A registered manager had recently left the home. A new manager had been recruited by the provider and was in the process of registering with the Care Quality Commission. 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.

Knowle Gate Care Home provides accommodation and personal care for up to 60 older people who live with dementia. 46 people were living at the home at the time of our inspection and most of those people lived with dementia.

The home is situated in Solihull, West Midlands. Communal areas in the home included large spacious lounge areas, dining rooms, a room where people could follow their interests and hobbies, a bistro and a cinema room. The home also had large well maintained gardens.

A month before our visit the provider of the home had changed. A plan was in place to manage the change. People were satisfied with home was run. Some staff told us they were looking forward to working with the new provider. Others felt apprehensive about the changes. The future leadership at the home had been discussed with staff and they assured us they had had the opportunity to attend team meetings and ask questions which had made them feel more supported and involved.

People felt safe and were happy living at the home. Procedures were in place to protect people from harm. Staff understood their responsibilities to keep people safe and were confident to raise any concerns with their managers. They understood the risks to people's individual health and wellbeing and risks were clearly recorded in people's records. Our discussions with staff demonstrated a consistent approach to the management of risks. Detailed plans were in place to ensure people would receive continuity of care if an unexpected event occurred such as, fire.

Accident and incident records were completed. The provider had implemented a new system to analyse the records each month to identify any patterns or trends to reduce further incidents occurring. Equipment was checked by staff and external contractors to make sure it was safe to use.

The provider's recruitment procedures minimised, as far as possible, the risks to people safety. There were enough qualified, skilled and experienced staff to meet people's needs.

New staff were provided with effective support when they first started work at the home. People and their relatives told us staff had the skills and knowledge they needed to care for them. Staff completed training and demonstrated an in-depth knowledge of people's care and treatment needs. They were skilled and

confident in their practice. We saw staff put their learning into practice and offered reassurance and comfort to people throughout our visit.

The staff demonstrated an understanding of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) so that they could ensure peoples' rights were being protected. The managers understood their responsibility to comply with these requirements. For people who were assessed as not having the capacity to make all of their own decisions, records showed their families and health care professionals were involved in making decisions in their best interests. Staff always obtained people's consent before they provided care and support.

Most of the people we spoke with provided positive feedback about the food and dining experiences at the home. Mealtime experiences were enjoyable for people and they received a varied and nutritious diet. Staff demonstrated good understanding of people's nutritional needs and people had opportunities to plan food menus in partnership with the chef. Medicines were stored safely and people received their medicines as prescribed. The provider and staff team worked closely with external healthcare professionals to ensure people's health and wellbeing was promoted and maintained.

People spoke positively about the staff that provided their care. Staff we spoke with showed concern for people's wellbeing and demonstrated they knew the people they cared for well. Several people had recently moved into the home from a nearby home run by the same provider. Some staff had also moved with the people to ensure they received care from staff they knew.

People and their relatives worked in partnership with the staff to plan their care which meant staff had an in-depth knowledge of people's preferences and support needs. Most care plans provided personalised information about people's their preferred routines, likes and dislikes. The new provider was in the process of implementing a new care plan document which would be written from the person's perspective. Training to ensure the staff had the skills they needed to write the care plans had begun to take place.

A keyworker system was in place. This meant people were supported consistently by a named staff member. People told us staff involved them in decisions about their care and staff knew the importance of people being involved in these decisions. People were encouraged to be as independent as they wished to be. People were treated with respect and were cared for in a dignified way.

We received positive feedback about how the service was personalised and responded to people's individual needs. People received care which was in line with their wishes and preferences. We saw throughout our visit staff responded quickly to people's request for assistance.

People were encouraged to maintain relationships important to them. Relatives were encouraged to be involved in their relatives care and there were no restrictions on visiting times. Overall, people spoke positively about the varied social activities that were available to them to occupy their time.

People and their relatives were invited to attend regular meetings so they could make suggestions about how the home was run. People and their relatives knew who to speak with if they had any concerns or complaints about their care and all felt confident concerns would be dealt with appropriately and fairly.

Staff told us they enjoyed working at the home, they felt supported by the management team and they received regular supervision of their work. The new provider and the managers promoted an open culture by actively encouraging feedback from people, their visitors and staff to put forward their suggestions to make continual improvements at the home.

The provider took action to ensure the home was run in-line with people's wishes. We saw good examples of team work and communication between the staff and their managers during our visit. The provider had a staff awards scheme that recognised contributions from staff, and recognised outstanding skills in caring for people at the home.

There were systems to monitor and review the quality of the home. There was an emphasis on continually looking for ways to improve the service people received, and also looking at learning if care fell below the standards the new provider expected.

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 felt safe living at the home. Procedures were in place to protect people from harm. Staff understood their responsibilities to keep people safe and our discussions with staff demonstrated a consistent approach to the management of risks. Accident and incident records were completed. Equipment was checked to make sure it was safe to use. The provider's recruitment procedures minimised, as far as possible, the risks to people safety. There were enough staff to meet people's needs. People received their medicines when they needed them.

Is the service effective?

Good

The service was effective.

Staff were skilled and confident in their practice. They had the skills and knowledge they needed to care for people effectively. Most people spoke positively about the food and dining experiences at the home. The staff worked closely with external healthcare professionals to ensure people's health needs were met. Staff understood and worked in line with the principles of the Mental Capacity Act 2005. Staff obtained people's consent before care was provided.

Is the service caring?

Good

The service was caring.

People spoke positively about the staff that provided their care. Staff showed concern for people's wellbeing and demonstrated they knew the people they cared for well. People told us staff involved them in decisions about their care and staff knew the importance of people being involved in these decisions. People were encouraged to be as independent as they wished to be. People were treated with respect and were cared for in a dignified way.

Is the service responsive?

Good

The service was responsive.

People received personalised care in line with their wishes and preferences. Staff were available when people needed them. People and their relatives worked in partnership with the staff to plan their care which meant staff had an in-depth knowledge of people's preferences and support needs. Most care plans and provided personalised information about people's their preferred routines, likes and dislikes. People and their relatives were invited to attend regular meetings so they could make suggestions about how the home was run. People and their relatives knew who to speak with if they had any concerns or complaints about their care.

Is the service well-led?

Good

The service was well-led.

The provider of the home had recently changed. There was a plan to manage this and people told us they were satisfied with how the home was run. Staff told us they enjoyed working at the home, they felt supported by the management team. There were effective systems to monitor and review the quality of the home.

Knowle Gate Care 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 was planned to check whether the provider was meeting the legal requirements and Regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15 June 2017 and was unannounced. The inspection team consisted of two inspectors, an inspection manager, a specialist advisor and an expert by experience. The specialist advisor was a specialist dementia nurse. The expert by experience was a person who had personal experience of caring for someone who had similar care needs to people living at Knowle Gate Care Home.

As part of our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR 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. The information contained within the PIR was reflected during our visit.

Prior to our visit we reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke to the local authority commissioning team who funded the care for a number of people. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They told us they had last visited in May 2017 and they were monitoring the quality of care provided to people because provider of the service had recently changed and the registered manager had left.

During the visit we spoke with ten people who lived at the home. Other people were unable to tell us about their experience of the care. We therefore spent time observing how they were cared for and how staff interacted with them so we could gain a view of the care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

We spoke with eight people's relatives and three visitors. We also spoke with 13 staff members including the regional manager, the deputy manager, three nurses, care workers, the chef and the maintenance person.

We looked at the records of six people and two staff records. We looked at other records related to people's care and how the home operated. This included checks the management team took to assure themselves that people received a good quality service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Knowle Gate Care Home. One person said, "I haven't been here very long but I feel safe here as I am cared for." Another told us, "Yes, I am safe because the staff are very good; they do what they can to help you." A relative commented, "Yes it is secure and safe. It ticks all the boxes. I have only positive feedback; they (staff) have got a lot of things right."

Another person's relative told us their family member sometimes had bad dreams which on occasions could cause them to feel frightened. The person was unable to use a call bell to summon assistance from the staff if they needed them. They said, "The Staff always check every couple of hours through the night and always reassure [Person] which does makes them feel safe."

Procedures were in place to protect people from harm. For example, we saw the provider's safeguarding reporting procedure was displayed in communal areas of the home to inform people how to report concerns if they felt unsafe. Our discussions with the deputy manager assured us they were aware of their responsibilities to keep people safe. Records showed concerns of a safeguarding nature had been correctly reported and this meant any allegations of abuse could be investigated.

People told us there was always enough staff on duty to keep them safe. Comments included, "Yes, they (staff) are around if I need them," and, "Yes, I think there is enough." The deputy manager told us the levels of staff on duty were determined by people's needs. Staffing levels were under constant review to ensure the level of staff on duty was sufficient to care for people and to keep them safe.

A nearby home run by the same provider had partially closed for refurbishment. As a result of this several people had moved into the home. A weekly teleconference was held with the local authority and clinical commissioning group [CCG] to ensure the moves had gone as safely and as possible for people.

Our observations and discussions with staff assured us there were enough of them to meet people's needs in a timely way and keep them safe. Staff confirmed they had completed training to safeguard adults. Training included how to raise concerns, and the signs to look for such as unexplained bruising to people's skin, which might indicate people were at risk. Staff described to us their responsibilities to keep people safe and they told us they were confident to report any concerns to their managers. One said, "If I was not happy with the care here I would not be working here, the residents are all safe." Another told us, "I would follow the current guidelines, such as reporting it to the manager, documenting everything, if the situation was not acted upon appropriately or within a timely manner I would report it to the local safeguarding team and CQC, we think of the best interests of our residents."

The provider's whistle blowing policy was on display for staff (a whistle blower is a person who raises concerns about wrong doing in their workplace). Staff were aware of the policy and told us they were confident to raise any concerns.

The provider's recruitment procedures minimised, as far as possible, the risks to people safety. The deputy

manager explained the home recruited staff who were of good character and checks were carried out before they started work. Staff confirmed their references had been requested and checked. Also, they had not started working at the home until their DBS (Disclosure and Barring Service) clearance had been returned and assessed by the management team. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

At the time of our visit there was only one staff vacancy. The provider's regional manager told us they planned to recruit more bank staff in the months following our visit to cover for any staff sickness and annual leave.

Risk assessments and management plans identified potential risks to people's health and wellbeing. Staff were knowledgeable about the risks and confidently explained in detail how people's support needs varied according to their abilities and preferred routines. These assessments helped to keep people and staff safe when delivering care. For example, one person was at risk of choking on food and fluids. Clear guidance was available to staff to reduce this risk and keep the person as safe as possible. This person also had a PEG tube and instructions were in place to for staff to follow ensure the person receive sufficient nutrition. (A PEG is used when a person cannot consume food, fluids and medicines orally).

Another person was at risk of falls and they had fallen several times in the six months prior to our visit. The falls had resulted in three injuries which had required medical treatment. Their falls risk assessment had last been reviewed in June 2017 and it advised staff to ensure their bed was positioned at the lowest height with sensor mats each side. Our discussions with staff confirmed they were aware of this risk and we saw they had followed the guidance to keep the person as safe as possible. However, we identified not all of the persons falls had been added onto their individual falls diary. We bought this to the attention of a nurse who told us this was recording error and a one off occurrence. They assured us this information would be corrected. We also discussed this person's falls with the deputy manager. They told us, "I am confident we have taken all of the action we can to prevent further falls. We are doing everything that we can which involves making referrals for specialist advice." We saw this had happened.

Due to a health condition another person spent a lot of time in bed which increased the risk of their skin being damaged. We saw clear instructions were in place such as, a tissue viability care plan to support staff to manage this risk. The person also had an airflow (pressure relieving) mattress. Staff were aware of this risk and they explained if any new risks were identified people's records were updated to ensure information was accurate.

People spoke positively about the way their medicines were administered by the staff. One person said, "I get my tablets when I need them, especially my pain tablets." Another told us, "My medication is always given on time." We saw staff followed good practice when they administered people's medicines. For example, they took medicines to people, provided them with a drink and watched them take their medicine, before returning to sign the MAR (medicine administration record) to confirm they had taken it. We reviewed 12 people's medicine records and they had been completed correctly. This assured us medicines were being managed safely.

Some people were prescribed 'as required' medicines. These medicines are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. Protocols (medicine plans) for the administration of these medicines were in place to make sure they were administered safely and consistently. This was important if a person was not able to verbally inform staff of their pain. Staff knew who was unable to tell them and they looked for signs such as, people crying or changes in their behaviour to indicate pain. This meant people received their medicines when they needed them.

Some people were prescribed creams to make sure their skin remained healthy. Creams were being applied by the staff but the plans in place to ensure these were applied as prescribed were not sufficient. This was because the plans did not inform staff where the creams needed to be applied onto a person's body. We discussed this with the deputy and regional manager. They assured us immediate improvements would be made.

Only trained competent staff administered people's medicines. Staff confirmed they had received training, and a manager observed their practice to make sure they were competent to do so. A series of checks took place so if any errors were identified prompt action could be taken.

Accident and incident records were completed. The provider had implemented a new system to analyse the records each month to identify any patterns or trends to reduce further incidents occurring. In May 2017 records showed 26 falls had occurred. We saw that 42 per cent of the falls had occurred at night time. In response to this the provider was in the process of reviewing the levels of staff on duty at night, some people were being checked more frequently by staff and others had been supplied with sensor mats. The mats alerted staff if the person got out of bed so they could offer prompt assistance. The regional manager told us whilst this was a new system at the home it had been very successful in other homes run by the provider.

There were processes to keep people safe in the event of an emergency such as a fire. The fire procedure was on display in communal areas which provided information for people and their visitors about what they should do. People had personal fire evacuation plans so staff and the emergency services knew people's different mobility needs and what support they would require to evacuate the building safely.

Staff confidently explained to us what action they needed to take if they heard the fire alarm to keep people and themselves safe. One said, "If the alarm goes off we go to the assembly point, I check the fire panel. If I get there first I would take charge. There is a box with a high visible jacket; there are walkie talkies we use." The maintenance person told us, "Fire drills are completed. So it doesn't impact on people too much I assess staff are in the right zone, I watch them and talk them through the fire plan."

Equipment used by people was checked by staff and external contractors to make sure it was safe to use. For example, the maintenance person completed daily visual checks of the environment and the gas safety systems had last been checked by an external contractor in April 2017.

Good

Is the service effective?

Our findings

People and their relatives told us staff had the skills and knowledge to care for them effectively. One person said, "The Staff are well trained and do their best." Another said, "They are well trained, especially the nursing staff." This made them feel in 'safe hands'. A relative commented, "The Staff are really nice, well trained."

Staff demonstrated an in-depth knowledge of people's needs and were skilled and confident in their practice. They told us they had completed the training they needed to be effective in their roles. One told us, "We have intensive training, moving and handling, infection control and dementia. We know what to do and how to do it with different people." This meant people received care, based on best practice guidance.

New staff were provided with effective support when they first started work at the home. One said, "We did an induction programme, we were really excited to start, there was 4 or 5 weeks of induction training." The induction included the 'Care Certificate'. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected.

Staff told us they had spent time shadowing (working alongside) experienced colleagues to gain an understanding of how people liked their care to be provided. They had also read people's care records before they worked unsupervised.

The regional manager explained training was in the process of being provided to staff to ensure they understood their responsibilities in line with the provider's standards and values. This training included 'blended' (computer based training) and 'face to face' learning sessions such as, infection control and health and safety. Staff spoke positively about the training. One said, "I like the face to face training because I can ask questions if I am unsure about something."

The staff team also had opportunities to complete qualifications such as, social care diplomas. Most care staff had completed or were working towards level two or three qualifications in health and social care. This ensured they had the skills they needed to meet people's needs.

A senior staff member was an accredited trainer and was qualified to provide some training to the staff team which including moving people safely. We saw staff put their training into practice. For example, during our visit we observed two staff members used a piece of equipment to safely move one person from a wheelchair into an armchair. Staff interacted with the person and explained to them what they were doing. The person responded well to this by smiling.

Some staff had also completed the 'Six Steps to Success: improving end of life care in care homes'. The training provided by the local CCG supported staff to develop their skills to provide high quality end of life care to people who lived in the home. The deputy manager said, "Dying with dignity is very important. It was really good training which took place on several days over a six month period."

The home provided care to many people who lived with dementia. Staff confirmed they had received training which made them feel confident to support those people. The Provider's PIR stated, 'Dementia care is supported by the Avery reconnect strategy.' We discussed this with the regional manager who explained the strategy was in the process of being updated by the Provider's lead for dementia care. This was to ensure good dementia care was provided from the person's perspective in line with best practice guidance.

Staff told us they felt supported by the management team and they received regular supervision of their work. Records showed us staff had regular opportunities to meet with their manager to discuss their role and to identify how to develop their skills. A schedule for these meetings was in place.

Most of the people we spoke with provided positive feedback about the food and dining experiences at the home. Comments included, "The food is brilliant," "It is a bit fancy for my liking," and, "Overall, yes food is good." A relative commented, "I think my relative would prefer simpler food." Records showed people did have the opportunity to attend meetings called 'food forums' to contribute their ideas to create menus and provide their feedback on the food. Minutes from a recent meeting showed us people had requested more fish be added to the menu. We looked at food menus and saw fish was available on Tuesdays and Fridays.

We observed the mealtime in two of the homes dining rooms and the experience was positive for people. People were shown visual choices of the meals available to help them to decide what they would like to eat. Staff were attentive and provided the support people required to eat and enjoy their meals.

Staff we spoke with, including the chef, demonstrated a good knowledge of people's nutritional needs, likes and dislikes. They knew one person had a health condition and required all of their meals to be pureed. Another person did not eat meat and another did not like bananas. A notice board in the kitchen displayed people's photographs, allergies and dietary needs. The chef said, "We can see at a glance what people require, it means they get what they need and what they like." People's nutritional needs were assessed regularly. Some people had risks associated with eating and drinking and clear guidance for staff to follow was documented in their care plans. Advice had been sought from external health professionals and staff demonstrated good knowledge of how to support people safely.

People's records showed the home's staff worked in partnership and maintained links with health professionals. For example, a local GP visited the home twice a week. During a recent visit one person had been prescribed some ointment because they had sore eyes. This same person had had their medicines reviewed in June 2017. This meant people who lived in the home received appropriate health care to meet their needs.

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

We checked and found the provider was working within the principles of the MCA and conditions on authorisations to deprive a person of their liberty were being met. The deputy manager and regional manager understood their responsibilities in relation to the MCA. People who lived in the home had been assessed to determine whether they had capacity to make their own decisions. Where people had been identified as not having capacity to make specific decisions about their care, appropriate discussions had

taken place with those closest to the person to make decisions in their best interests. The outcome of these clearly recorded.

Staff had received MCA training and they demonstrated to us they understood the principles of the Act. They gave examples of applying these principles to protect people's rights, such as, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. For example, one said, "The principle is not to assume people do not have capacity until they are assessed."

Good

Is the service caring?

Our findings

People spoke positively about the staff that provided their care. Comments included, "They (staff) are all lovely, l like them." "They are kind to me. I feel fortunate to be here." And, "Lovely staff, very pleasant." Relatives shared this view point. One said, "Nothing is too much trouble for the staff. [Staff member] is fantastic, they regard my Dad as her little helper, which he loves." Another told us, "Caring comes naturally to them (staff), they really do care." This made them feel confident their relative was happy and was well cared for.

All the staff we spoke with showed concern for people's wellbeing. They told us the support people received was always delivered to a high standard. One said, "The people here come first, I love my job." Another told us, "We have high standards, Avery (provider) have set us high standards so far." The deputy manager and the regional manager felt confident all of the staff were committed to providing high quality care to people.

Several people had recently moved into the home from a nearby home which is run by the same provider. One person said, "I was a bit worried at first but I felt welcomed from day one, I am getting settled." Some staff had moved from the nearby home with the people to ensure they received care from staff they knew. Other staff explained they had plenty of time to sit and talk with people to get to know them and their families to find out 'all the small things' that were important to them. Staff also watched people's body language to find out what they liked and disliked if people were unable to tell them. Staff said this helped them to gain an understanding of how these people liked their care to be provided.

Staff demonstrated they knew the people they cared for well. We observed positive interactions took place between the staff and the people who lived at the home. For example, we saw one person and a member of staff sitting and having a drink together. Music was playing and the staff member was whistling the tune of the music to the person. The person responded well to this by smiling. We saw staff knelt down to talk with people so they were at the same height as them, and people responded well to this and engaged in conversations. It was clear staff had built up good relationships with people. For example, we saw one person say to a staff member, "I like you." The staff member replied, "I like you too."

Staff knew how to provide comfort to people and we saw appropriate distraction techniques were used when people became anxious. For example, one person was unable to locate their bedroom and this made them anxious. We saw a staff member gave the person a hug, held their hand and showed them where their bedroom was. Another person could become anxious if they felt alone. A staff member told us, "I often take ten minutes to talk with them about their family. It always makes them smile."

People were encouraged to maintain relationships important to them. Relatives were encouraged to be involved in their relations care and there were no restrictions on visiting times. One relative said, "I feel welcomed; I have given them (staff) lots of information about [Person] to help them to write the care plan."

It was clear some friendships had developed between people who lived at the home. During the morning of our visit some people chose to go for a walk together and then had a cup of coffee in the bistro area. One

person said, "It's lovely we can have a coffee, we feel like we have been to a coffee shop."

People told us staff involved them in decisions about their care and staff knew the importance of people being involved in these decisions. One person told us, "I come and go as I please; it's up to me how I spend my time."

People told us the staff encouraged them to be as independent as they wished to be. One person explained they had previously broken their arm and the level of care staff provided had reduced as their arm had started to heal which meant they had remained independent. Staff recognised and demonstrated they understood the importance of promoting people's independence. One said, "Myself as a carer, I encourage people every day. People wash some body parts themselves others choose their own clothes, its important."

People told us they were treated with respect and were always cared for in a dignified way. For example, one person said, "They (staff) always knock my door and wait before they come in. It's important to me because I might be undressed." We saw this happened throughout our visit and this showed they respected people's right to privacy.

Some staff members had undertaken further training in meeting the needs of people who lived with dementia and how to promote their dignity. Records showed some staff had completing a training course to become a 'Dignity Champion' at the home. The purpose of this was to gain a greater understanding of how people's dignity was being maintained and to make best practice recommendations to staff to benefit people who lived at the home. We saw the importance and the meaning of dignity had also been discussed in one to one meetings between staff and their manager which included raising the awareness of dignity which was linked to people having control and choice over their life.

Good

Is the service responsive?

Our findings

People told us the staff were attentive and were available when they needed them. One person said, "If I press my buzzer, they (staff) come quickly." We saw this happened throughout our visit. Another person described the laundry service provided in the home as 'excellent'. They explained it was very important to them that their clothing was carefully washed, ironed and returned to them. They said, "The laundry runs like clockwork, I am very pleased."

A relative felt confident the staff were responsive to their family member's needs. They explained a staff member had noticed their relative had been more confused than usual and in response to this had arranged for the GP to visit who identified an infection and prescribed antibiotics. They said, "After a few days they were back to their normal self, it was a weight off my mind." Another told us their relative really enjoyed watching sport on television. They informed us the home had purchased Sky television which meant their relative could continue watch their favourite sports. We saw this person choose to watch a cricket match on a large television screen in the cinema room. We asked the person if they were enjoying the match. They responded by smiling and they put their thumb up in the air.

We saw throughout our visit staff responded quickly to people's request for assistance. For example, one person could not locate their reading glasses. A staff member helped them to locate them. The person said, "That's a relief, I am as blind as a bat without my specs."

There was a robust referrals and admissions process in place to ensure that people could be appropriately supported at the home. The deputy manager explained this process was important because they needed to check the home was the right person to live. They said, "When we assess we think…. who already lives here, will they fit in, and can we give them the care they need?" Some people told us they had had the opportunity to visit and look around the home before they had decided to move in.

We looked at a selection of peoples care plans and most provided personalised information about their preferred routines, likes and dislikes. This helped the staff to provide person centred care in accordance with people's wishes and preferences. The new provider was in the process of implementing a new care plan document which would be written from the person's perspective. Training to ensure staff had the skills they needed to write the new care plans had begun to take place. Staff spoke positively about the new care plans and one said, "I think the Avery care plans are better, they are less clinical and more person centred." The regional manager explained that when people's care plans were reviewed the information would be transferred onto the new paperwork.

Care plans we looked at had been reviewed in the month prior to our visit. The information reflected people's needs which helped the staff to provide the care people needed. Staff told us if a person's needs changed they would tell the manager or a nurse and the care plan was then rewritten.

People and their relatives worked in partnership with the staff to plan their care which meant staff had an in-depth knowledge of people's preferences and support needs. One person said, "Yes, they (staff) asked all

about my care and wrote it all down." A relative told us they had had a meeting with the nurse to plan their relatives care. They said, "It's a good thing they involve me, I know all of the important details as [Person] can't tell them."

A keyworker system was in place. This meant people were supported consistently by a named staff member. People and their relatives knew who their keyworkers were. One explained a photograph of their keyworker was displayed on the back of their bedroom door and this gently reminded them who their key worker was.

Memory boxes were located on the wall outside of people's rooms which contained photographs and things that the person enjoyed. For example, one person used to be a fireman and their memory box contained a small replica model of a fire engine. The boxes served two purposes. One was to help people to locate their bedrooms so they were not reliant on staff to help them and the other was for them to know what people liked so they could 'spark up conversations'. A staff member said, "The boxes are great, especially when new people move it. It helps us and it helps them to remember who they are."

Handover meetings took place at the beginning of each shift as the staff on duty changed. We attended this meeting during our visit and the health and well- being of each person was discussed. A '10 at 10 meeting' also took place each day. During the meeting the heads of department within the home discussed issues and shared information about the service. Together these meetings ensured staff had up to date information which meant people received the care and support they needed.

Overall, people spoke positively about the social activities that were available to them. Comments included, "I enjoy the pottery classes and outside entertainers such as the singers." "'It's a bit isolated at times, as the floors keep to themselves unless there is outside entertainment when we all get together, I would like more activities to get involved with'. And, "There is plenty to keep me busy."

The activities coordinator spoke passionately about providing meaningful activities to people to keep them stimulated and occupied. They had had the opportunity to visit other homes to gather ideas to improve the activities to benefit people at the home. We saw a flexible activities programme was on display in communal areas of the home and each morning they did the 'daily sparkle'. They explained the 'daily sparkle' was a simple but effective way to engage people in conversations. For example, talking about the latest news headlines and solving crossword puzzles together. A variety of activities took place during our visit which included a 'gents group' and a pamper session.

We were informed 'Oomph' was being implemented at the home. Oomph is an award-winning social enterprise which provides fun, inclusive and effective exercise classes for older adults. Staff told us the overall aim of Oomph was to make residents happier, healthier and improve their well-being.

It was a warm and sunny day when we visited. People and staff chose to spend time together in the garden and enclosed balcony areas of the home on the first floor. One person said, "It's good to feel the sun on my face." The regional manager explained in the near future the provider planned to purchase raised flower beds so people had the opportunity to be involved in planting flowers and vegetables. There were also several small communal areas and a relative said, "The quieter areas are great for [person] they can sometimes get a bit anxious if too many people are around them." Staff told us having quieter communal areas was beneficial to some peoples well-being.

'Old time' photographs of the local area were on display in the corridors of the home. Staff told us the picture's helped them to 'spark up' conversations as many people had previously lived locally to the home. One said, "It's great for some people as it helps them to remember what the area once looked like."

People and their relatives were invited to attend regular meetings so they could make suggestions about how the home was run. The dates of these meetings were displayed in communal areas throughout the home. The frequency of meetings had been increased from monthly to weekly by the new provider to communicate their future plans for the home and to gather people's feedback on the service they received.

People and their relatives knew who to speak with if they had any concerns or complaints about their care and all felt their views were listened to and acted upon. Comments included. "If I had a complaint I would tell the manager." And, "If I had to complain I would tell the nurse." The provider's complaints procedure was displayed in the entrance hall and within people's bedrooms. It included information about external organisations people could approach if they were not happy with how their complaint had been responded to.

We looked at the complaints file maintained by the management team. We saw four complaints had been recorded in the 12 months prior to our visit. All had been resolved to the complainant's satisfaction. The home had also received 27 compliments. Comments included, 'It is beautifully decorated and kept very clean,' and 'a high standard of professionalism'.

Good

Is the service well-led?

Our findings

A few weeks before our visit the provider of the home had changed. We spoke with people, their relatives and staff about the management of the home. People told us they were happy living at the home and they were satisfied with how the home was run. They confirmed the recent management changes had not affected them. One said, "It's the same really, I know (deputy manager)." A relative told us, "I know who the managers are. They are very pleasant and approachable." They were looking forward to meeting the new manager when they started work at the home.

Staff enjoyed working at the home, there was an open culture and they felt supported by their managers. Some staff told us they were looking forward to working for the new provider. One said, "With the changes, the care is the same, we try to carry on as normal as we can. As long as the new manager is supportive it will be fine." Another told us, "I think it will be good for everyone." However, other staff felt apprehensive about the changes. Comments included, "The previous company was good, I hope the culture stays the same, they were kind to residents and staff." "We are in transition now and a bit apprehensive, I hope it stays the same." And, "I hope nothing changes too much, it doesn't need to."

We spoke with regional manager about this and they were aware some staff felt apprehensive. Records of recent staff meetings showed the future leadership at the home had been discussed. Staff had had the opportunity to ask questions which had made them feel supported and involved. One said, "After the meeting I felt better about everything."

The regional manager told us the provider, "Would not make changes for changes sake. We are not going to fix it if it's not broke." They assured us any changes such as; new care plan paperwork would be introduced slowly so it did not overwhelm the staff team. A clear transition plan was in place to manage change and progress was being continually monitored. Representatives of the provider had already met with the local authority to begin to build relationships and to introduce themselves as the homes senior managers.

At the time of our visit the registered manager had recently left. An experienced new manager had been recruited and they were in the process of registering with the Care Quality Commission. They were completing their induction and planned to start working at the home at the end of June 2017. The new manager would be supported by the deputy manager who had been working at the home for over 12 months. The provider's regional support manager was offering on-going support to embed the providers values and ways of working.

The regional manager had been working at the home nearly every day since the provider had taken over. They were working closely with the deputy manager who was responsible for leadership at the home until the new manager started work. The deputy manager felt supported. They told us, "Things are fine at the moment; I am looking forward to moving forward and the new manager starting."

The managers had a 'hands on' approach and were a visible presence at the home, operating an 'open door' policy, and we saw they spent time sitting and talking with people during our visit. This approach ensured

managers had an overview of how staff were providing care and support to people and gave them the opportunity to speak with people and staff.

We saw good examples of team work and communication between the staff and their managers during our visit. Staff confidently approached managers who provided them with support and advice. We looked at communication processes which included handover records. This showed us that staff could pass on information and receive important messages.

The provider had a staff awards scheme that recognised contributions from staff, and recognised outstanding skills in caring for people at the home. This showed the provider had a way of identifying good care and encouraging all staff to develop their skills to improve the service.

The deputy manager told us they were committed to providing good quality dementia care to people by continually developing their knowledge and skills. They worked in partnership with the local CCG and were part of the Dementia Action Alliance group which aims to build a dementia friendly community. A Dementia Friendly community is somewhere where people with Dementia are understood, respected and supported, and confident they can contribute to community life. The deputy manager said, "I have shared my knowledge with the staff to raise awareness."

Staff told us their work performance was monitored through supervision meetings. At the meetings staff had the opportunity to discuss their training or development needs. One said, "We have meetings every couple of months, they are helpful." They told us the meetings made them feel motivated to do a good job because they knew what was expected of them within their role.

There were effective systems to monitor and review the quality of the home. There was a strong emphasis on continually looking for ways to improve the service people received, and also looking at learning if care fell below the standards the provider expected. Audits and checks such as, safe handling of medicines took place and were effective to benefit the people who lived at the home. These audits were carried out to ensure if any areas of improvement were identified they could be addressed quickly. Completed audits were shared with the provider who used a 'quality indicator system' to assess and evaluate the service people received. Action plans were implemented if improvements were required. The provider had also increased the frequency of clinical risk meetings to weekly instead of monthly to gain an overview of any risks and drive forward improvements.

The management team also welcomed external audits from health professionals. They explained the audits were a good opportunity to highlight areas which could make improvements. For example, an infection prevention audit had been completed in September 2016 by the CCG. The report identified minor improvements were required. Immediate action plans had been implemented and continually reviewed to ensure sufficient progress was made.

People and their relatives were invited to attend regular meetings so they could make suggestions about how the home was run. The managers promoted an open culture by encouraging feedback from people and their relatives. We were made aware that the provider planned to send quality questionnaires to people gather their feedback immediately after our visit. The feedback wold be analysed and an action plan would be implemented if improvements were required.

The home had recently been rated on a care comparison website as one of the best care homes in the area, with an average rating of 9.7/10. This comprised of 12 reviews made up from people who used the service and their relatives over a 12 month period. The deputy manager told us how they encouraged people and

their relatives to use the website to rate their experiences, whether this was positive or negative.

The managers told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly and of being able to monitor the information about the home.