St John's Winchester Charity

Moorside

Inspection report

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Date of inspection visit:
25 July 2016
26 July 2016

Date of publication:
31 October 2016

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 25 and 26 July 2016 and was unannounced. Moorside is a care home registered to provide accommodation for up to 27 older people who require nursing or personal care and the treatment of disorder, disease or injury. The home provides care for people living with dementia and includes a day centre facility and short stay respite care for people living in the community. Moorside is located close to the centre of Winchester and the accommodation is arranged into three 'clusters' for up to eight people. Each cluster has a separate dining room, lounge and kitchenette. This provides people with a small and homely environment within the larger home. There is an attractive garden to the rear of the home which backs onto the river and a large day centre and activities room on the ground floor. At the time of our inspection there were 25 people living in the service.

A registered manager was in post at the time of our inspection. 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' living at Moorside. Staff had completed training in safeguarding people from abuse and understood how to report their concerns. The registered manager acted on concerns to keep people safe and used learning from incidents to prevent a reoccurrence. People were cared for safely.

People were supported to be as independent as possible and risks to their health and wellbeing were assessed. This included risks to people from falls and behaviours which may challenge others. Staff understood how to support people to manage risks and acted to prevent people from experiencing harm.

Staffing levels were sufficient to meet people's needs. People were supported by nursing and care staff on each cluster to ensure the appropriate mix of staff skills were available to meet their needs. We observed staff had enough time to spend with people to meet their needs in a patient and meaningful way. The provider carried out the appropriate pre-employment checks to confirm people were supported by staff who were suitable for their role.

People's medicines were managed safely. Nursing staff administered people medicines and were regularly assessed as competent to do so by the deputy matron. When a medication error had occurred the registered manager reviewed procedures with the nursing staff to enable them to learn from the incident. Prompt action was taken with staff to rectify some recording errors we found and a procedure put in place to prevent a reoccurrence. Guidance was available and used by staff to ensure people had medicines prescribed 'as required' when they needed them. This included pain relief when people may not be able to verbalise their need for this.

Staff completed an induction and on-going training in their role to enable them to meet people's needs effectively. Staff communicated well during daily handovers to keep each other informed about changes to

people's needs, their progress and any concerns. The registered manager attended handover and facilitated discussion to help staff think through their responses to meeting people's needs. Staff shared their skills and experience to support each other's learning and provide effective care for the people they supported.

Decisions about people's care when they lacked mental capacity were guided by the principles of the Mental Capacity Act 2005 (MCA). 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. Not all decisions made in people's best interests had been recorded; however the registered manager took immediate steps to implement this process during our inspection. We found people's rights under the MCA were protected.

People told us the food was good and they were satisfied with the choices available to them. We observed that people received the appropriate support from staff to eat when this was required. People living with dementia can benefit from a flexible approach to eating because they may not always choose to eat at mealtimes. We saw snacks were available to people throughout the day and staff used opportunities as they presented to encourage people to eat. Risks to people from malnutrition or other risks associated with eating such as difficulties in swallowing were assessed. Guidance was in place and acted on to ensure these risks were managed appropriately to support people with their eating and drinking needs.

People had access to a range of healthcare professionals including; nurses on site, GP's tissue viability nurses, speech and language therapists (SALT's), community mental health teams, physiotherapists, dentists and opticians. People received appropriate care to meet their specific healthcare needs.

People told us staff were caring and compassionate. We observed that staff knew, understood and responded to people in a caring way. Staff had information available to them about people likes, dislikes and history and staff were able to describe these to us. People told us they were involved in making decisions and we saw staff enabled people to participate in decisions about their day to day care.

People were treated with dignity and respect by staff. People and their relatives were cared for and comforted when people were at the end of their lives. A person's family told us how well they and their relative had been cared for in these circumstances. People's decisions for their end of life care were recorded, known by staff and respected.

Care and treatment plans were personalised. The examples seen were thorough and reflected people's needs and choices. People's needs were reviewed regularly and as required. Monitoring records were kept to enable staff to evaluate people's needs and adjust their care accordingly. For example; health observations, weight and bowel monitoring. People received care in line with their assessed needs.

The needs of people living with dementia were central to the design and delivery of care and treatment at Moorside. This included; the environment, activities, staff skills and staff behaviours. The registered manager and staff were committed to providing care that was responsive to people's needs. Their approach was informed by best practice dementia themed research and organisations leading in dementia care. People were engaged in meaningful interaction with staff and enjoyed a variety of individual and group activities supported by dedicated activities staff and volunteers. People living with dementia received person-centred care that promoted their well-being.

The registered manager provided positive leadership aimed at creating an open and empowering culture within the home. Staff spoke positively about the registered manager and told us they 'led by example'. Staff

were supported in their learning and development and to understand their roles and responsibilities. Staff told us they were well supported by the management team.

There was a positive atmosphere in the home and comments from people and their relatives about the home included 'homely, welcoming and comfortable with excellent caring and kind staff'. Feedback from people and their relatives was sought through an annual questionnaire and regular residents and relatives meetings. Feedback was acted on for example; to provide activities of interest to people and to improve the quality of care delivered. 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.

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 protecting people from the risk of harm.

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.

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 supervision of their work. People received their care from staff that were appropriately supported 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 varied and nutritious diet which reflected their preferences and dietary needs. People at risk of poor nutrition were supported appropriately to prevent risks to their health and wellbeing.

People were supported by staff to access health care services as required and their healthcare needs were met promptly.

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 decisions and wishes about their preferences for end of life care were known and respected by 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. People's care and treatment needs were reviewed and evaluated to ensure they received appropriate care and treatment.

People living with dementia received person centred care in an environment that promoted their wellbeing. People's activity and social needs were met through a range of group based and individual activities provided by a team of activity staff, care staff and volunteers.

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 was a positive open and empowering culture in the home. The registered manager encouraged a learning and development approach with staff based on best practice to provide a good quality service for the people they supported.

People, their relatives and staff spoke positively about the management and leadership of the service. Staff were supported to understand their responsibilities and to be accountable for their actions.

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

Moorside

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 25 and 26 July 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we spoke with a team manager from adult services in Winchester to gather their views on the service. We reviewed the information we held about the service, which included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We requested a Provider Information Return (PIR) and this was completed by the provider before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We carried out observations on each of the three clusters to see how people were being cared for and we observed lunchtimes. During the inspection we spoke with five people and three people's relatives. We reviewed recently completed written feedback on the quality of the service from four people and five people's relatives. We spoke with the registered manager, the assistant director, deputy matron, the chef, two activities staff, three care staff, a volunteer and two nurses.

We reviewed records which included four people's care plans and monitoring records relating to people's care, people's medicine administration records, three staff recruitment and supervision records and records relating to the management of the service. These included staff training records, quality assurance records, the annual development plan, policies and procedures. The record of complaints, accident and incident reports and staffing rotas for the period 30 May to 17 July 2016.

This service was last inspected on 6 December 2013 and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe at Moorside a person said "I feel safe and there are no difficulties" and another person said "Yes I feel safe". Records showed staff had completed training in safeguarding and had access to information and guidance about how to report any concerns. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. For example; staff we spoke demonstrated they understood the signs of abuse and how to act on any concerns. A staff member told us about a concern they had raised and how this had been dealt with promptly by the registered manager and we saw an investigation had taken place. Staff told us they were confident the registered manager and deputy manager would act on any concerns. We spoke with the registered manager about safeguarding incidents and they evidenced how they had taken the appropriate actions and used information from safeguarding concerns to identify learning for the staff team and drive improvements to the service people experienced. People were cared for safely by staff who understood how to protect them from abuse.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. People's care plans included individualised risk assessments in relation to their risks from; falls, malnutrition, pressure ulcers and environmental risks. Guidance was also included in people's care plans for staff on the problems people may experience if their needs were not met. For example; if a person's communication needs were not met this could place them or others at risk of behaviours that may challenge others, or if their personal care needs were not met this could lead to the risk of self-neglect. Risk assessments included guidance to support people to remain as independent as possible. For example a person's risk assessment for making a cup of tea included encouraging the person to pour the milk. However, the pouring of hot tea was to be carried out by staff. People were supported by staff who had guidance and information on how to support them safely.

Staff we spoke with were knowledgeable about people risks and how to support them safely. For example a member of staff told us about how they supported a person who could display behaviour that challenged others. They said "(person) is getting physically aggressive towards care staff so (person) is on a behaviour chart. I speak to (person) calmly and they are fine I have had challenging behaviour training. It's how you present and respond. That helps massively". Another staff member told us about a person who was at risk of falls and why and how they were monitored to encourage their independence and protect their safety. We saw that people were sensitively accompanied by staff when they were at risk of falls or disorientation and staff spoke calmly with people at risk of behaviours that challenged others. A person enjoyed travelling in the lift and staff had identified they were at risk of harm because they sometimes attacked their reflection in the mirrored wall of the lift. The mirror was covered so that the person could continue to enjoy using the lift and was protected from harm. People were supported by staff to manage the risks to their safety and well-being.

When people had a fall, a protocol was in place to ensure the person was monitored by staff post fall and any injuries were identified on a body map. Information was sent to their GP and medical treatment was sought as necessary. People's falls risk assessments were reviewed and updated to ensure actions identified to reduce the risk of falls remained appropriate or were amended as necessary. The registered manager

monitored falls to look for developing trends in order to protect people from the risk of falls.

The home was arranged into three 'clusters' accommodating a maximum of eight people in each. One nurse and three care staff worked in each cluster, at weekends this was reduced to two nurses across the home in total. People and staff told us the staffing level was sufficient to meet people's needs. We reviewed the staffing rotas for the period 30 May – 17 July 2016 and saw the staffing levels were as described. A person said "OK staff numbers, all the staff are very good I haven't come across needing one and they weren't there". A nurse said "staffing levels are good and that enables you to give good care". Staff vacancies were being recruited to. Existing staff or the provider's own bank staff were used wherever possible to cover any gaps in the rota due to vacancy or sickness. Agency staff were used as a last resort so that people experienced a continuity of care from existing and familiar staff. Other staff resources included; activities staff, domestic and kitchen staff and administration staff. People were supported by sufficiently skilled and experienced staff to meet their needs safely.

Safe recruitment procedures were completed to ensure people were assisted by staff who were of suitable character. The provider requested full application forms with details of past employment history and any gaps in employment. References from previous employers evidenced good conduct in previous health and social care employment. A Disclosure and Barring Service (DBS) check was completed, the DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. 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 or cautions on their registration to practice. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Procedures were in place and followed to ensure that people's medicines were ordered and supplied in a timely manner and disposed of appropriately. Nurses administered people's medicines and had completed safe medicine administration training and had their competency assessed by the deputy manager. Competency assessments were repeated annually or as required. We observed people being given their medicines and saw that staff followed the correct procedures to ensure peoples' medicines were administered safely. Arrangements were in place to receive and dispose of medicines safely.

During our inspection the registered manager held a meeting with clinical staff to discuss a recent medicine error and share learning from this event to prevent a reoccurrence. As a result of this meeting, improvement actions were identified and implemented such as; staff to monitor each other on the completion of people's medicine administration records (MAR) and sign as checked following each shift. These records are completed when people take their medicines and when the medicine is not taken and the reason why. This would prevent medicine errors from going undetected and ensure peoples medicines were managed safely.

People's medicine administration records (MAR's) included a photograph, their name date of birth, details of their GP, and any allergies. Staff administering medicines used codes to explain non-administration of medicines. For example if a person had refused their medicines or if they were in hospital. An explanation the reason why the code applied was recorded on the back of the MAR. We found that the codes were not always used consistently and were not always fully defined. It is important to identify the correct reason why a medicine has not been taken so the appropriate action can be taken to address this. We raised this with the deputy manager who arranged to address this immediately with the relevant staff. The new checks the registered manager put in place during our inspection, assured us errors in recording would be identified and acted on promptly.

People who were prescribed medicines to be taken 'as required' had protocols in place to guide staff on

their safe use. For example; if they were prescribed medicines to calm them if they became agitated or medicines to alleviate constipation. An assessment tool was in use to identify when a person, who may not be able to clearly articulate their needs, was in pain. This guided staff on when to give 'as required' medicines prescribed for pain relief. We observed a nurse administering medicines to a person who was unable to express their need verbally. The nurse explained each medicine and checked for the person's non-verbal consent. The nurse then assessed that the person was experiencing pain due to their facial expression. They offered pain relief and the person agreed non-verbally. People received their medicines when required.

Good

Is the service effective?

Our findings

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff new to care completed the Care Certificate which sets out the learning outcomes, competences and standards of care that care workers are expected to achieve. New staff also worked alongside more experienced staff to learn about people's needs prior to working alone. Records showed that most staff had completed the training identified as mandatory by the provider. This included training in subjects such as; safeguarding, moving and positioning, infection control, dementia care, the Mental Capacity Act (2005) and food hygiene. People needs were met by suitably trained staff.

We saw the registered manager used a learning and development approach with staff in their day to day interactions, as well as in response to incidents in the home. We observed they attended the morning handover with staff in each cluster to monitor what was happening in the home and to provide guidance for staff on people's care and treatment. For example; we observed the registered manager facilitated staff to think through helpful responses to a person with behaviours that may challenge others. During our inspection the registered manager facilitated a meeting with nursing staff to investigate and identify learning from an incident. The meeting was structured to support staff to identify all the factors which influenced the incident so improvements could be identified and made effectively. We observed that staff were knowledgeable about the people they supported and shared their knowledge with each other to ensure people received effective care and treatment.

A nurse told us how they used their background and specific training in mental health to support their colleagues learning. They told us how other nursing staff also shared their skills and experience to enhance the team's knowledge for example in wound care. Staff were encouraged to develop their skills and interests to achieve positive outcomes for people. For example a nurse had piloted a project using a seasonal affective disorder (SAD) lamp to test if this improved the symptoms of a person living with dementia and depression. SAD is related to changes in people's moods caused by seasonal changes. The pilot had healthcare professional approval and consent from the person and their representative. They told us there had been 'good results' so far for the person. Staff were completing a programme of dementia training that included competency checks following each module. The registered manager told us this was important to enable them to check what was taught was delivered and to "build staff confidence".

Staff told us they were 'well supported' by the registered manager and senior staff. One staff member said "I have been supported very well in work and in my personal needs and the nurses have helped me a lot I love working here." Records showed that formal processes such as supervision and annual appraisals were completed or planned. Staff had access to continuing and professional development, such as health and social care qualifications. Staff told us, and records confirmed, they were supported with their development needs. People were supported by staff who received support and professional development in their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

A process was followed prior to an application being made on behalf of a person to deprive them of their liberty that included a mental capacity assessment. The process in use included a best interest decision making tool. Records showed the best interest tool had not always been completed. However, during our inspection the registered manager implemented this to ensure the correct procedure was followed prior to an application being made. A best interest decision making process was important to evidence that a specific decision taken on behalf of a person who lacked capacity was in their best interests and as least restrictive as possible, in accordance with the MCA.

Peoples' care plans were underpinned by a mental capacity assessment to identify whether they were able to consent to their planned care and treatment. When people lacked the capacity to give their consent, decisions were made in their best interest and these were identified throughout their care plans. This included the use of restrictions such as; bed rails and lap belts. People's relatives or legal representatives were involved in making decisions in people's best interests and this was recorded. Staff had completed training in the MCA and DoLS. Staff demonstrated a good understanding of the principles of the MCA and how to support people to make their own decisions wherever possible. For example a staff member said "people can make unwise decisions, you can give your opinion but if they want to do it they can. For example; if a person chooses to wander at night, or not to eat we let them, we encourage them to eat snacks we keep in the kitchen such as; biscuit's yogurts and sandwiches". Records showed that a person who chose to walk around at night and not to always sleep in their bed was able to do so. A nurse said "MCA and DoLS are about respecting people's human rights and the least restrictive options. For example allowing (person) to be with people and let them be and ensure you know where they are, we don't restrain them." We saw people were able to move about areas of the home without restriction. People were patiently and appropriately supported by staff in their decisions and choices.

People were complimentary about the food provided in the home. A person told us "The food is always nice; you get at least two and sometimes three choices." People told us that snacks were available when wanted and one person said "If you don't want a sandwich there is always nice biscuits I've had three today already!" We observed people eating at times throughout the day and not just at meal times. This is important for people living with dementia who may want to eat outside of fixed mealtimes and benefit from a flexible approach to eating. We observed lunch time in the home and saw it was a relaxed and social experience. Staff ate their lunch with people to encourage people to eat. We observed that staff were visibly pleased when people who did not always eat well had enjoyed and finished their meals. The food appeared appetising and people told us they were enjoying their meals.

Some people required staff assistance to eat and we saw this was provided by staff who were attentive and encouraging. When people required their food to be served in a safe consistency for their needs this was assessed by a Speech and Language Therapist (SALT) and we saw the guidance provided by them was followed by staff. A safe consistency could be pureed or soft foods when people were assessed as at risk of choking or had swallowing difficulties. Staff were knowledgeable about people's support needs when eating. A staff member told us "(person) struggles to open their mouth so you assist using a plastic spoon

not to damage their teeth. She loves fruit and sweet things – we try different things she mostly eats her puddings". We observed the person being assisted using a plastic spoon.

Risks to people from poor nutrition were individually assessed using a recognised malnutrition tool. People's weights were regularly recorded and monitored monthly. When people were identified as needing to gain weight the chef was informed and they told us how they prepared higher calorie foods such as smoothies to support people to maintain a healthy weight. The chef spoke to people and their relatives about their food preferences, dislikes and needs and this information was recorded and updated as required. Information about peoples preferred drinks and food was also available in the kitchenettes as guidance for staff on each cluster. Feedback was also sought from each cluster following mealtimes to help the chef identify what people enjoyed.

People were encouraged by staff to take fluids throughout the day. We observed staff were reminded of the importance of good hydration during handover. People had drinks to hand and were frequently asked if they wanted a hot or cold drink. A person told us "you can always get a drink when you want."

People were supported to maintain their health by nursing staff on site and had access to other health care practitioners as needed. The service worked with; GPs, tissue viability nurses, SALT's, community mental health teams, physiotherapists, dentists, chiropodist and opticians to ensure people's health needs were met appropriately. Staff implemented their guidance. For example, people with specific conditions such as diabetes and Parkinson's received care in line with their assessed needs. This included daily monitoring of specific symptoms, and administering medicines that were time specific. Staff understood the risks to people from these conditions and described the actions they took to mitigate these. Records confirmed people had attended appointments with other healthcare services and were supported to maintain good health.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People told us staff were caring and compassionate. A person said "They (staff) give you anything you want" and another person said "They are kind and staff take time to help you, it's very nice". A staff member said "We have time to be with people and take our time to talk to them and say what we are going to do. We don't only look at the resident but take on the whole family and if you talk to the family you get to know the person you are looking after".

People received care and support from staff who had got to know them well. It was evident from our observations and the conversations we had with staff that they knew, understood and responded to people in a caring way. Staff told us about people's interests and history and how people communicated their needs. For example; a staff member told us about a person and said "oh they are a garden person, they used to dance and sing, and they were an office worker and made a lot of cakes". They went on to describe how they knew when the person was upset or in pain, their family relationships and their personal preferences for their appearance. A staff member said "We read the life stories, they are interesting and this tells me about their family, past, and employment." We saw information on people's life history included pictures and details of interests past and current, their personal history, for example where they lived, their pets, children, grandchildren and likes and dislikes. A Staff member told us "we never stop learning about people" and a person said "The staff are polite and respectful, they are always nice here and they always know who you are".

People's care was not rushed enabling staff to spend quality time with them. We observed interactions between staff and people that were patient and attentive. For example we observed a staff member sitting and chatting with a person. The staff member was attentive to the person's comfort, encouraged them to eat a snack and to participate in an activity, the person appeared relaxed and happy and they were clearly enjoying the companionship offered by the staff member. When people achieved or enjoyed an experience staff celebrated this. For example; a person who had been unsettled attended a church service in the home and reported after this "my heart feels light". The staff member was visibly pleased the person had been able to stay in the service and had benefited from the experience. Similarly when people ate their meals or participated in activities staff reported these positive experiences to each other so that people's care could be delivered in line with their preferences to support positive outcomes for people.

Staff told us that people were encouraged to be as independent as possible and their decisions were respected. A staff member said "I'm doing what is in their best interests and I help them to be independent, that is massive for me. It's easy to make someone a cup of tea but I will get them to use the tea pot if they can and butter their own toast." We observed that people were not rushed in the mornings, people decided when to get up and have breakfast and there was a clam and unhurried atmosphere. A person said "its good care, they are kind and include me in everything. I won't have no men (male care staff) and they show me things and I can say no. I like it here." We observed staff giving people choices and seeking their consent before supporting them with care and activities. For example, we observed a person refused a bath, the care staff then offered a bed bath which was accepted by the person.

People's dignity was respected by staff. We observed a staff member raised concerns in handover about comments made by a relative in front of a person which the staff member considered disrespectful. The staff member shared their concerns with the team and explained how they had responded to promote the person's dignity. The registered manager told us and records confirmed that staff brought their concerns about behaviours which may be experienced by people as disrespectful to their attention and they acted on these. The registered manager said they "watched carefully the skills, body language and expressions that staff use with people" to check staff engaged positively with people. We observed staff used people's preferred names and spoke with them in a kind and patient manner. If people required support with personal care tasks this was carried out discreetly to ensure their dignity was maintained. Staff told us how they supported people to ensure their privacy and dignity were respected when providing personal care and we saw door signs were used to ensure people's privacy was respected in these circumstances.

People and their relatives were given support when making decisions about their preferences for end of life care. People's care plans included information about their wishes and advance decisions. Staff were attentive to the visiting family of people on end of life care. The relative of a person receiving end of life care told us staff had cared for the person "very well" and been very supportive to them during this time and said "You cannot fault the care." The family of a person had written to say 'how wonderful, caring and loving all of you have looked after our mum….we all became one big family and we will always be grateful to every one of you." A staff member told us "I look forward to coming here every single day, you are not just looking after the people, you are looking after the relatives as well, as the majority are grieving and they need a lot of support" People and their relatives were supported with care and compassion at the end of people's lives.

Good

Is the service responsive?

Our findings

Care plans were personalised and detailed the individual aims and objectives of the care delivered to each person. This provided individualised guidance to staff on how to meet people's needs and provide person centred care and treatment. Speaking with staff they were able to explain how they supported people in line with their care plans. For example; how they responded to people who had behaviours that may challenge others, the support people required to make decisions and how they preferred to be supported with their personal care. Care plans were reviewed and updated monthly or as required and people's relatives were invited to be involved in reviews. We saw that people's relatives had contributed to the development of their care plans, including people's likes, dislikes and histories. This was important because some people living with dementia may not be able to communicate their needs and preferences and relied on other people who knew them well to ensure their views and preferences were known and acted on.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Daily communication records described how people spent their time and any concerns that had arisen. Other monitoring records were completed to enable staff to evaluate people's needs such as their; weight, bowel movements, personal care records and general health observations such as temperature and blood pressure. We saw that people's care plans were updated when their needs changed for example when their continence support needs had changed or the number of staff required to support them had changed. This meant that people's changing care needs were communicated and recorded by staff to ensure people received appropriate care and treatment.

It was evident that the registered manger and the staff were committed to providing care that was responsive to people's needs. We found the registered manager and staff demonstrated a thoughtful and proactive approach to meeting the needs of people living with dementia. For example; we spoke with a staff member who showed commitment and concern about finding ways of communicating with a person living with dementia who had behaviours that challenged others, in order to find helpful and meaningful responses to their needs. We observed staff discussed people's behaviours with each other to share information and find approaches that supported people. This included what people liked and disliked and what non-verbal communication people displayed and what this could mean. For example; staff described how a person's non-verbal behaviour meant 'no'. What people enjoyed, such as looking at photos from their previous travels and events that had surprised staff such as a person enjoying a bath which they had previously rejected.

The environment was designed to promote meaningful interaction between the people living there. For example; the home was arranged into small clusters of eight people to provide a 'homely' feel. This enabled people to become familiar with their surroundings and a smaller group of other people and staff. This can be helpful for people living with dementia who may become confused and disorientated by changes. Each cluster had a fire place and hearth which the registered manager told us had been installed to provide a focal point and create a homely atmosphere to encourage interaction between people. One person told us how they liked the sideboard on their cluster and said "it's just as much as I would have at home. There is a

sideboard cupboard with bits and bobs and you can borrow things". We observed people sitting together in communal areas enjoying the company of other people, staff and volunteers. Contrast in colour in the environment and objects can be helpful for people living with dementia when they experience orientation and perception difficulties. At the time of our inspection the bathrooms were being upgraded and decorated using 'dementia friendly' colours. Clusters were colour coded and equipment such as blue plates were used to provide a contrast with food. For example; white food cannot be clearly seen on white plates. The registered manager told us "this helps encourage people with eating and the plates are shaped to enable people to scoop." There was a small cosy/quiet corner for people to sit if they wished to be alone or to entertain their visitors. A sensory room was available for people to provide gentle stimulation using sight, sound and touch stimuli which can help people living with dementia relieve stress and promote positive feelings. People living with dementia were supported in an environment designed to meet their needs.

We noted that music was played on each cluster to promote a relaxed atmosphere. Whilst TV was available the registered manager explained this was not put on routinely but when requested to avoid a reliance on passive activities such as TV watching. Each cluster had an activities box which contained resources to provide activities of specific interest to the people living on that cluster. The resources were designed to be used spontaneously with people when appropriate such as massage accessories. This enabled staff to respond to people's activity needs as and when required rather than solely in a planned way. We observed staff and volunteers proactively used opportunities to engage with people. For example; we observed a volunteer spontaneously begin a 'rhyming slang' quiz with a person from London who clearly enjoyed this whilst it was also helpful to stimulate their memory. We saw the activities worker initiate a conversation with a person about the daily newspaper they were reading. They went on to enjoy some lively conversation together about the person's previous employment linked to the story in the paper. Another activities worker spent some time with people singing along to songs people know from the past. People were encouraged to join in with instruments, including one person with their guitar. One person, who had been very confused in conversation joined in with the singing, was word perfect and fully engaged. Activity staff explained how they facilitated group activities and spent time with people on a one to one basis to meet their individual needs. A staff member said "just spending five to ten minutes with a person can make all the difference". People care plans included information about their 'top ten activity tips' such as; 'call me over I like to sit and chat, I like a cup of tea and a chocolate biscuit and to talk about family.' We saw this person was often invited to have tea and a chat with staff. People's individual social and activity needs were met.

Throughout our inspection we saw plenty of people enjoying the garden, eating outside and entertaining visitors. A person said "It was lovely, we went out in the garden and had our dinner the air is lovely near the river". Another person said "Lovely garden, I'm lucky really I quite like my life I'm quite happy here". The home included a 'day centre' which was used by people living in the home and people living in the community who attended on a daily basis. We observed people were asked if they wanted to join activities in the centre such as a faith service and were supported by staff and volunteers to do so if they wished. The day centre included a large screen for a cinema club, a 'tea corner' with tea cups, pots and cakes, a piano and a record player for musical events. The registered manager told us they were trying to "inspire activities" and a staff member said "Recently there has been a lot more focus on activities since the new registered manager came and staff here are motivated to enable people to participate and make use of the skills they've got". A residents meeting had been held in June 2016 where people were consulted on their ideas for future activities and whether they were happy living at Moorside. Records showed people had reported they were happy living at Moorside and had gone on to be consulted about their enjoyment of recent activities such as the summer fete. People were shown pictures of the event to stimulate their memory of it and enable them to give feedback. People had spoken about enjoying music activities, films, spending time in the garden and meeting people at the day centre and we saw these activities were provided.

The provider had a complaints procedure and this was displayed in the home. We saw that all concerns and complaints raised had been investigated and responded to appropriately in line with the provider's procedures. A system was in place for people to raise their complaints and concerns and this information was acted on.

Good

Is the service well-led?

Our findings

The registered manager was passionate about and committed to developing a positive and empowering culture within the home. We saw they had developed and outlined an approach that included the delivery of learning and development sessions on a range of topics for care and nursing staff. Underpinning their approach was the aim to create a 'culture of openness, increase knowledge and understanding of dementia care and generally elevate staff morale and wellbeing in the delivery of excellent person-centred care.' The registered manager planned to deliver these sessions over the coming months. Staff had confidence in the way the service was managed and told us the registered manager provided positive leadership. A staff member said "The registered manager is brilliant she is so good with the staff and always looks for ways to develop them." Another staff member said "The manager has a very good brain which is in the right place. She does things for residents comfort and peace of mind and comes and helps out. She likes to be hands on. They (manager) have changed a lot in the home environment and she goes head on for their (people's) comfort."

Staff told us they were well supported by the registered manager and deputy manager to understand their role and responsibilities. Staff were supported through training, supervision, appraisal and regular team meetings. Records showed staff discussed their learning and development needs as well as the requirements of their role in relation to people's needs. The registered manager used the information from investigations following incidents to enable staff to reflect and contribute to learning that improved the quality of the service people received. For example; preventing medication errors.

Minutes of a team meeting reflected positive feedback from staff about the registered manager's 'open door' approach to communication with staff. The registered manager had held a team building event which was aimed at encouraging staff understanding of each other to promote a positive team culture and appreciation of the diversity of staff backgrounds. The event focused on international homeland food and staff were invited to wear traditional costume. The registered manager told us the event had been positively received by staff who had requested further similarly themed occasions.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Feedback from the 2016 'annual quality of life survey for residents' showed the comments were positive and people and their relatives had reported their appreciation of; the caring approach of staff, the homely environment and the high standards of care people received. Relatives meetings were held and the feedback from these meetings was reported to staff and discussed in team meetings to drive improvements to the service. For example; staff had discussed dignity in care and lunch time supervision arising from relative's feedback. People and their relatives gave consistently good feedback about the service.

The registered manager was actively involved in developing partnerships with organisations to ensure the service was informed by current and best practice initiatives. For example; working with universities in the areas of research and dementia care and creating partnerships with key national organisations in the care of older people living with dementia. Through these partnerships the registered manager told us they were

developing 'dementia friendly champions' to model and encourage 'excellence' in caring for people living with dementia.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. This included regular internal audits such as; medicines management, care plans, housekeeping and personnel audits. Checks had been carried out at night and staff were required to register the hourly night time check on people by pressing the call bell. The registered managed checked the frequency of these calls to ensure people received their planned night time checks. A system was in place to identify any patterns or trends arising from an analysis of when people had falls to prevent reoccurring accidents. We reviewed the annual development plan for the home which included planned improvements for the; environment, staff training and quality assurances processes. We saw the plan had been updated with progress towards actions and some had been completed. For example; some improved care documentation had been introduced, improvements had been achieved in activity resources such as the sensory room and activity boxes on clusters and competency based dementia care training was being delivered. There were processes in place to enable the provider and registered manager to assess and monitor the quality of the service people received and to drive continuous improvement.