Parkview Gloucester Ltd

Park View Gloucester

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

At the last inspection on 24 and 25 October and 2 November 2017 we found two breaches of regulation. People's risk levels had not always been sufficiently assessed to fully minimise potential impact on people, quality monitoring systems had not always identified shortfalls in quality and risk management and robust staff recruitment procedures had not always been followed before staff worked with people.

We asked the provider to complete an action plan, which we received, to show us what they would do and by when, to meet Regulation 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to improve the overall rating of the service.

During this inspection, on 4 and 5 December 2018, we found people's risks were assessed and reassessed following changes in health and abilities. Staff started work after appropriate recruitment checks had been completed. Quality monitoring processes identified areas for improvement, which were being planned and completed. The breaches in regulation had been met.

The overall rating for the service has improved to 'Good'.

About the service:

•□Park View is a newly built, residential care home, which opened in 2016. It can provide personal and nursing care to 102 people. At the time of the inspection areas of the home were still being commissioned and 69 people in total received care. The home catered predominantly for people who were 65 years and over. Staff supported a wide range of needs which included people who required very little support, to people who were fully dependent and required nursing care. It also supported people who lived with to dementia.

People's experience of using this service:

•□The building and its adaptions helped people with diverse needs live safely and comfortably. The provider had identified that improvements were needed to the areas where people who lived with dementia were supported. We have made a recommendation about seeking current best practice in doing this.
•□Risks to people's health were identified, assessed and action taken to reduce these, or where possible, remove risk altogether.
•□The home's policies and procedures, staff knowledge and practices supported a zero tolerance of abuse or discrimination.
•□Some people commented, there needed to be more staff, however, we observed people receiving timely support and call bells were answered without delay.
•□Necessary recruitment checks were completed, before, staff started work at the home in order to protect people from those who may not be suitable to care for them. On-going staff recruitment ensured staff with

the right skills and knowledge were employed.
•□People's medicines were managed safely and people received help to take these.
•□Planned maintenance, servicing and cleaning arrangements kept the environment and equipment safe and clean.
•□Infection control arrangements reduced the risk of infection.
•□The building was secured but technology allowed people and designated relatives to come and go as they chose.
•□People's needs were assessed before they moved in and re-assessed at intervals, to ensure their care and treatment remained appropriate.
•□Staff received training and support to be able to manage people's needs, preferences and expectations.
•□People had good access to health and social care professionals when needed.
•□People had a choice in what they ate and drank and their nutritional wellbeing was supported.
•□People's care was planned with their involvement and, where appropriate, with the involvement of those who represented them. Care records were kept up to date so staff and visiting professionals had the right information about people's needs.
•□Care was delivered in a personalised way, respecting individual choice and preference.
•□People had access to supported activities and opportunities to socialise but some felt there was not enough. Action had been taken to support more personalised activities.
•□People were supported to retain skills and to be independent.
•□Staff were caring and compassionate towards people. They understood people's needs and had developed good relationships with them.
•□Staff supported those who mattered to people and family and friends were made welcome. Where appropriate, the involvement of people's relatives and others close to them, was encouraged and valued.
•□Staff worked with other professionals and agencies to ensure people's rights were upheld. Where needed senior staff advocated for people and ensured people had access to independent advocacy.
•□People's privacy and dignity during care was upheld and information about people's care and treatment was kept confidential and only discussed with appropriate persons. All care and treatment records were kept secure.
•□People diverse preferences were explored with them and staff aimed to support these and ensure these were respected. People were treated equally irrespective of disability, age, religion, culture, diverse personal relationships or sexual preference; as were those who mattered to people. The provider's policies and procedures and the managers' expectations supported this practice.
•□People's wishes and decisions at the end of their life were respected and met. There were arrangements in place to support a dignified and comfortable death.
•□People's consent was sought before care and treatment was provided. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
•□People, no longer able to give consent or make independent decisions, were protected. Where appropriate people's mental capacity was assessed and decisions made on a person's behalf, were made in their best interests. Appropriate representatives were included in this process.
•□Managers promoted an open, inclusive and empowering culture which supported effective communication between them, people, relatives, staff and visiting professionals. Managers were accessible and approachable.
•□Feedback from people, relatives, visiting professionals and staff had been welcomed and used for learning and improvement purposes.
•□Areas of dissatisfaction were proactively managed and complaints investigated and resolved where possible.

•□Quality monitoring systems led to action being identified and taken, which led to better and improved outcomes for people.
Rating at last inspection:

•□The last inspection report was published on 20 December 2017 and the services rating was 'Requires Improvement'.

Why we inspected:

•□This inspection was a scheduled inspection based on the previous rating.

Further information is in the detailed findings below.

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.

Improvements had been made to how people's risks were assessed and to the implementation of the provider's staff recruitment process in order to protect people.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

The home's environment provided comfortable, modern living for people with diverse needs. The home had been purpose built with additional adaptions to support these needs. The provider had identified that some improvements to how the first-floor environment was presented were needed so that it could better support the needs of people who lived with dementia.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in activities and social events. It had been recognised that activities needed to be more personalised to people's individual needs and preferences and action had been taken to address this.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Improvements had been made to the quality monitoring processes in order for necessary improvements to be sufficiently identified and acted on. A plan of on-going improvement was in place to further enhance people's quality of life and their opportunities.

Details are in our Well-Led findings below.

Park View Gloucester

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

•□This consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case caring for an elderly person.

Service and service type:

•□Park View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.
•□The service must have a registered manager. A manager who was registered with the CQC was in position. This means the manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

•□This inspection was unannounced.

What we did:

•□To help us plan the inspection, we reviewed all the information we held about the service. This included notifications forwarded to us by the provider about events they must legally inform us about and the

Provider Information Return (PIR); sent to us in October 2018. The PIR is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

• During a visit to the home we gathered information: we spoke with 10 people who used the service, five of whom lived with dementia and we spoke with three relatives. We spoke with nine members of staff and three Directors of the company. Staff included the registered manager, deputy manager, home services manager, the dementia lead, a unit lead, the clinical lead, a care leader, an activities co-ordinator and the head chef.

• We reviewed care records relating to five people's care; these included risk assessments, care plans and wound management records. We reviewed records relating to the Mental Capacity Act for four people. We inspected the medicines system which included storage and related records. We reviewed five staff recruitment files.

• We requested to be forwarded to us, and we received, a copy of the staff training record, maintenance and servicing record, the service improvement plan and an audit of completed actions for improvement.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

At the last inspection in October and November 2017 people's risk levels had not always been sufficiently assessed to fully minimise potential impact on people. Robust staff recruitment procedures had not always been followed before staff worked with people. This was a breach of regulation 12 and 19 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. During this inspection we found the requirements of these regulations had been met. People's risks had been fully assessed and staff started work, after recruitment checks were completed. These actions helped to protect people from avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management:

- Risks to people had been identified and risks assessment processes determined the level of risk and how this would be reduced or removed.
- We reviewed risk assessments related to falls, use of bed rails, anticoagulant therapy, weight, nutrition and choking, the development of pressure ulcers and people's behaviours. There was clear information for staff on how people's risks must be managed in order to keep them safe.
- A process for monitoring people, post falls for injury and for giving staff instruction in the care of a person taking Warfarin (a blood anti-coagulant medicine) was in place.
- We recommended that in addition, a post falls protocol be implemented to monitor people who were prescribed an anti-coagulant if they experienced a fall and possibly sustained a bump to the head or an actual head injury. This would help with the early detection and management of a potential intercranial bleed. This recommendation was acted on immediately and on the second day of the inspection new care plans were in place for all people on anti-coagulants; referring to this protocol.
- Technology was sometimes used to help keep people safe, such as preventing falls. For example, bedrooms had movement sensors which sounded when people were mobile. This helped staff identify when people needed of additional support.
- Environmental risks were identified and assessed and reduced or removed. Regular health and safety checks and planned maintenance and servicing arrangements kept the building, its systems, the equipment and grounds safe to use.
- The home's entrances and exits were always secured but technology allowed people (where they were assessed as safe to do so) and those close to them, to enter and exit independently.

Staffing levels:

- There were enough staff allocated to different areas of the home to meet people's needs.
- When required, for example, during staff sickness or when waiting for recruitment checks to complete, agency staff were used to ensure staff numbers remained adequate.

•□A dependency tool helped managers determine the numbers of staff required. The numbers of staff increased as new areas of the home opened and more people needed support. For example, more staff, with the right skills and qualifications were recruited prior to the opening of the first half of the nursing floor in June 2018.
•□Staff recruitment files showed that appropriate checks were carried out on potential applicants, before they started work. One Director told us they were considering the use of psychometric testing to enhance the staff selection process. People's views on potential applicants were already taken into consideration when selecting new staff.

Using medicines safely:

•□People's prescribed medicines were ordered, checked in safely and administered as intended by the prescriber. People received the support they needed to take their medicines.
•□Medicine records were well maintained and checked regularly to both prevent and quickly identify any errors.
•□Staff who administered medicines received training and were subject to on-going competency checks to ensure they carried this out safely and knowledgeably.
•□Arrangements were also in place to monitor the safe and appropriate use of some medicines which carried higher risk. For example, those prescribed to be used 'when required', anticoagulants, anti-psychotics, insulin, pain relief and end of life medicines.
•□Treatments for wounds were prescribed, used and recorded appropriately; often with the involvement of specialist tissue viability practitioners.

Preventing and controlling infection:

•□Cleaning schedules were followed and resulted in a clean and comfortable environment for people to live in.
•□Equipment used during care was kept clean.
•□Laundry was managed safely, for example, laundry soiled with body fluids was managed and washed separately from other laundry.
•□Staff had received infection control training and knew how to support safe practice. For example, staff washed their hands between caring for different people, wore disposable protective gloves and aprons when delivering personal care and when supporting people with their food.
•□Potential health related infections, such as chest infections, were identified by staff quickly and appropriate action taken. People and staff had been provided with support to have the Flu vaccine.
•□Entrance to the main kitchen was restricted to designated kitchen personal only who wore protective clothing. Food was transported in a separate lift, in appropriately heated trolleys, by designated kitchen staff, to ensure safe delivery of food to people. The Foods Standards Agency had awarded the highest rating of '5' [very good] for food safety and hygiene.
•□Visitors to the home were encouraged to use hand sanitisers when they visited.

Systems and processes

•□Safeguarding processes were in place to ensure people were protected from potential abuse. The provider's policies and procedures were in line with the local authority's safeguarding policy and protocols. This meant information related to safeguarding concerns was reported to the local authority and shared with other agencies who have a responsibility to safeguard people.
•□The provider had systems and processes in place to prevent situations which may harm people. For

example, during the inspection the fire alarms sounded; this had not been a planned. We witnessed staff responding to the fire detection system efficiently and according to the provider's procedures and their fire safety training. People had been made aware of what to do when the alarms sounded; one relative told us they knew what they had to do in this situation.

• A process was in place to ensure important information was shared with senior staff and their teams each day. A daily meeting took place between heads of departments and the manager in charge on the day. Information about any challenging issues, plans or risks were shared between departments. This ensured all managers were aware of these, had the same information and could work collectively to address and resolve these.

Learning lessons when things go wrong:

• Reflective meetings were held following complaints or when feedback had suggested possible improvements to the service were needed so lessons could be learnt and improvements made.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Outcomes for people were good and feedback from people confirmed this, although the floor which supported people who lived with dementia, required further adaption so it could fully support the needs of this group of people.

Adapting service, design, decoration to meet people's needs:

- The home was purpose built (completed in 2016) and was built in line with the overall redevelopment plans for the area.
- Its situation allowed for easy access to the local community facilities, the public park next door and to a large covered shopping development opposite, which provided additional and easily accessible social opportunities.
- The home's accommodation, fixtures and fittings provided comfortable modern living for people with diverse needs. Adaptions had been made to make daily living easier, for example, bath hoists and walk in showers supported safe and easy bathing.
- The provider had identified that the environment on the first-floor where people who lived with dementia were supported needed further adaption. The decoration and signage was not sufficiently adapted to support people to be able to orientate themselves, make sense of their surroundings and to provide appropriate stimulation.
- Most older people experience changes in visual ability and with dementia visual perception can also be challenged. The use of different colours, pictorial design, tactile experience and appropriate signage can help people make sense of their environment. In the case of the first-floor décor, apart from the bedroom doors, which were different colours but because of the building's design could not be seen when looking down the corridor, all corridor walls, ceilings, floors and hand-rails were of a similar colour tone. This resulted in limited points of reference for people and for some may potentially offer little help in for example, distinguishing where the floor ends and the walls begin.
- Although the management had been aware that changes to this were needed, decisions on how this was to be achieved had not been agreed. The senior management had wanted to ensure the right leadership was in place (for this floor) before decisions about the environment were finalised. At the time of this inspection however, this floor was almost at full occupancy (34 people) and we were subsequently informed that a suitably qualified dementia lead was now in post.

We recommend that the service consider current guidance and best practice in order to make appropriate and suitable changes to the environment on the first floor, so this can better support the needs of those who live with dementia.

- Each floor provided comfortable communal lounges, dining rooms and kitchenettes and on the floor which accommodated people's apartments, a small domestic laundry.

•□The home was wheelchair friendly with wide corridors and doorways, passenger lift to all floors, lowered light switches, floor length windows in all communal rooms and some bedrooms and a low-level reception desk welcomed people.
•□An uncluttered and spacious 'resident and visitor' café area in the main reception area provided a separate place to meet other than the living and care areas.
•□There was easy access for all to a rear garden and limited off road car parking.

Assessing people's needs and choices; delivering care and ensuring consent to care and treatment in line with standards, guidance; staff skills, knowledge and experience:

•□People's needs were assessed before they moved into the home and regularly thereafter. This enabled staff to plan how they were going to plan people's care and ensure care and treatment remained appropriate.
•□Staff received relevant training to be able to meet people's needs and choices safely and in line with current best practice. Nurses were supported to maintain their registration and professional development requirements with their professional regulator the Nursing and Midwifery Council (NMC).
•□Managers, for example, ensured the service worked in line with Gloucestershire's Dementia Training and Education Strategy. Staff had received training in line with best practice, in planning care for those who lived with dementia and supporting people with challenging behaviours. A member of staff who had completed dementia leadership training was now in post and other staff were to be supported to complete specific trainings in dementia care.
•□Staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were therefore presumed to have capacity and supported to make independent decisions. Consent had been sought from people before care and treatment had been provided.
•□In line with the principles of the MCA and where, appropriate, people's mental capacity had been assessed. Where people lacked mental capacity to make specific decisions, records showed these had been made in people's best interests. Records showed that people's representatives had been included in this process. One relative told us they helped to make decisions about their relative's care because they were too confused to do this.
•□Staff had sought appropriate authorisation under DoLS when restrictions had been placed on people to ensure their safety; added conditions had been followed.

Supporting people to eat and drink enough with choice in a balanced diet:

•□People received the support they needed at mealtimes and staff promoted a pleasant dining experience. People told us they liked the food, comments included "It's fine" and "It fills me up."
•□People were helped to make choices about their food and drink. Choices based on religious and cultural preferences were met. The head cook met with people following admission to talk about likes, dislikes and specific dietary needs.
•□People's nutritional risks were assessed by staff trained to do this. Information from this was shared with the head cook so an appropriate diet could be organised. People at risk of not maintaining their weight were provided with a fortified diet; food with added calories. People with swallowing problems were assessed by speech and language therapists and provided with appropriate textured food and drink; sometimes needed to prevent the risk of choking.
•□A link had been made with a nutritionist and managers planned to look with them at different ways of supporting people's hydration needs.

Staff providing consistent, effective, timely care within and across organisations; Supporting people to live

healthier lives, access healthcare services and support:

•□Nursing staff met each day to ensure they were aware of who, throughout the home, required their clinical support. For example, with the administration of insulin, specific pain relief medicines, wound care or a review of a health condition.
•□To ensure timely and appropriate care for people who had a sudden deterioration in health, nurses were introducing a specific assessment tool. Used alongside a recognised pathway of communication, this would enable home staff to gather necessary information and communicate this effectively to external care professionals, such as GPs, NHS 111 and paramedics. For example, particularly important when the risk of potential Sepsis is identified.
•□Staff worked alongside professionals such as NHS Rapid Response to assess and manage some health needs in the home; avoiding hospital admission. For example, in some situations the administration of intravenous antibiotics.
•□Referrals were made to various health and social care professionals when needed. These included to GPs, community nurses, community palliative care teams and tissue viability, continence, and mental health practitioners. Also included were referrals to physiotherapists, occupational therapists, speech and language therapist, social workers and best interests assessors.
•□Relatives and friends played a large role in supporting people to attend appointments but where this was not possible, staff provided this support.
•□People had access to NHS dental and optical services as well as regular chiropody.
•□The staff promoted healthier living and independence by for example, providing keep fit sessions in the home on a regular basis, the cook talked with people about the NHS guidance on 'healthy eating' and staff were aware of the risks of self-isolation and supported people's ability to socialise.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect, and involved as partners, in their care.

Ensuring people are well treated and supported:

•□We observed kind and supportive interactions from staff towards people. Staff spoke with people in a respectful way and demonstrated a genuine interest in what people had to say. They were patient and listened to people; some people needed more time to express themselves than others and they were afforded this.
•□Feedback from people about staff was positive and comments included "All the people who work here are excellent, kind and thoughtful. They make sure I'm okey dokey and there's always somebody around", "It's a fantastic place, friendly, remarkable" and "They make you feel like one of the family, there's a friendly atmosphere…a warm feeling in the place".
•□Feedback from relatives included, "They'll go over and above to care for Mum" and "They attend to the small details that make all the difference". One relative told us their relative's prescription had not arrived in time and the registered manager "went out of her way" to locate supplies of the medication from other pharmacies rather than let her relative miss a dose.
•□Staff worked in a flexible way to work around people's preferences and abilities. One person told us they had not felt ready to get up earlier in the day, so the staff had arranged to help them later.
•□Managers aimed to have minimal changes to the staff team which supported people who lived with dementia in order to provide continuity of care. Staff therefore knew what upset people a what improved their wellbeing.

Supporting people to express their views and be involved in making decisions about their care:

•□People's wishes, preferences and expectations were explored with them, and where appropriate, with their representatives, in order to plan and deliver their care around these.
•□Staff provided people with information about their care and treatment to help them make informed decisions. During our visit one person was making decisions about their treatment which staff were supporting. All staff understood that this person, who had capacity to make the decisions they were making, had a right to make decisions which could be viewed by some as being unwise. The registered manager was making sure that the person remained informed about their treatment options and aware that at any time, they could alter their decisions and this would also be respected.
•□Independent advocacy was arranged for people who had no one to support them to do this.
•□People's individual communication needs were known to staff and recorded in people's communication care plans. The registered manager was aware of the need to make information available to people in a format which met their needs (Accessible Information Standards). Therefore, information when needed

could be provided in different formats, for example, on different coloured paper, large print or audio disk.

Respecting and promoting people's privacy, dignity and independence:

•□We observed people's privacy to be maintained. Care was delivered behind closed doors, staff knocked on people's doors before entering their bedroom or apartment. These areas were respected as being people's private spaces. People could receive visitors and spend time alone with them.
•□People's dignity was maintained during care, for example, they were not undermined, people were communicated with in a respectful way, afforded choice and control and supported with their daily needs.
•□People's independence was supported, for example, people were supported by staff to do what they could for themselves for example, when delivering care.
•□People who required less support from staff, for example people who lived in their own apartments, still had access to designated, 24-hour care staff to support them if required. This helped them to retain their independence but with help available where needed. A member of staff told us how they helped these people. For example, they could go with them to a GP appointment, to the shops or sometimes helped people with the changing of their beds and laundry.
•□The homes entrances and exits were secured at all times, but through the use of technology, people (assessed as safe to do so) and their designated representatives, could enter and exit the home independently. Those spoken with told us they enjoyed the freedom to be able to do this and told us they would have done this when in their own home. One person said, "It's an excellent idea".

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

People's personal care needs were met through good organisation and delivery. People had access to social opportunities and activities but people commented that these were not meeting their individual needs or preferences. Action had already been taken to further support more meaningful and personalised activities and time was needed for more personalised activities to be established.

Personalised care:

•□People were supported to take part in activities and social gatherings which took place in the home and in the community. The monthly newsletter, which went out to all people living at the home, included detail about the activities and events taking place. One activity co-ordinator's working hours were designed to support activities in the evening and alternate weekends. One activities co-ordinator had just left the service.

•□Whilst we had some feedback from people and relatives that the activities were not always providing them with the opportunities they would prefer, and for some, the activities needed to be more personalised, the management team were aware of this.
•□To help support more personalised activities a new appointment to the activity team had just been made. This new member of staff was due to start work soon. They had experience in supporting personalised activities and supporting those who lived with dementia with meaningful activities.
•□The existing activities co-ordinator had continued to organise activities and sessions such as the music and movement session we observed, keep fit and Tia Chi sessions, regular visits by a church group for communion, singing hymns and fellowship, group and individual shopping trips, coffee mornings and quiz, baking sessions, reminiscence led activities and visiting people on a one to one basis. They also organised external entertainers and supported community links and intergenerational projects. The home had recently been involved in a schools' art project. School children and people who lived in the home had completed pieces of art together. One relative told us that their relative had really enjoyed this.
•□We observed a singing and movement activity where 21 people participated. People were obviously enjoying this as they were fully engaged. Despite their numerous diverse needs and abilities all were supported to take part. At another time we observed some people enjoying board games and the activities co-ordinator supporting people on a one to one basis. For example, helping one person to engage in conversation using a large print book to do this.
•□We observed that apart from one communal room, on one unit, where there were well stocked book shelves, in other communal rooms, on other floors, there were very few books, games or other activity equipment out on display for people to engage in. This was apparent on the floor which supported people who lived with dementia. We fed this back to the registered manager and one of the Directors, who told us they would look into this and provide what was wanted or needed.

•□People's personal care and their treatment was planned with their involvement or, where appropriate,

with the involvement of a representative and someone who knew them well. Recorded care plans showed this to be the case and people and relatives also confirmed this.
•□Information about people's life histories, their preferences and what was important to them was gathered and taken into consideration when planning this care. This helped the delivery of people's personal care and treatment to be person centred. One person said, "I feel that they listen and help me in the right way".
•□One person who lived with their spouse told us the staff had planned with them, how both of their different needs would be met. They said, "Staff know when I need a break." They went on to tell us they could leave their spouse in the care of the staff when needed.
•□Staff communicated effectively with people, and their relatives where appropriate, about their personal care in order to ensure it was delivered according to their wishes. One relative told us they were encouraged to write in a 'communication folder' in their relative's bedroom when they visited. This helped this relative communicate with the staff about aspects of their relative's care, which they felt would help enhance its personalisation. This relative told us staff acted on their feedback.

End of life care:

•□People's end of life wishes were explored and recorded so staff had guidance about these at the appropriate time. Staff spoke to people about these when they were first admitted but also at times when people felt able to or wanted to discuss these.
•□Although at the time of our visit no one was at the end of their life; one person was being supported by staff and their GP as they were gravely ill.
•□End of life medicines were prescribed in anticipation by GPs so that if needed, a pain free and comfortable death could be supported.

Improving care quality in response to complaints or concerns:

•□People and relatives knew who they would speak with if they had a complaint or were not happy about something. The relatives we spoke with were aware of how to raise a complaint with the management. Only one had done so and they confirmed they had received good response.
•□Information about the complaints procedure was shared with people on admission and could be seen in the home.
•□Any form of complaint or dissatisfaction, irrespective of its level of seriousness, had been listened to, recorded in the home's complaints record and acted on and resolved (where possible) according to the provider's complaints policy and procedures. There had been seven areas of feedback received in the last month and all had been addressed.
•□Any form of dissatisfaction or complaint was discussed during the daily heads of department meeting so this, if needed, could be collectively addressed and resolved.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection in October and November 2017 the service's quality monitoring processes had not been sufficiently able to identify areas of shortfall and effect improvement. This was a breach of regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. During this inspection we found this requirement of regulation had been met. Effective processes had been brought in to ensure risks were appropriately assessed and that these processes were effectively maintained and that appropriate recruitment checks were completed before staff started work.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements; Leadership and management:

- All the management team were responsible for and understood their role in contributing to the provider's quality monitoring system. They did this by following the provider's audit programme and by using other checking methods, for example, to assess staff practice and performance. They reported their findings to the registered manager who completed their own audit and checks on these findings and they submitted a monthly report to the provider.
- Directors representing the provider had different areas of responsibility and visited the home on a frequent basis. They along with the registered manager were fully aware of any risks or challenges the home may face; an emergency business contingency plan was in place.
- Arrangements were in place for the overall clinical governance of the home. For example, the deputy manager advised on all policies and procedures relevant to clinical practice and processes and they, and the clinical lead completed clinical audits. For example, on medicines and wound care records and ensured best practice was upheld.
- One Director provided operational support to the registered manager and carried out their own audit of the home's performance. On their visits they also spoke with people and their relatives and sought their feedback. They were also involved in the interviewing of some staff and understood the staff culture.
- The homes service improvement plan (SIP) recorded all areas for planned actions leading to improvement. The SIP included target and completion dates as well as levels of progress for identified actions. Completed actions included the recruitment of a dementia lead, recruitment of two more clinical leads (one for nights) and completed best practice update session for all staff in moving and handling. Progress was seen taking place on actions that were nearly completed. These included, improvements to how managers, formally, explained to staff, the action they were taking after, for example, a staff concern had been raised and changes being made so that people had a designated link to a member of staff with whom they could discuss any aspect of their care with.
- Regulatory requirements were understood by all managers and included knowledge of a meeting current

legislation, completing notifications to the Care Quality Commission (CQC) and ensuring the last rating of the service issued by the CQC was clearly advertised.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong; Continuous learning and improving care:

•□Plans for improvement included those which supported person centred care and a high-quality of care. These were seen in the recognition of the need for more meaningful activities and the need to improve the environment for people who lived with dementia. Also in the on-going and planned training in end of life care with a local Hospice and the Care Home Support Team on dementia care and challenging behaviours.
•□Continuous learning which resulted in better care for people was promoted, supported and shared. Examples of this was seen through the introduction of the National Early Warning Score (NEWS) after five members of staff had attended a local training session in this. This was the new process being established in the home to more quickly identify and communicate concerns when a person's health deteriorated suddenly.
•□Duty of Candour was understood and an open and transparent culture promoted so that when things went wrong or not as well as expected, people and relatives received an explanation and an apology where appropriate.
•□Reflective meetings were held to look at where improvement in practice and processes could better benefit people.

Engaging and involving people using the service, the public and staff:

•□The views of people, relatives, staff and other stakeholders had been formally sought by way of a questionnaire in 2017. The collated information from this, and the actions taken in response to the feedback, was available for people and other visitors to read. Another formal request for feedback was due soon.
•□Planned 'Relative and Resident' meetings had resulted in poor attendance and a 'CAMEO' (Come and Meet Me) social group had been tried, also with little response. Feedback from relatives and others who matter to people indicated that they preferred the ability to talk with senior staff when they needed to so in response to this relatives and representatives of people are provided with the registered manager's email address and can telephone when they wish to.
•□Meetings with 'residents' took place and feedback from them was sought and acted on. A monthly newsletter was produced with one section called "You said, We Did". The December 2018 issue included, feedback on improvements made to the cook's pastry, adjustments to the heating to reflect the colder weather, the introduction of a 'Welcome to staff' board in response to people wanting to put a name to new staff faces and people not knowing what alternative choices were available at a mealtime; now added to the table menus. A new music system was added to the home in response to people wanting to hear more background songs and music. People could make requests and the music would be played over the system for them.

Working in partnership with others:

•□Staff worked with various agencies and professionals to help support people. These included commissioners of health and care, local authority safeguarding and mental capacity assessors to ensure people's needs, either when they were in the home or when they left, for example after short-term care, were appropriately met.
•□Links with some community groups were in their infancy and included an initial contact with

representatives of the local Black Elders Day Centre and planned contact with representatives of the local LGBT community.