Avery Homes (Nelson) Limited

Birchwood Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

About the service
Birchwood Grange Nursing Home is a nursing and residential care home. It is registered to provide accommodation and personal care for up to 150 older people. The service supports people living with dementia, a mental illness, and/or a physical disability. At the time of the inspection there were 150 people living at the service.

People's experience of using this service and what we found
Staff provided exceptional care. The registered manager and the deputy were passionate about delivering a high-quality service. The service promoted a positive culture that was person-centred, open, inclusive and empowering, which achieved outstanding outcomes for people. The service was effectively monitored, through robust systems of governance. The range of management information that was comprehensive. This supported effective decision making and allowed for prompt action where performance was outside defined parameters. The service had measurable outcomes, and their quality processes demonstrated they were achieving outstanding outcomes for people.

People received safe care. There were examples of good practice in relation to the management of medicines, including storage, disposal, completion of medicine records (MARs), and administration. People were protected from the risk of harm and abuse. Effective standards of practice were followed to protect people from avoidable harm and abuse. A culture of safety was rooted in the philosophy within the service and staff were attentive in noticing risks and addressing them.

The service worked in partnership with other organisations and kept up to date with new research and development to deliver the latest best practice. Professionals gave consistently exceptional feedback about the willingness of the service to work with others. Staff were appropriately trained. They assumed their roles with ease and confidence. The service liaised with other health care professionals to provide staff with specialised training, so they were able to meet people's individual needs. The service was delivering exceptional dementia care, which was shaped around Bradford University dementia care mapping, which is an established approach to achieving and embedding person-centred care for people with dementia.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed. There was evidence the service went the extra mile to ensure people were supported to make decisions.

The service invested time and went above and beyond in getting to know people well and involving them in decisions about their care. We found positive evidence people were listened to and supported by staff to make choices about their care and support. Staff were extremely knowledgeable about diversity and human rights. There was strong evidence people's human rights were respected. Staff treated people and their

relatives with the upmost kindness and provided extra time to support them when they were in distress or feeling anxious. This quality was acknowledged in compliments received from relatives. Staff spoke with people in a respectful way, giving people time to understand and respond. Personal care was given discreetly and sensitively.

The arrangements to provide activities were excellent. The activity coordinator was extremely passionate and worked with staff to create activities to ensure people were not isolated. New technology was also used creatively to offer practical interventions to address the specific circumstances of people, who because of their needs, were not inclined to join in activities. The service delivered high quality person-centred care. Our review of people's care records evidenced they were personalised and clearly articulated guidance for staff on how to direct people towards their desired goals. The service provided outstanding end of life care. Exceptionally well completed anticipatory care plans were in place, including Do Not Attempt Resuscitation (DNAR) forms. The anticipatory care plans were used to an excellent effect to prevent hospital admissions and enabling death at preferred place.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 14 February 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Outstanding ☆

The service was exceptionally effective.

Details are in our effective findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Details are in our caring findings below.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive.

Details are in our responsive findings below.

Is the service well-led?

Outstanding ☆

The service was exceptionally well-led.

Details are in our well-Led findings below.

Birchwood Grange Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, one specialist advisor for people experiencing mental health, a medicines inspector and two Experts by Experience on one day and one inspector on another day. An Expert by Experience is a person who has personal experience of using services or cares for someone living with dementia/and or mental health needs.

Service and service type
Birchwood Grange Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they 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 before the inspection
We looked at statutory notifications the provider had made to us about important events. In addition, we reviewed all other information sent to us from members of the public and stakeholders, such as the local

authority. We also used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We contacted the local authority commissioning team and clinical commissioning group (CCG) for feedback about the service. Many people at the service were living with dementia and so we also sought feedback from Harrow Memory Services who placed some people at the home.

During the inspection
Many people at the service were living with dementia, which meant it was difficult at times to obtain people's views verbally. Therefore, we spent a considerable amount of time observing the interactions between people and staff.

We spoke with 15 people, eight relatives, fifteen members of staff including the chef, the deputy manager, the registered manager and regional director. We also had feedback from senior managers of the CCG and the local authority. We reviewed records relating to the management of the service including quality audits, accident and incident analysis, compliments and complaints files and staff meeting minutes. We looked at seven staff files in relation to recruitment and staff supervision.

After the inspection
We spoke with two social care professionals. We continued to seek clarification from the registered manager to validate evidence found. We also contacted four relatives of people receiving care for their views about the service and confirm some of the feedback we had received.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people were safe and protected from avoidable harm.

Using medicines safely
• Medicines were given to people in a timely and efficient manner. One person told us, "I have many tablets a day and inhalers. Staff give it on time." Another person said, "I get my medicines on time. Staff are extremely vigorous about that. [Regular monitoring is carried out on my high-risk medicines]."
•There were examples of good practice in relation to the management of medicines, including storage, disposal, completion of medicine records (MARs), and administration. The service used an electronic medicines administration records (EMAR) system. All processes were performed electronically. Extra steps were taken to prevent over ordering, administration error and stock control. For example, when administering medicines, the EMAR had an alert system, which warned staff if the person was PEG fed (percutaneous endoscopic gastrostomy) or taking medicines covertly. Staff followed simple and clear traffic light system for different times of administration. This prevented medicines being administered to people at wrong times.
• A medicines policy was in place. We also saw copies of the medicines guidance from the Royal Pharmaceutical Society of Great Britain, the Nursing and Midwifery Council (NMC), the National Institute for Health and Clinical Excellence (NICE), and Brent CCG safe handling of medicine guidance. Copies were in a policy folder, therefore easily available to staff.
• Staff were trained to administer medicines and had their competencies checked to ensure they continued to follow good practice.
• Medicines were stored safely. There was a locked room and a locked medicine trolley used to store people's medicines. Storage temperatures of medicines were being monitored each day including the room and the refrigerator temperature. The temperatures were all within the recommended ranges. The medicines were stored neatly and tidily which made it very easy to locate. We randomly checked expiry dates and all medicines checked were in date. Extra security was added by marking the medicines with a date of when it was opened to assist with an early alert before the medicines expired.
• The service had records of monthly monitoring of medicines, including antipsychotic medicines use. The EMAR system provided updated summary of medicines administration, which allowed managers to monitor the medicines administration and detect any errors as early as the medicine round is completed. In addition, the service provided extra level of security in case of technology failure. There were printed updated MARS sheets available to be used if the electronic system could not be accessed.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems to help protect people from the risk of harm and abuse. A relative told us, "My relative is safe. I have no qualms whatsoever. The service is excellent." We observed good standards of practice were followed to protect people from avoidable harm and abuse. Assessment tools were available to support staff in completing assessments. Staff demonstrated a good understanding of the various forms

of abuse, how to recognise them and how to report them. A staff member told us, "Abuse is when people are harmed or mistreated. I would always speak to the manager or senior nurse, but I can also contact the Care Quality Commission (CQC).
• There was a safeguarding policy and procedures and staff were aware of these. Staff had received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. They were aware they could contact the local authority safeguarding team and CQC when needed.

Assessing risk, safety monitoring and management
• A culture of safety was rooted in the philosophy within the service and staff were attentive in noticing risks and addressing them. One staff said, "We work with other professionals and organisations, so people here receive the best care." We could see evidence of this in records. We found evidence of good partnership working with members of the multidisciplinary team when concerns for investigation were referred.
• Staff assessed risks associated with people's care and well-being and took appropriate action to ensure they were safe. People had equipment as needed, such as profile beds, pressure relieving air mattresses, and sensor equipment for those at risk of falls. Risk assessments and management plans were detailed and current, they were regularly updated in response to people's changing needs and where possible signed by the person or their relative.

Staffing and recruitment
• There were enough staff on duty to support people who used the service. Staff spent time with people for a chat and when people requested support staff attended to their requests swiftly. One staff member said, "We have enough staff. Sometimes people call in sick and we can contact staff who are off or ask someone from another floor for help."
• Recruitment records showed appropriate checks to employ safe and suitable staff to work with people were completed.

Learning lessons when things go wrong
• There were clear records to show how the service had managed incidents to make improvements to the service. Prompt action had always been taken in relevant examples. For example, following, a few medicines errors, an electronic system for medicines management had been installed to help to prevent medicines related incidents by allowing close monitoring and ability to alert staff of potential incidents at early stages.

Preventing and controlling infection
• The communal areas of the home were all clean and well maintained. There was an infection control policy and measures were in place for infection prevention and control. Staff had completed training in infection control. They wore personal protective equipment (PPE) such as gloves and aprons. Arrangements were in place for managing clinical waste to keep people safe.

Outstanding ☆

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now improved to outstanding. This meant people's outcomes were consistently better than expected compared to similar services. People's feedback described it as exceptional and distinctive.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service went above and beyond to ensure they had comprehensive information about people. People's needs, and preferences had been incorporated into care plans, which were holistic. Where people were not able to be involved in their assessments due to their complex needs, the service looked for creative ways of getting this information from others. For example, seeing that one person could not participate fully in their assessments, the service used a communication application that provided video interaction with their closest relative who lived in another country. There were other examples evidencing this.
• People and relatives consistently spoke very highly about the service provided. They said, "We are fully involved. This is an excellent service. They are on point with my relative." Another relative said, "The service is outstanding. Our views are respected." One person said, "My choices and preferences are responded to fully."
• The service worked in partnership with other organisations and kept up to date with new research and development to deliver the latest best practice. The service was an active participant in the implementation of the local Enhanced Care in Care Homes model (EHCH). EHCH model is based on a collection of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner to make the biggest difference to people receiving care. An example of this is integrated care. Our review of integrated care evidenced the service was delivering outcomes that were higher than expected. Notable impact for people receiving care, included yearly reviews of dental care for all 150 people using the service by a qualified dentist. Furthermore, there was timely access to community specialist palliative care services, and therefore improved quality of care for people nearing the end of life. Evidence showed a decrease of hospital admissions for people receiving end of life care from 75 people in 2017 to 58 in 2018, and 42 in 2019.
• The service always ensured key changes to practice were made because of new legislation, standards and evidence-based research. There were many notable examples, including championing improvements in dental care locally following the implementation of NICE guidance on oral health and the subsequent CQC report, Smiling Matters. Faced with limited resources locally, the registered manager took it upon himself to identify a pathway to improve access for dental care. He identified other key stakeholders who could support his line of thought. Subsequently, resources were put together in partnership with Brent Public Health and the Dentistry service at Whittington Hospital. This resulted in a pathway being created, which greatly improved access. Data showed 31% of people at the service received dental care in July 2019. This was a significant improvement compared to previous figures, which were 0.7% to 1.3% for the previous two months, respectively. Furthermore, all care plans fully covered oral health. This was a sharp contrast to NICE findings, which showed out of 291 care plans reviewed across 100 care homes, 63% of care plans partly

covered oral health and 10% of care plans did not cover oral health at all.
• The service was exceptional in adapting care, so it was provided in-line with the latest evidence-based research. For example, the service had introduced an initiative by the British Lung Foundation called 'singing for lung health'. (There is increasing evidence that singing regularly as part of a group is good for general health and wellbeing, especially at improving quality of life for people living with a lung condition.) One person receiving care at the service had attended training and was delivering singing sessions to people at the service. This had improved the wellbeing of the participants. For example, episodes of crises, which caused difficulties in carrying out day to day activities were reduced. Furthermore, by signing up for this initiative, the service demonstrated they went above and beyond.

Adapting service, design, decoration to meet people's needs
• The service was delivering exceptional dementia care, which was shaped around Bradford University dementia care mapping, which is an established approach to achieving and embedding person-centred care for people with dementia, recognised by NICE. The premises had been adapted to help promote independence and accessibility for people with dementia.
• There was dementia friendly pictorial signage to communal areas and bathroom facilities. The signage was clear with contrasting colour between text and background, so people could recognise the signs. There were clear signs at key points throughout the communal areas and the bathroom facilities, including toilets and exit points.
• There were 'landmarks' to help support people to navigate their way around, both inside and outside. For example, there were a variety of lounge areas for people to choose from, and in each one there were objects of reference which people would recognise from their past.
• Several evidence-based initiatives had been implemented to improve the well-being of people living with dementia. For example, animal assisted therapy was used at the service. The service kept rabbits, chickens, and the registered manager brought in two dogs for animal-related activities, which people told us they loved extremely. The approach drew heavily on research evidence, demonstrating a reduction in anxiety and aggression during and in the aftermath of animal contact in care settings. The positive effects of animal assisted therapy had been noted with some people living at the service.
• Dementia care delivered at the service was highly regarded by professionals. We observed several multidisciplinary meetings attended by a range of health and social work professionals. We met with a professional from Harrow Memory Services group who praised the excellent work of the service and spoke positively about people's experience. The professional told us, "The environment is visually stimulating. If I was worried I wouldn't place people here. It is an excellent home."

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care
• Professionals gave consistently exceptional feedback about the willingness of the service to work with others. One professional told us, "The registered manager has been pivotal to the success of the EHCH Forum and is a key advocate and facilitator between commissioners and care homes."
• The leadership was highly knowledgeable of healthcare systems and how to effectively navigate them. People had access to Integrated Care Partnerships (ICP), which comprised GPs, consultant physicians, nurses, physiotherapists, occupational therapists, pharmacists, and social workers. ICPs are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. One professional told us, "Referrals are completed appropriately and in a timely manner to safeguard people's wellbeing and ensure appropriate treatment plans are in place." Consequently, people were exceptionally supported to lead healthier lives. For example, there was evidence of reduction in pressure ulcers, unplanned weight loss, infections and use of anti-psychotic medicines. The service had reduced the average number of people with pressure ulcers from 14 to 4 out of an average of 120 people at risk, over a period of four years. Weight loss greater than 3.5kgs had also been reduced owing to good nutrition and timely

referrals to specialists.
• The service constantly strived to improve access to healthcare services. In one example, the CCG had taken a decision to withdraw a GP enhanced contract in June 2019 (Enhanced services are defined as primary medical services other than essential services. This is designed based on the needs of the local population). Seeing the impact of this on access to treatment, the service, remarkably had this decision reversed, leading to one senior manager of the ICP, commending the exceptional efforts of the registered manager. He had written to us, "The registered manager has represented the care homes and residents extremely well, whilst also recognising and supporting the strategic priorities of the commissioners. This had been ably demonstrated recently following a decision by the CCG regarding decommissioning of the GP enhanced care contract, where the registered manager robustly defended the service whilst working constructively with the CCG to find a resolution that protects the interests of residents in all care homes across Bent."

Supporting people to eat and drink enough to maintain a balanced diet
• We asked people if they liked the food offered, including whether they could choose what they wanted to eat. One person told us, "Food choice is very good. We have a wide range of dishes every day." A relative told us, "Food choice is great. You choose three things and they sort it for you."
• Food was presented in an appetising manner. The service used creative ways to make food as attractive as possible when people were on specific diets. The chef had picture evidence of how puree or soft meals were prepared, including the use of moulds to ensure food looked aesthetically pleasing.
• People were offered choices and they were clear about what they were choosing to eat. The menu text was clearly readable and included pictures of the meal selections available to support people who could not read. People were asked what they wanted before meals were served. Some changed their minds and a different meal was served.
• The service provided food and drink of plentiful quantity and quality. People's nutrition and hydration status was kept under review.

Staff support: induction, training, skills and experience
• Staff were appropriately trained. They assumed their roles with ease and confidence. They had been provided with essential training, including, manual handling, safeguarding, Mental Capacity Act 2005, equality and diversity, first aid awareness, fluids and nutrition and medicines handling.
• New staff were provided with training and the workplace assessment of competence, which met the requirements of Care Certificate standards. The Care Certificate is based on an identified set of standards that health and social care workers adhere to in their daily working life.
• A professional told us, "In all the cases I have observed with staff, I have noticed high standards of care. They have a sound knowledge regarding prevention and management of pressure ulcers, including wound management and choice of dressings. Staff always follow the care plans and advice."
• The service liaised with other health care professionals to provide staff with specialised training, so they were able to meet people's unique needs. For example, in partnership with Brent Public Health and the Dentistry service at Whittington Hospital, the service offered advanced oral care training to staff, which included use of high concentration fluoride toothpaste.
• Staff volunteered to be 'champions' in subjects they were passionate about. These roles promoted evidenced-based best practice. Champions included end of life care, dignity, dementia, infection control and safeguarding. All the champions received additional training and shared their knowledge within the team.
• Staff felt supported by their managers and had access to regular supervision and appraisal. Nurses had access to profession-specific supervision.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• The service went the extra mile to ensure people were supported to make decisions. This was typified in one example. One person had an estranged relationship with their family. The managers had worked extremely hard with other professionals to coordinate and arriving to a decision that was in the best interests to the individual, whilst ensuring the competing demands from the family members were met without causing further strain in the family relations. A professional who had been involved praised the efforts of the service, stating, "I have seen evidence of the considerable efforts the deputy manager and staff to bring clarity and agreement to bear in order to achieve an agreed best interests decision."
• The service had a nominated champion for mental capacity who spearheaded staff training. Staff were fully trained and had a comprehensive understanding of the MCA and the DoLS.
• People's care records detailed their mental capacity, and others important in their care and support.
• The registered manager and the deputy ensured consent was sought and that people were supported to make their own decisions. Where people lacked mental capacity, best interest decisions were made.
• Relevant procedures had been followed in relation to DoLS. There were eight people who were subject to a DoLS authorisation for their safety. Conditions on authorisations to deprive people of their liberty were being met. This was monitored monthly to ensure people did not remain restricted unnecessarily even when their needs changed.

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has remained the same. This meant people were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; respecting equality and diversity
• People and their relatives told us staff were well qualitied and skilled to care for people using the service. They described staff as having excellent understanding of their cultural and religious needs. One person told us, "My spiritual needs are met. There is a temple here, if you choose you can go." Another person said, "A woman from the church comes around once a week." A relative told us, "My relative is very well looked after here. There is a Hindu temple and a service every day. They played the Garbo music (a form of dance and music style from the Gujarat region of India) for Diwali. The food is all Gujarati. The corridors are like a Bollywood wing. They have Indian channels on the TV."
• There was a strong focus on inclusion, equality, diversity and human rights. We found strong evidence people's differences, for example, along the dimensions of religious beliefs, gender, race, sexual orientation, age and ethnicity were respected. The service's motto was 'Our diversity is our strength.' People were supported to mark religious festivals, holidays and observances, including Christmas, Easter, Diwali and Ramadan. This was complimented by a relative, who wrote, 'The garden is incredible. Every November when its Diwali they clear the carpark and have a fantastic display of fireworks. Every celebration is done, St Patrick's Day, you name it they do it.'
• Staff were knowledgeable about diversity and human rights. They had received training in dignity, equality and diversity and this was regularly refreshed so they knew about the latest good practice. They knew how to respond to a wide range of religious and cultural beliefs and traditions in areas such as diet, personal care needs, language and death. For example, the home had its own temple within an Asian unit. The Asian unit was decorated by staff with support from families and people to ensure it reflected their religious and cultural beliefs. We observed people praying in the temple.
• The service adopted new innovations both to engage older people to feel part of the community and to give some insight to young people to challenge certain stereotypes they may have relating to older people. Intergenerational care, the practice of purposefully bringing young and older people together to share experiences that are mutually beneficial, was employed to engage and to reduce systematic stereotyping and discrimination against older people (ageism). Students from local schools and colleges visited the service and undertook a range of responsibilities including, helping with activities, and friendship. The initiative convincingly evidenced the wellbeing that resulted. Demonstrable impact included people now being able to interact with computers for basic functions. For example, a few people using the service were now able to use technology to speak to friends and families abroad, research and view what the internet had to offer and thus alleviating isolation. One person was able to buy some essentials using an online website, which they would not have been able to do. Students also reported extremely positive feedback from the experience, including improvement to their attitudes when communicating with older people with

dementia. One student said, "This week has taught me a lot and has really boosted my confidence and communication skills."
•The service provided an exceptionally positive and inclusive setting to enable people to express their sexual orientation without threat of discrimination. There was an LGBTQ+ (lesbian, gay and bisexual communities) champion who represented relevant issues. The service volunteered at the Opening Doors London Rainbow Café. This is a membership body which aims to support ageing members of the UK LGBTQ+ community. The LGBTQ+ champion had received extremely positive feedback from Open Doors London, including, "[The LGBTQ+ champion] has been a volunteer supporting the monthly Rainbow Cafe run by Opening Doors London for over a year. This is testament to her genuine and heartfelt commitment to supporting the older gay community." The service's newsletter had a section about LGBTQ+. Rainbow flags were visible at the home. We judged the culture at the home ensured people's sexual orientation or gender identity would be respected.
• Staff treated people and their relatives with the upmost kindness and provided extra time to support when they were in distress or feeling anxious. This quality was acknowledged in compliments received from relatives. One relative said, "This particular staff member is always approachable and answers all my questions and worries with comforting full explanation." Another relative said, "This member of staff knew I was upset because my relative did not want to talk to me. She tried hard to get my relative to talk. My relative ultimately said a few words." A third relative said to staff, "Thank you for your soothing hugs."
• People and their relatives strongly praised the sensitive, considerate and compassionate care provided by the service. Staff were strongly driven by the service's values, which were imaginative and person-centred. The values of 'caring, collaborative, dynamic and enabling' were embedded and were consistently displayed by staff towards people. For example, an option of water or juice was given and which side it should be placed – left or right. This made it easier for people who might have mobility or dexterity needs. Staff paid attention to the intricate detail, which otherwise would have had a negative impact on one's care if ignored.
• People who were distressed were supported by staff who could recognise and respond appropriately to their needs. For example, the service had identified a person who required support to understand a legal ruling, which affected contact with their loved one. Once this had been resolved, the service was supporting people concerned to rebuild their relationship. Ultimately, the person was no longer distressed, and arrangements were currently underway for them to move to an alternative accommodation that will encourage more contact with their loved one.
• The service considered creative ways to support people and their families during difficult times. For example, they had prepared a 'travel bag' to cater for emergencies such as those that might occur when caring for people receiving end of life care. Items contained in this bag included, a blanket, mobile phone charger, and other day to day essentials, which families could use if any emergency occurred while they were visiting their loved ones. There were also provisions for guest rooms where appropriate, so families and friends could be close when their relative was unwell.

Supporting people to express their views and be involved in making decisions about their care
• The service invested time and went above and beyond in getting to know people well and involving them in decisions about their care. We found positive evidence people were listened to and supported by staff to make choices about their care and support. People told us they felt involved in discussions about their support needs. One person told us, "We are involved in the planning of care. We got the whole booklet."
• The care plans for Gujarati speaking people were written in Gujarati. This meant people understood and took an active part in assessments and planning of their care.
• People were provided with information in the most accessible format. For example, a variety of communication methods were employed including, pictures and large print. Where necessary, families or advocates were consulted. This ensured people with limited capacity understood options available to them.

Respecting and promoting people's privacy, dignity and independence

• Staff were always respectful of people's dignity and human rights. They spoke with people in a respectful way, giving people time to understand and respond. Personal care was given discreetly and sensitively. For example, we witnessed a staff member discreetly asking someone if they wanted support with personal care.
• Some staff had been trained to become dignity champions. They raised awareness and took the lead in promoting creative solutions to dignity related issues. For example, the service had introduced 'dignity cover' to ensure an incontinence bag was not in view.
• People told us staff knocked quietly before they entered their rooms and any personal care was given discreetly and in private. The service had introduced door bells to help with privacy. Bells could be clearly heard and had different tones that allowed people to personalise their rooms.
• Equally, information about people was treated as a privacy and confidentiality matter. Care records were stored securely in locked cabinets in the office and electronically. The service had updated its confidentiality policies to comply with General Data Protection Regulation (GDPR) law.
• People's independence was supported as far as possible. There was evidence of positive risk-taking. The service always weighed the likely benefits and harms of exercising one choice of action over another. For example, one person was partially blind but wished to cook their own meals in the main kitchen. Associated risks included, scalding and lacerations from sharp instruments. However, by putting in place an effective risk management plan, the service enabled the person to exercise real choice and control, and therefore their independence.

Outstanding ☆

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now improved to outstanding. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to the

• A range of regular meaningful and fulfilling activities were on offer. The activity coordinator was extremely passionate and worked with staff to create activities to ensure people were not isolated. Whenever possible, the person, family, friends and staff were involved in choosing the activities. A relative told us, "The activity manager is fantastic. She goes above and beyond call of duty."

• Staff were attentive and ensured people were participating in activities. They offered spontaneous and planned activities, which ranged from shopping trips, visits to pubs, local walks, visiting places of interests, including church or temple. People enjoyed tea parties, music sessions, family events, arranging flowers and looking after hens and rabbits. We observed people listening to a guitarist who played relaxing music and people were engaged and reacted positively to it.

• That said, the service creatively engaged people who excluded themselves from activities due to a range of barriers, including experiencing mental health conditions. Responding to these needs, the service was exceptional in identifying ways to engage with them to help minimise isolation, distress and anxiety. For example, new technology was used creatively to employ a range of practical interventions to address specific circumstances of an individual's loneliness. For example, a ground-breaking pilot research, by the service in partnership with Imperial College, into loneliness in older people, had demonstrated the value of tablet computers and smart speaker technology in alleviating loneliness amongst older people. The findings of this research with older people at the service showed people being able to communicate and engage virtually with families or friends, via email or video call. We saw evidence people could communicate virtually with their families. Having championed this initiative, this was being rolled out to other care homes locally.

• Other innovative strategies to reduce loneliness included animal assisted therapy in the form of HenPower. HenPower aims to reduce loneliness by introducing chickens into care homes. The service previously kept chickens in its back garden, which were being used for training purposes with people. Due to the success of the trial, more chickens had been ordered. There was evidence during the trial this had encouraged people to go outside to interact with chickens, including topping up their water and food. Following our inspection, we received confirmation the service had resumed the project, with its own chickens. From the evidence observed, this had provided purpose for one person who previously refused to engage.

• Relatives were extremely appreciative of the impact of HenPower on their loved ones. A relative of a person receiving care had donated a second chicken coop due to the positive impact the project was having on her relative.

• We were impressed with the responsiveness and ability of the service to find creative solutions to empower and engage people. People, their relatives, staff and members of the local community, including schools

and colleges were all involved in a new innovative project called 'Our London'. Our London was a six-month project for creative writing and poetry. This was funded by the Mayor of London Culture Seeds Fund. External artists were invited to create projects based on people's personal requests. Eventually, these will be made into a book and performed with the community/family. The project was scheduled to conclude in April 2020, where people would share what they would have created. It was too early to evaluate the full impact, but the project showed promising potential of keeping people engagement with the wider community and living fulfilling and meaningful lives. This demonstrated the extent the service was willing to go to ensure people were kept engaged.

End of life care

• The service provided outstanding end of life care. At the previous inspection, the service was working with St Luke's Hospice to deliver end of life care. They had just introduced Gold Standards Framework (GSF). The GSF is a professional accreditation awarded to care homes in recognition of their high-quality end of life care practices. At this inspection we found the partnership had ensured high-quality end-of-life care was provided.

• Based on comments from people's relatives and our own observations, it was clear people received excellent end-of-life care. A relative commented, "Your team is outstanding. The home was like a second home to us. Your friendship gave us comfort and helped us come to terms with our relative's illness."

• The deputy manager was passionate about delivering quality palliative care. She told us, "I believe we only have one opportunity to get it right to make sure people and relatives are treated with the upmost dignity, compassion and empathy to ensure people's final journey is fully supported with choice and control when it most matters."

• The service had an end of life care champion to support the development of others. As part of her role, the champion ensured everyone in the organisation was committed to delivering high quality end of life care. She had completed a palliative care module at St Luke's Hospice.

• Exceptionally well completed anticipatory care plans were in place, including Do Not Attempt Resuscitation (DNAR) forms where people had agreed to this. These were highly useful as they comprehensively described the interventions which could be taken at the right time. They empowered people and their relatives to record decisions about people's care needs, including wishes and preferences should their health declined in some significant way. Where this happened, people's wishes were respected.

• One person's wish was to return home before they passed away. The service ensured appropriate advice and equipment was in place before the person moved to their preferred place of death. A relative of the person was supported with relevant training, including oxygen monitoring. A local GP had been contacted about support that might be needed.

• The anticipatory care plans were used to an excellent effect to prevent hospital admissions and enabling death at preferred place. It was evidently clear there was a reduction in hospital admissions from the service between 2017 to 2019, because people were dying at their preferred place.

• The service had established close links with end of life care professionals to ensure the support reflected best practice. A single point referral system had recently been developed. This gave access to community specialist palliative care services. Support provided by the palliative care team included, management of physical symptoms and pain control, emotional and psychological support.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• The service delivered high quality person-centred care. Our review of people's care records evidenced they were personalised and clearly articulated guidance for staff on how to direct people towards their desired goals. Integrated care pathways had been created for people who required this level of multidisciplinary care. We were impressed by the coordination of care for people with long-term conditions and those receiving end of life care.

• People's care and support was planned proactively in partnership with them. For example, the service had adopted 'Play List for Life'. This was an innovative approach to reconnect people with their past and families through music. People and their relatives were supported to create music playlists based on people's personal history and music preferences. This was based on evidence which suggests music tailored to tastes and memories, alleviate dementia symptoms such as stress and distress. We reviewed evidence demonstrating music had a calming effect on some people who displayed behaviours that challenged.
• The registered manager constantly strived to deliver support in a way that met people's needs. For example, he promoted a range of activities, including those helping to achieve better health and exercise. To promote healthier lives and wellbeing, the service introduced exercise bikes with video links that were used to enable people to go on virtual cycling trips to locations around the world, listening to music of their choice. This had a notable impact on people's wellbeing and physical health. We saw that one person who previously did not wish to participate in activities had become fully engaged with this.
• People's care plans were updated through periodic assessments to ensure these continued to reflect people's needs. External professionals told us the service focused on providing person-centred care and support and achieved exceptional results.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were known and understood by staff. At the assessments stage people where asked if they had a communication need. Once this was established the service took steps to ensure people received information they could access and understand. Communication support was provided if needed. This was clearly recorded in people's care plans.
• A range of communication methods had been developed to inform and involve people in their care. These included, newsletters, service website and Facebook and team meetings. People were also enabled to give their views through families, advocates and interpreters.

Improving care quality in response to complaints or concerns
• The service had a complaints procedure which people and their relatives were aware of. People told us they were aware they could speak with staff or the registered manager if they had any concerns. They felt they would be listened to if they needed to complain or raise concerns. Relatives commented that when they made suggestions, these had been received and responded to positively.
• Four complaints had been raised in the last 12 months, which had been investigated and concluded promptly.

Outstanding ☆

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence 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 this key question was rated as good. At this inspection this key question has improved to outstanding. This meant service leadership was exceptional and distinctive. Leaders and the service culture they created drove and improved high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• There was an excellent culture which always put people at the heart of everything. For example, initiatives such as HenPower, 'Isolation Project' and 'Play List for Life', were not offered to people as 'one size fits all' but rather with slight variations to meet people's varying needs.

• Our review of the service demonstrated it exceeded individual desired outcomes. This was evidenced in a range of areas including cultural and spiritual interests, mental health, end of life care and management of chronic conditions such as dementia.

• We heard some outstanding feedback from professionals. One professional told us, "Overall it is an excellent home for its size and is managed in an amazing way. People have their own committee to promote changes they want to see. I could not find any real fault in it at all and again for a home that size it is an absolute achievement." This view was shared by people, their relatives and members of the community.

• The delivery of care took an inclusive approach by involving people, their families or representatives, staff and the voluntary sector. For example, 'Singing for Lung Health' was a group led intervention of people receiving care, demonstrating how the service provided excellent self-directed support options for people who were able to do so.

• The registered manager constantly thrived to empower staff through effective delegation and provision of opportunities to develop skills. Staff were assigned to be 'champions' for specific roles they were interested in, which clearly had a positive impact on their confidence. They spoke positively about the nature of support. A member of staff said, "I want to thank management for this opportunity. They have taught me and trained me and have been so supportive. This isn't just my job, it's my life and I love it here."

• The service recognised and celebrated staff success as evidentially this was motivating high performance and enhancing staff engagement. The latest newsletter acknowledged the staff members of the month with the caption, "All these members of staff showed exceptional commitment to their colleagues, residents and the home and we want to say a tremendous congratulation."

• People's achievements were also celebrated. The newsletter had a section on "Resident of the month'. The latest issue recognised the work of one person for 'not only helping with the activity team, but also helping to look after the rabbits and being a befriender of many of our residents'. This demonstrated one of many brilliant examples of an inclusive approach.

• The achievements of the service were recognised with a top 10 position out of 1500 care homes by Care Homes UK review, 2018.

• The registered manager won the British Care Awards/2018, home manager of the year, out of 1500 registered managers.

• The service empowered staff to develop their skills through training and personal development to help drive improvement. The activity manager was nominated for the Great British Care Awards/2019, having won the award in 2017. The Asian kitchen chef was a finalist for Asian vegetarian chef of the year/2019. The Asian kitchen was one of only three pure Asian kitchens in a London care home. The chef of the service was nominated for chef support manager/2019. They had both been invited to attend the award ceremony at the House of Parliament.
• Staff spoke highly of the constant support they received from their registered manager and senior staff. One staff member said, "The manager comes around every day and asks if everything is ok. I feel listened to and feel my opinion matters. For example, I asked for footstools which we can use for people to elevate their legs and he made sure we had them. This helped people to be more comfortable when sitting in their lounge or in their rooms."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• We evaluated the leadership as outstanding. People, their relatives and professionals consistently described the registered manager in complimentary terms such as 'inspirational, enthusiastic, approachable and exceptionally caring'. We found a strong commitment to providing people with high quality person-centred care.
• There were performance metrics used to measure achievement. These included, reduction in pressure ulcer incidents, nutrition (unplanned weight loss), reduction in infections and significant incidents. We evaluated performance of the service in terms of how these outcomes were being achieved for people. Records clearly demonstrated outcome measures were being achieved to a high standard. For example, the service had reduced the average number of people with pressure ulcers from 14 to 4 out of an average of 120 people at risk, over a period of four years. These improvements had been maintained, with a gradual decrease of incidents of pressure ulcers.
• As the local chair of the EHCH, the registered manager was highly knowledgeable of the integrated care partnership's requirements for meeting people's needs. The joint outcome measures for the delivery of the partnership's strategy, included, reduction in London Ambulance Service calls, reduction in the number of accident and emergency attendances and emergency admissions from care homes. Excellent progress had been made in reducing the number of hospital admissions from the service, from 75 in 2017 to 58 in 2018, and 42 in 2019. Equally, there were fewer people dying in hospital due to an increase in proportion of people dying in their place of choice.

Continuous learning and improving care
• The service continuously sought to make improvements. There was a rigorous approach to monitoring incidents to support improvement. The service was monitored, through robust systems of governance. They collected management information of high quality via audits, feedback from people and other sources. This supported effective decision making and allowed for prompt action where performance was outside defined parameters.
• The process for investigating incidents took several steps. The first step was the identification of the incident, followed by a selection of incidents warranting further investigation. The third step was the actual investigation, followed by the dissemination of results and therefore any learning. For example, our findings of the service's performance against quality indicators showed a progressive decline in the number of significant incidents, use of anti-psychotic medicines, infections, weight loss greater than 3.5kgs and medicines errors, which suggested the service was continuously making improvements.
• The registered manager complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of notifiable events.

Working in partnership with others

• The service worked effectively in partnership with health, social, academic and voluntary sectors to deliver positive outcomes for people. We evaluated the impact of the partnership as outstanding. For example, the service was distinctive in that their registered manager was the chairperson of the EHCH Steering Group. This therefore meant the service proactively engaged with healthcare services to ensure people benefited from the most up to date care and support. For example, many initiatives such as oral care project had been piloted at the home before they were rolled out to other local providers. This gave the service an opportunity to be ahead with current care practices. Notable impact included people having timely access to dental care.

• The leadership of the registered manager as the chair of EHCH forums was commendable. A senior professional told us, "As we continue to develop the integrated care partnership in Brent, the registered manager has remained engaged and supportive whilst maintaining clear leadership for his colleagues, representing and voicing their views and ensuring a collaborative approach to the best outcomes for care homes in Brent."

• As stated, the service always looked for partnerships and learning opportunities by working closely with various academic institutions to stay abreast of best practice and current research.

• The service supported the NHS Graduate Management Training Scheme. The registered manager had attended relevant training and was able to provide a work placement for the students. He had received excellent feedback from the students. One student said, "The garden area was a great space for volunteers, staff, residents and their families. Evidence shows that interaction with nature, wildlife and domestic animals can have a positive impact on a resident's experience during their time in residential or nursing homes and Birchwood Grange Nursing Home appeared to have encompassed all of these elements in their design. The sensory room seemed a particularly great space for the residents, especially for those suffering with dementia. Other touches that stood out as personable were the decorations on residents' doors based on their hobbies and careers and the in-house hairdresser's salon."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• There was an excellent commitment to engage with and involving people, their relatives and the wider community to obtain feedback on the services provided. Survey returns form people and their relatives showed the service was rated highly.

• There was a deep-rooted culture of volunteering and befriending. For example, the activity team comprised 150 volunteers, who ranged from nursery children to university students. They played a significant role in many aspects of people's lives, including reducing loneliness.