Care UK Community Partnerships Ltd

Mountfitchet House

Inspection report

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and High Lane
Mountfitchet
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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Mountfitchet House is registered to provide accommodation for up to 60 people who require nursing and personal care. At the time of our inspection there were 42 people living at the service. The service is located in the town of Mountfitchet close to local shops, amenities and facilities. Off road parking is provided as well as accessible premises for people, staff and visitors. Access to the accommodation is provided by stairs or a passenger lift to all floors of the purpose built two storey building. There are four individual units and a total of 60 single occupancy rooms with en suite wet room facilities. Bathing facilities are available for people with this preference.

This was the first inspection of this service since it first registered in October 2014. This unannounced inspection took place on 1 December 2015.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were only employed at the service once all appropriate checks had been completed. These checks helped the provider determine staff's suitability for either a nursing or care role working with people living in the service. There were a sufficient number of suitably experienced staff working at the service. An effective induction process was in place to support new staff including nurses. This included an assessment of staff's overall suitability for their chosen role.

Staff with medicines administration responsibilities supported people to take their prescribed medicines safely. Staff received regular medicines administration training and an assessment of their competency to do this safely. Staff knew the reporting procedures for any concerns they had, or may have had, about people's safety.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager and staff were knowledgeable about when an assessment of people's mental capacity was required. They had determined people's lack of mental capacity and applications had been made to, and acknowledged by, the local authority. This was to lawfully deprive some people of their liberty in a lawful way. People's care was provided where it was in their best interests.

Staff understood and were attentive to people's needs and supported people in a compassionate manner. Staff knew what was meaningful and important to people. People's privacy and dignity was respected by staff who ensured they had gained permission to enter people's rooms.

People were involved in planning their care. People's care plans and records were regularly reviewed and updated accordingly. The registered manager provided people with information on accessing independent advocacy if any person required this support.

People were supported with their health care needs. This was by the most appropriate, or a combination of, health care professionals such as speech and language therapist or GP. Health care professional advice was adhered to by staff. Prompt action was taken in response to the people's changing health care needs. Up-to-date risk assessments to help safely support people with risk to their health were in place and these were kept under review according to each person's needs.

People were supported to achieve and maintain a healthy weight. This was with sufficient quantities of food, drinks and snacks for people to access whenever they wanted. This included those people at an increased risk of malnutrition, dehydration or weight loss. Pureed and soft food diets and choices were available and provided.

People were given various opportunities to make key suggestions about any aspects of their care they wanted to make changes to. Staff responded promptly to and recognised when a person was concerned about issues which affected their day-to-day life at the service.

A range of effective audit and quality assurance procedures were in place. These were used as a means of identifying areas for improvement and also where good practice had been established. Information was shared through a range of forums including residents', managers' and staff meetings.

Staff were supported with their personal development by managers who kept themselves aware of the day to culture in the service. The registered manager supported staff as well as engaging with people on a day to day basis.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff had a thorough understanding about how to protect people from risks of harm. People were supported to be as safe as practicable.

An effective recruitment process was in place and this helped ensure that staff were suitable to work with the people using the service. A sufficient number of suitably qualified and competent staff were in place.

Risk assessments recorded the risk to people and their health and well-being. Staff adhered to safe medicines administration practice.

Good

Is the service effective?
The service was effective.

People's independence was respected and they were supported with their decision making by staff who knew them well.

Health care professionals visited the service regularly and staff followed their advice.

A selection of menu options and alternatives were in place and offered that were appropriate to people's nutritional needs. People were supported to have and access sufficient quantities to eat and drink.

Good

Is the service caring?
The service was outstanding in the way it cared for people.

The regional director, registered manager and all staff were committed to meeting or exceeding people's preferences and expectations.

Staff really valued their relationships with people and fully understood their needs in a way which showed people always came first and foremost.

Staff frequently exceeded people's expectations to provide compassionate support which gave people every possible opportunity to have care that was as meaningful as possible.

Outstanding

Is the service responsive?
The service was responsive.

People suggested and were supported with a wide variety of their preferred social activities, hobbies and interests.

People were empowered to make meaningful decisions about how they lived their lives.

People's comments, compliments, suggestions and concerns were used as a way to identify what worked well.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led.

Quality assurance and audit processes and procedures were in place and these were effective in identifying areas for improvement.

Staff were supported by the registered manager and representatives of the provider. There was an open and honest culture which the registered manager fostered on a daily basis.

The registered manager and provider used a variety of methods and sources of information to help keep staff skills up-to-date. Staff physically demonstrated the shared beliefs and values of the provider by continually striving for improvement in everything they did.

Mountfitchet House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 1 December 2015 and was completed by two inspectors 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with twelve people living at the service, nine relatives, the registered manager, the regional director, clinical governance manager, deputy manager, two nursing staff, one senior and two care staff and the chef. We also spoke with a visiting GP.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed other people's care to assist us in understanding the quality of care people received.

We looked at three people's care records, the minutes of residents', managers' and staff meetings. We looked at medicine administration records and records in relation to the management of the service such as health and safety checks and records. We also looked at staff recruitment, supervision and appraisal process records, training records, and complaint and quality assurance records.

Good

Is the service safe?

Our findings

People told us and we saw that they were safe living at the service. This was because staff responded promptly to people's call bells. One person said, "I call for assistance and they [staff] are there straight away." A relative told us, [Family member] loves it here. They get the care they need at the time they need it without having to wait long at all." Another person said, "It is very nice here and I am well looked after – I am safe enough here."

Staff told us and we found that they had received training and regular updates in safeguarding vulnerable people. They had a thorough understanding of the different types of abuse that could occur. They said that they would be confident about reporting abuse or poor care practices within the service and knew how to report concerns to external organisations such as the local safeguarding authority if necessary. One person said, "If I had any concerns, which I don't, I would tell [name of staff] straight away." Staff knew how to escalate any unresolved concerns should this be required. Staff told us that they knew people well and if someone was not their usual selves they would investigate this. This showed us that that there were systems in place to help ensure that people were as safe as practicable.

Information was available to people in the service about how to report any concerns to staff, the local authority or the CQC. Staff had access to the contact details for reporting any potential or actual safeguarding events. A person said, "I am settling in well. I feel safe as they look after me and there are always staff around." A relative added." My [family member] has been here some time now and they used to fall at home. They are safe now with the staff to support them." This meant that the provider and staff had the appropriate measures in place to help ensure people were kept as safe as possible.

Risks to people, including those at an increased risk such as from choking or falls were managed effectively. Where people exhibited a combined risk such as those associated with falls, medicines and equipment, these were considered jointly. This was to help ensure that all risks were looked at holistically. A relative told us, "I feel it's a really safe home. Staff manage their [moving and handling] really well. I feel alright leaving them [family member] here when I go home." More urgent reviews of people's risks were undertaken where there was a need. For example, the introduction of new equipment or a change to people's medications. This meant that the registered manager had processes and measures in place to support people safely with their risks.

People told us that they were able to take risks such having a pet visit them with relatives, eating as independently as possible and going out in the service's transport. One person told us, "They [care staff] look after me very well and I feel secure here." Another person told us that when they used their call bell that staff came quickly to help when they had experienced a fall. Staff told us, and we saw, that some people were supported by two members of staff. This was for those people whose assessed needs required moving and handling assistance.

Accidents and incidents, such as people experiencing a higher than expected number of falls, were investigated and action was taken to prevent recurrence. For example, referrals were made to the most appropriate health care professional. This included the person's GP or falls team. The registered manager told us and we saw that where falls team interventions had occurred that people had experienced less or no further falls.

The provider used a recognised dependency assessment tool to help determine staffing levels. Other aspects considered included people's preferences and what each person's individual care and nursing needs were. During our inspection we saw that there were sufficient numbers of staff to meet people's care and nursing needs. We also saw that staff had the time to spend with people talking, interacting and engaging in meaningful conversation. A call bell monitoring system was in place and we saw that staff responded to people's request for assistance promptly. One person told us, "I feel safe here. I know that I need staff to keep me safe especially with my medicines." The manager and all staff spoken with told us that there was always enough staff to meet people's needs. One care staff said, "It's nice working here as I get time to take people out. There is never a time when we can't cope or meet people's needs safely."

The registered manager had arrangements in place to ensure that there were sufficient staff when there were unplanned absences. These included the use of agency nurses, staff changing shifts and working overtime. They told us and we saw that two new nurses were due to start as soon as the checks for any unacceptable criminal

Good

Is the service safe?

records had been completed. They told us that the key to ensuring people's safety was recruiting the right staff and not just to fill vacancies. Staff were satisfied with the number of staff on duty each day and their skill levels.

Staff told us that there was a robust recruitment and induction process in place. The records we looked at confirmed this. Checks included those for people's previous employment, recent photographic identity, nursing staff's evidence of registration with the Nursing and Midwifery Council and written references. The registered manager explained the induction process for new staff and the standards they had to achieve before being offered a permanent position. Another member of staff told us about all the records they had to provide as well as their job interview before they were offered employment. This showed us that the provider only employed those staff who were deemed suitable to work with people living at the service.

We found that recording, storage, administration, disposal and ordering of people's medicines followed current guidance. Nurses and senior care staff who handled medicines received medicines administration training. This included a number of assessments of their competence before they managed and administered medicines on their own. People were happy with the way that staff managed their medicines. Staff were able to tell us about the requirements to support people with their medication such as with skin patches or sedatives. The records showed that people were only offered sedation were this was the least restrictive option. There were care plans in place with guidance on how to administer 'as required' medicines and the maximum allowed doses. During a medicine round people were asked if they wanted a pain killer. One person told us, "The nurses give me medicine for my pain and it helps." Another person said "They [staff] stand by you while you swallow them [medicines]." The clinical lead told us that they were kept up-to-date with current guidance from organisations such as the British National Formulary. This was to ensure that people were prescribed safe doses of their medicines.

Good

Is the service effective?

Our findings

A relative told us, "The staff seem well trained." Staff told us that they had supervision and felt well supported by the senior team. A nurse told us that they could get 24 hour clinical support if they needed it. They particularly appreciated the support from the clinical lead in the home. However, they said that they found it difficult to provide emergency support for staff on other units at night as they did not know anything about the people in the other units. Key information about people that staff cared for was not easily accessible. Electronic care records were not always quick to access. This meant that there was a risk that in the event of an emergency that important information would not be immediately available.

Staff were supported with a formal induction and shadowing opportunities with experienced staff. We found that nursing and care staff completed a competency workbook that covered a wide range of clinical and care related topics. Staff self-assessed their own knowledge and confidence. The clinical lead then carried out an assessment of their competence. They told us that they had recently received training on moving and handling, medication administration, percutaneous endoscopic gastrostomy feeding [this is where a person is fed through a tube in the stomach] and wound care. The registered manager told us and records we viewed confirmed that they regularly had external speakers who provided training on a variety of topics such as tissue viability and dementia care. One member of staff told us, "The training here is much better than at the previous care home I worked in."

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

Staff had received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We found that staff's understanding of these subjects was thorough and had enabled people to be cared for where it was in their best interests. Appropriate applications had been submitted and acknowledged by the local authority to lawfully deprive 22 people of their liberty. This was to help ensure that people were safely supported with their decision making. One member of staff said, "The MCA and DoLS are about making sure we make [lawful] decisions on people's behalf whilst keeping them safe." Records viewed showed us when and whether people could or couldn't make specific decisions. For example, when they wanted to go out and what they wanted to wear.

Staff told us that GPs and relatives had on occasions been consulted for permission to use covert administration of medicines [this is where medicines are hidden in people's food]. The pharmacist had also been consulted about the safety of giving the medicines covertly. This was only done when a person living with dementia was refusing medicines that were vital to their medical condition or to their physical or mental wellbeing.

Staff told us that they had the training they required to meet people's needs effectively. Training deemed mandatory by the provider included medicines administration, moving and handling, risk assessment and first aid. This was planned and delivered to ensure that staff had the skills and knowledge necessary based upon people's individualised care needs. A member of staff told us, "We are always having to complete our [mandatory] training. The [registered] manager lets us know when this has to be completed by." Another member of staff said, "We get regular training from the in-house trainer as well as e-learning."

We saw that plans and processes were in place to ensure all staff received the support they needed. The registered manager and staff confirmed that they were well supported. The service's regional director told us that they visited the service most weeks. One staff member said, "I have a formal supervision every few months. I can raise any matters that affect my work as well as discussing training and future development." The provider and registered manager were keen to develop all staff's knowledge and provide for any additional training needs. This included the roll out of the Care Certificate to staff. This is a nationally recognised qualification for all staff with care

Good

Is the service effective?

responsibilities. This included additional training including basic life support. Mangers and care staff told us how they were completing various qualifications and nurse revalidation [the process by which nurses demonstrate they practice safely] for April 2016 and that they were supported with this. Monitoring arrangements were in place to ensure staff completed, supervisions, appraisals and training in a timely manner. Staff confirmed that any training to meet people's care needs was provided. For example, for those people who were supported to eat who could not do this orally.

We saw that people, including those with food allergies, sugar free, or soft and pureed diets, were offered a choice of food and drinks. This included a variety of drinks, meals and snacks that were accessible throughout the day. We saw that staff respected people's independence with their eating and drinking. We saw that some people were supported with their eating and drinking by staff to ensure people ate and drank sufficient quantities. One person told us, "I am allowed a glass of red wine at lunch and dinner – the food is excellent and you get enough choice." A relative told us, "They [people] are in a restaurant rather than a dining room and they are offered different juices and these can be in wine glasses, shown both dinners, the tables are dressed at all times

and families are welcome." Another person said, "I have breakfast in my room, my choice and my other meals in the dining room. I like to get up and get washed and dressed and then have my breakfast."

The chef went round each day to check that the food was up to the required standard for everyone. The chef was covering from another of the provider's home. He said, "The systems are the same here so I can see straight away what foods each person has such as a soft food diet.". The chef explained the alternative meals people preferred or could have if they wanted. These included omelettes, salads or a sandwich. Relatives confirmed that this option was always provided if requested.

People, where required, were referred to the most appropriate health care professional. Where people were at an increased risk of weight loss or due to their levels of skin integrity food and fluid intake levels were recorded and monitored. This also included regular weight checks. This was to help ensure that people received a healthy, balanced or fortified diet that was appropriate to their needs. A relative told us, "Staff communicate with me well and keep me up to date with any health concerns. They asked me whether I wanted them to have a flu injection." Staff said that they had good support from the local GPs, the nurse practitioners and the community matron. Staff made referrals to the specialist nurses such as the tissue viability nurses if they needed specialist advice on people's wounds or pressure sores. People told us that they saw the GP when they needed to and that they had regular chiropody. A visiting GP confirmed to us that guidance they provided was being rigidly adhered to. They told us that nursing staff were very quick in alerting them to any changes to a person's health. People could be assured that the staff would take action to reduce and prevent any risks associated with their health.

Outstanding ☆

Is the service caring?

Our findings

People and their relatives were very complimentary about the staff and the care they received in the home. One person said, "The staff are nice. I don't think they could do more for me. I'm happy being here." Another person said, "The staff are good." A relative told us, "We're very happy with the care. Staff take time to chat to [people] when they pass by." A third person said, "Staff always treat me respectfully, no rudeness from any of them – they are very good." Another relative said, "The nurses and care staff are really helpful. The staff are so nice. They would do anything for you and you can ask them anything." Staff recognised if people who were not able to communicate their wishes verbally, wanted some help or support with their care needs.

Person centred care was demonstrated and staff knew the likes and dislikes of people and there was good banter amongst many of them during our inspection. Examples of this included people being given the choice of walking with a mobility walker with carers or using a wheelchair if the person had become tired on their way to the lounge. People valued their relationships with staff and felt that staff exceeded their expectations. One person said, "A bath I enjoyed enormously, I cannot have soap as I am allergic and the staff they were aware of this and did not use soap before helping me with the bath – staff completely understood this. Staff behaved beautifully when I was being bathed – it was an excellent experience." A relative said, "Kitchen staff stop and have a sing song and other staff from other units going on their breaks still stop and say a quick hello to [family member] – really friendly staff – there are no boundaries."

We saw and people confirmed that staff were always polite and spoke to them in a respectful way. Examples included ensuring people's private conversations were respected and also staff acknowledging when people wanted to be on their own. Staff gave people time to consider their decisions as well as allowing people to do things at their own pace. All staff were passionate about making a difference to people's lives. One staff said, "I have worked in other services but Mountfitchet House is by far the best." They told us that as well as being a purpose built building it was the staff who provided the care and that this was "as good as it gets." Staff champions for people living with dementia were in post. In addition, speakers had given presentations to staff and people at the service about this and many other health conditions. This we found had helped the whole staff team to understand each person living with dementia and other health conditions much better. For example by providing objects that people showed an interest in.

We observed care staff being caring and attentive with a person who had difficulty speaking. They said, "It is alright take your time", then the nurse came over and knelt by the wheelchair – both showed empathy, patience and knowing the person they were able to go through a list of things until they discovered that they wanted the toilet. We also saw clear instructions for staff about one person's preferred method of communication when asking them if they needed a pain killer. A visiting GP told us that staff were very good at managing people's pain relief with as and when medicines. Another person had a range of medicines available to make them comfortable at the end of their life if they needed them. A visiting GP told us that staff listened to people and that they were attentive to their needs. This showed us that the service and its staff considered each person's needs individually.

Staff described how they respected people's privacy and dignity. This included distracting people with general conversation during the provision of personal care. Other ways staff used to respect people's dignity was by gaining permission to enter their room and closing doors or curtains. A relative said, "Staff are very good at preserving their [people's] privacy and dignity. They cover them up and when hoisting and always close the door when they carry out any care." They added, "Staff support me as well." This showed us that staff communicated well with people as well as putting them at ease.

Each person had a senior care staff member who had specific responsibilities for the individual aspects of care which really mattered to the person. This was to ensure that people's care needs were met. For example, one person told us that their relative visited with the family dog. We saw that as well as the registered manager's pet dog, several other dogs visited people during the day. Each pet was the subject of much jovial discussion and people 'smiled' as a result. A relative told us, "If there was a [name of web site] for care homes this would get my vote for [Family member]. Nothing has been too much trouble." Another relative said, "Although the reception area is really

Is the service caring?

nice, what matters is what goes on behind those doors [for each unit]. They [hairdresser] cut [family member's] hair as I never could and they sent me photos at how pleased [family member] was."

We saw that staff regularly sought or asked about people's general well-being and responded appropriately where this was required. For example, we observed the way staff responded to, and spoke with, people who had used their call bell. One relative said, "This is where [family member] will probably spend the rest of their life. The care they get though is amazing."

Throughout the day we saw that all management staff including those visiting the service engaged in general conversation about what they and people were doing. People were seen to respond and engage in general conversation. People told us the registered manager, nursing and care staff, chef and activities staff were always talking to them, asking how they were and if everything was alright. After lunch we saw the chef asking people if the lunch had been up to standard and if the food had been what they expected. A relative said, "There is a relaxed atmosphere here and sometimes [family member] has a lay in until 10.30am if they want to stay a little longer then they [staff] leave [family member] – some [people] come down to breakfast in their dressing gowns."

All people, relatives and staff we spoke described the service like a hotel but in a way that met people's needs. For example, by having dementia friendly furniture and memory boxes to help people find their room. One nurse said, "We encourage relatives to bring in items such as memorabilia that the person would recognise. They added that this often stimulated people into talking about areas of their life they found important. We observed that this was the case.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. The registered manager and staff were aware of the organisation such as Age UK which offered this service if required. This showed us that people's wishes, needs and preferences were respected where people were not able to speak up for themselves.

People were given many opportunities to be involved in reviewing their care needs. This included people who were not able to communicate verbally. Regular reviews of people's care took place and these involved the person as much as possible. A team leader told us that people's views were the most important. They added that this was because the care provided was what people wanted rather than what staff thought they needed. Care staff also used the information from relatives and friends about the aspects of people's lives that were important to them. This was to inform people's care plans.

People told us and staff confirmed that visitors could call in at any time people were in the home. One relative said, "I can come at any time even if this is during the night to be with [family member]." Another relative said, "Lovely carers, incredible and they know us by name and personalise things – we bring in all the grandchildren and the great grandchildren." This demonstrated that the provider had considered the Human Rights Act 1998 and people's right to a family life.

Good

Is the service responsive?

Our findings

People and staff told us about the social activities, hobbies and interests they had taken part in. These included involvement with a resident pet dog, birds such as owls and communal games. We saw in a newspaper cutting that one person had been involved in a Royal Society for the Protection of Birds survey. This was because they had recorded the number and types of birds visiting the service's gardens. Other hobbies and interests that people were supported to take part in included baking mince pies and a Christmas pudding, gardening or sitting in an area with sensory plants, a Halloween party which people, relatives and staff had enjoyed. Games and puzzles were provided in an appropriate colour/size and format so that people were able to take part as much as possible.

We observed the activities staff interacting, assisting and reassuring people. They said, "We have got Christmas carols later and I shall need some help putting up the tree – it is December 1st – will you come along to the meeting later to help plan for Christmas?" Later in the day we saw this event taking place much to the enjoyment of people. Another staff member asked a lady, "Do you want to come to the meeting, are there any films you would like us to show?" To a man who said he wanted to go to a garden centre "Yes we can arrange that, you missed the last one but I will put your name on the list for that." To a lady, "We shall be doing the Christmas decorations and Christmas tunes and sherry this afternoon, are you going to come and help me?" This meant that staff made every effort to involve people in as many social activities as possible.

People had the freedom to choose when, where and what they wanted to do including going out into the local community to a pub, garden centre or a museum. This helped promote people's social inclusion. Three activity's staff also supported people seven days a week with many other activities such as one to one time for people who were cared for in bed. This included hand manicures, reminiscing about the person's life history or reading a book. This was to help prevent any risk of social isolation. One care staff said, "It is good to learn about and know what people did in their lives as they were also young like us once." They told us that this helped them support people in a much more person centred way and respond to any given situation. For example, if the person was now living with dementia they were able to provide care based upon previous experiences the person had enjoyed. This was confirmed during our observations and in people's care records. Staff responded to people's requests, whatever these were, with enthusiasm. People, relatives and a visiting GP spoke highly of the staff and their attitudes towards people's care provision. A relative said, "One of the reasons I chose this home for [family member] was that there is always something to do. I am often invited to help or take part, which I do." At recent residents' meetings people had confirmed the various social activities that had been provided. These included making gingerbread men biscuits, and a sherry and mince pie event. We saw that people had been supported by staff to be involved in and making the mince pies.

We saw that people's care records were up-to-date. People, their relatives and healthcare professionals had been involved in producing these. The clinical lead told us that as part of people's assessment of care needs that all possible aspects that could impact or improve the quality of people's lives were considered. This assessment included a record of people's life histories, what their aspirations and goals were and particular preferences people had. This was to help ensure that the service and its staff were able to safely meet the person's needs. Records we viewed confirmed this. One person said, "I have not lived here long but all the staff are just wonderful. They do everything I ask. I can take part in communal activities or I can do want I want to do." Nursing and care staff showed us how they reviewed the progress each person had made and what their future aspirations were. Any changes in response to people's needs were then implemented. For example, if a person had been provided with bed rails, walking aids or a change to their medicines. A relative told us, "[Family member] had issues with the bed when they fell twice in April and the deputy manager discussed bed sides with pads and the problem is now sorted – she rang me at home when it happened."

One person told us and we saw in meeting minutes where people had requested something new or a need for this was identified then it had been provided. For example, a new or favourite film that people wanted to watch in the service's cinema room. One relative told us, "[Family member] asked for a prawn cocktail and the staff went and bought the prawns and made them a cocktail. [Family

Good

Is the service responsive?

member] loved it." Another person told us and we saw that at the residents' meeting they had suggested a "wear it pink" tea party and in response to this request this event had raised a sum of money for a well-known charity.

A relative gave us many examples of how the leadership of the service had improved their family member's care. These included, "I would tick the excellent box, primarily for the care, the staff you cannot fault them and I like the respect I get from the staff and if I query anything like [family member's] medication they respond very quickly. I had concerns about [family member's] bowel movements so they reviewed and changed their medicine." And, I found some redness on their [skin] and they said that they were treating it and he had seen the nurse and the got the doctor involved, for his feet they got the chiropodist in." We saw that this was the case. A visiting GP told us that any changes to a person's health care needs were reported and acted upon swiftly.

The service had an old fashioned style shop that people could visit within the home. This was run with the help of relatives selling a selection of groceries. A relative was very complimentary about the shop and how staff involved people in the home. They described how staff provided a lot of person centred care. They said, "They [people] have movies and sing-alongs and [staff] bring animals into the home. They're very good at stimulating residents and keeping them interested." The registered manager explained that free Wi-Fi as well as wired internet access was available throughout the home and several people currently used computers to access the internet to keep in touch with relatives and friends. This showed us that people were supported to have their care provided in a person centred way.

The registered manager told us that people's suggestions were always considered and acted upon wherever possible. We saw that this had been the case. One person told us and the registered manager confirmed that they had requested to go to their family's Christmas dinner and in response to this request they were being supported by staff to do this. Staff used a nationally recognised organisation to assist them in developing new opportunities for people's interests. The activities staff, as champions, for this role were actively looking at exploring additional options of where and what other interests people could be supported and encouraged to go to.

We saw that people who required a call bell were supported to access this equipment. Other monitoring equipment included sensors to alert staff to people's movements. The registered manager showed us how trends in when people had got up during the night had helped them determine when people wanted to go to the toilet as well as reducing the risk of falls.

People were supported to raise concerns or make suggestions before they had the potential to become a complaint. People, their relatives or representatives knew how to make a complaint and staff knew how to respond. Information in the form of a service user booklet was provided on how to raise a concern or complaint. One person said, "I have no complaints. If there is anything bothering me I just have to say and they [staff] sort it out for me. I can't fault any of them [staff] or anything."One relative told us how they had made a suggestion to improve the dining experience. They said, "It is the little things that can make the biggest difference to [family member's] life. The registered manager and regional director confirmed that they were reviewing this and that they would implement changes where possible.

Good

Is the service well-led?

Our findings

People's views about developing and improving the service were sought in the most appropriate way. This included residents' meetings as well as staff spending time with people, seeking their views. People's comments were then used as a way to drive improvement. One person whose family member also lived at the home told us, "I would recommend it [the service] my [family member] is in the room next door and [they] come in to see me very often." A relative told us, "The [registered] manager is a nice lady and the deputy came and did the home assessment – they have an open door policy and you can go and talk to the [registered] manager anytime." Another relative said, "Staff work well together and I saw a domestic [staff] help a lady to the toilet, not her job but she wanted to help the resident."

The registered manager told us that whatever people had to say their "door was always open". We saw that the visiting management and senior staff were present around the home and engaging with people and relatives. Nursing staff told us that as well as clinical meetings they also ensured comments from people were recorded in daily notes as well as passing these to the registered manager. This helped identify the finer points of people's care and that prompt action could then be taken if required.

Quality assurance procedures had identified key themes on what the service did well and where improvements were required. For example, requests for further visits to craft fairs, garden centres and plays including Jack and the bean stalk. We saw that this had been suggested by people and responded to. This was because they had enjoyed them so much. One person told us, "They [managers] are all good. I can and do speak with them nearly every time I see them. I rarely need to complain as such as they respond so well." A relative said, "I have seen the relatives' meeting [advertised] on the board, had nothing by post or email but I know when the next one is." Another relative said, "It [the service] is not just for the residents, the staff make us so welcome and we can take [family member] down to the coffee bar and have cakes – it is very nice." They told us they were not able to think of anything that could be improved as it was all so good.

People we spoke either knew who the registered manager was or how to contact them if required. This could be through relatives, staff or advocates. People and relatives commented favourably about how much time the registered manager spent out of their office meeting them. One relative said, "The manager is or makes themselves available at any time – she is very approachable." We saw that this was the case throughout the day of our inspection.

We were told and saw from records viewed that the local school had been involved choosing the names of the four units in the service. The children had been invited to and opened the service in 2014. Strong links were maintained with the local community and included various trips out to local parks, theatres, garden centres, visiting schools, church groups and local businesses. Other links included a visiting mobile library and staff taking people to special family events. This showed us that people were supported to avoid the risk of social isolation.

Staff spoke confidently about the provider's values of treating each person as a person and making sure their wishes were always responded to positively. Staff confirmed that they liked working at the service. One said, "I come here for the residents – I do like it here."

Staff were regularly reminded of their roles and responsibilities at supervisions, staff and clinical governance meetings. Staff told us they felt very confident that they would be supported to escalate any issues or concerns they became aware of if this was required. One care staff said, "I would report it straight away to the [registered] manager or the deputy manager." The clinical lead nurse also worked shifts, completed spot checks and worked with staff at nights/weekends. This helped managers identify any issues at all times of the day and night in a proactive manner and put measures in place to support staff such additional shadowing or mentoring. Another staff said, "The [registered] manager has 'open surgery's where we can discuss anything. They like to know what's going on. There is a good staff team with an open and honest culture. It is nice to see get promoted and grow in confidence."

The registered manager had provided leadership at the service since it opened. They had from records viewed, notified the Care Quality Commission of incidents and events they are required to tell us about. They told us that they key challenges were expanding the service whilst ensuring that the right staff with the right skills were in place first. Staff confirmed that an additional staff member had been employed as the number of people using the service had increased.

Good

Is the service well-led?

A combination of formal audits and quality assurance procedures were undertaken by the provider, registered manager and senior nurse and team leaders. Other audits were undertaken by an external pharmacist. We saw that a service improvement plan was in place and actions had been implemented. We also saw that checks were in place to help ensure that these actions had been effective. This included the need to ensure that the correct medicines administration procedures were adhered to. Any trends identified during audits allowed the provider to determine the best course of action. For example, only retaining those staff who consistently demonstrated the service's required high standard of care.

A visiting GP was complimentary about the communication improvements they had observed and that people's health care needs always came first and foremost. We saw that the registered manager and all staff as well as people living at the service, worked as a team. One care staff said, "I can contact [name of registered manager] at any time. They are supportive even if it is only a small thing [to me]." We saw that regular visits were undertaken by the clinical development manager. Nursing staff told us that this helped ensure that they kept their skills up-to-date and put these into practice.

Staff champions were in place for subjects including dementia care, Parkinson's disease and a clinical lead. This was to promote and develop staff skills and improve the overall quality of service provided. From our observations throughout the day we saw that all managers and staff understood the key risks and challenges in running the service. This included managing risks to people using the service such as those people at an increased risk of malnutrition or falls. This showed us the provider strived for improvements in the quality of care it, and its staff, provided.