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# Knowle Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 1 November 2017 and was unannounced. The service was previously inspected on 12 July 2016 and was at that time not meeting the regulations related to safe care and treatment and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe and well led to at least good. We found improvements had been made at this inspection to meet the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Knowle Court 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.

Knowle Court provides accommodation and care for up to 22 older people, some of whom may be living with dementia. The home is situated in a quiet village on the outskirts of Huddersfield. Accommodation is in single and double bedrooms. On the day of our inspection there were 22 people living in the home.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this inspection the service had a registered manager who was also registered as the provider of the service, which was owned by himself and his family. In this report they are referred to as the registered provider. A manager was also employed.

People told us they felt safe. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence. Robust emergency plans were in place in the event of a fire or the need to evacuate the building.

We found improvements had been made in the management of medicines.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

Sufficient staff were on duty to provide a good level of interaction and safe recruitment and selection processes were in place.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice; however some mental capacity assessments required clarification about the specific decision to be made and some best interest processes had not been evidenced.

We made a recommendation about good practice where people may lack mental capacity to consent to certain decisions.

Staff told us they felt supported. Records showed they had received an induction, role specific training and regular supervision and appraisal. This meant staff were supported to fulfil their role effectively.

People told us they enjoyed their meals. People's nutritional needs were met and they had access to a range of health professionals to maintain their health and well-being.

The service worked in partnership with community professionals and used good practice guidance to ensure staff had the information they needed to provide good quality care.

Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs. People told us staff were caring and we observed staff interacting with people in a caring, respectful manner. Observation of the staff showed that they knew people well and could anticipate their needs.

Individual needs were assessed and met through the development of detailed personalised care plans which considered people's equality and diversity needs and preferences. People and their representatives were involved in planning their care and people's needs were reviewed as soon as their situation changed.

Activities were provided at the service, so people were supported to live fulfilling lives.

Plans were in place to ensure people were supported at the end of their lives in line with their wishes.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The registered provider had an effective system of governance in place and they had taken action to improve the quality and safety of the service. Everyone at the home knew their roles and welcomed feedback on how to improve the service.

The home was welcoming and comfortable and people told us they liked the family atmosphere of the home. The registered provider and the manager were available in the home to provide support and had an overview of the service. They knew the needs of people who used the service and people, relatives and staff were positive about their input.

People who used the service and their relatives were asked for their views about the service and these were acted on.

## 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.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

The building was maintained and managed in a safe way and emergency plans were in place.

Staff had a good understanding of safeguarding people from abuse.

Medicines were managed in a safe way for people.

Incidents and accidents were analysed to prevent future risks to people.

### Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was considered when decisions needed to be made, although some specific decisions required mental capacity assessments and best interest processes to be recorded.

Staff were trained to support people who used the service and supported with regular management supervision.

People were supported to eat and drink, and to maintain a balanced diet.

People had access to external health professionals and the registered provider worked well with other services to provide effective care.

### Is the service caring?

Good

The service was caring.

People told us and we saw staff were kind and caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

People were supported to make choices and decisions about their daily lives and to maintain and improve their independence.

People's diverse needs were catered for.

## Is the service responsive?

Good

The service was responsive.

People's care plans contained sufficient and relevant information for staff to provide person-centred care.

People had access to activities in line with their tastes and interests.

End of life wishes were recorded.

People told us they knew how to complain and told us staff were always approachable.

## Is the service well-led?

Good

The service was well-led.

Action had been taken to improve the service and governance systems had improved.

The culture was positive, person-centred, open and inclusive. The registered manager and registered provider were visible in the service and knew people's needs.

The service was led by peoples' views and preferences and the registered provider used good practice and partnership working to drive improvement at the home.

# Knowle Court

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 November 2017 and was unannounced. The inspection was conducted by two adult social care 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. Their expertise was as a user of regulated services.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. 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 used this information to help plan the inspection.

A small number of people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with twelve people who used the service and five of their relatives. We spoke with two care staff, one senior care staff, the deputy manager and one kitchen assistant, the manager and the registered provider (who was also registered as manager). We looked in the bedrooms of four people who used the service with permission and spoke with one community professional.

During our inspection we spent time looking at six people's care and support records. We also looked at three records relating to staff recruitment and training, incident records, maintenance records, and a selection of audits.

Good

# Is the service safe?

## Our findings

People we spoke with told us they felt safe at Knowle Court and the relatives we spoke with told us they felt confident their family member was safe. One person said, "I get my medication regularly. She always comes on time." A second person said, "I can go to the smoking area any time I want, I just ask."

At our last inspection the service was not meeting the regulations related to safe care and treatment because risk assessments were not always in place for people. At this inspection we found improvements had been made.

Systems were in place to manage and reduce risks to people. People's records were securely stored in a cupboard in a room which was locked when not occupied. All the records we saw included comprehensive risk assessments for risk of malnutrition, pressure ulcer development, manual handling and additional person specific assessments such as for a person with diabetes or depression. They had been updated each month. The risk assessments were legible and up to date and were available to relevant staff so they could support people to stay safe. Staff said they read people's care files and always had pre shift handovers, which had enough information to enable them to care for people safely. This showed the registered provider had taken action to deliver safe care and reduce risks to people.

Risk assessments and care plans also contained information about how staff would care for people when they experienced behaviours that may challenge others, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. An overview of recent falls and other risk issues was recorded on a white board in the office to support effective risk management during each shift. We saw a log of falls and incidents was recorded each month and discussed in each staff meeting to look for patterns and ways to prevent reoccurrence across the service. This meant the registered provider was keeping an overview of the safety of the service.

At our last inspection in July 2016 we found the registered provider was not meeting the regulation related to safe care and treatment because people did not have personal emergency evacuation plans (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. At this inspection we checked and found improvements had been made and people had an individual PEEP in their care records and also located in a grab file by the door. Regular fire drills were completed and staff

were aware of the procedure to follow. This showed us the home had plans in place in the event of an emergency situation.

Checks had been completed on fire safety equipment, emergency lights and the fire alarm. People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). A series of risk assessments were in place relating to health and safety.

Risk assessments were in place for equipment such as the stair lift and hoists and we saw evidence they had been serviced and maintained to ensure they were safe to use.

We discussed the way in which the security of the building was maintained and the registered provider told us this had been agreed with people using the service due to the noise of an alarm which was previously used. Following our inspection the registered provider sent us a risk assessment to evidence they had weighed up and minimised the possible risks associated with this system.

During our inspection a member of the team found a loose floor board on the upper floor, which the registered provider placed a warning sign around and took action to secure, to prevent the risk of falls.

We found the water in one of the hand basins in a bedroom was hot to touch and the registered provider showed us the temperatures had been checked weekly and were within the safe range. Water temperatures were checked weekly and a thermostatic mixing valve was used on each outlet.

Staff we spoke with understood their role in protecting people from abuse and discussed how knowing people well meant they could detect changes. One staff member said, "The main thing is to be observant so you see changes in behaviour." They told us they had annual training updates followed by an assessment about safeguarding.

Staff we spoke with understood how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. One staff member said, "If I was concerned about a manager I would escalate through CQC or go to 'Gateway to Care.'" We saw information around the building about reporting abuse and whistleblowing.

Records showed safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

People and staff told us there were enough staff on duty. One staff member said they were occasionally short of staff in the evening, but a manager would usually step in to provide support. We saw appropriate staffing levels on the day of our inspection which meant people's needs were met promptly and people received sufficient support. The registered provider had their own bank of staff to cover for absence and asked familiar staff to do extra shifts in the event of sickness. This meant people were normally supported and cared for by staff who knew them well.

The service was committed to its equality and diversity policy and we saw evidence this was implemented. We reviewed recruitment records for three people. Each had completed an application form and supplied original documents such as passports to demonstrate their identity, right to work in the UK, address and National Insurance Number. Each person had supplied two references, one from their most recent employer. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were

carried out as standard practice. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed recruitment systems were robust.

Medicines were managed safely. We saw the service had an up to date policy, copies of professional guidelines and current BNF (British National Formulary). Patient information leaflets for all the medicines prescribed for people living in the home were retained in a folder so staff could readily consult relevant information about the medicines they administered to people.

Medicines were managed only by staff who had been trained and assessed as competent to administer medicines and we saw a current list of names, signatures and initials of these staff. The service had a system in place to ensure medicines were ordered and delivered before people needed them and a procedure to obtain emergency medicines if these were required. Medicines were stored securely in locked cupboards inside a lockable room.

Daily temperature checks of the room and medicines fridge were recorded and staff knew the safe temperature range for medicines storage. We noted the room temperature had been close to the maximum 25 degrees Celsius, and had reached 25 degrees once in the previous month. Staff said they were aware of the risk and during warmer summer months a cooling unit was used in the room to maintain a safe temperature. Medicines no longer required were disposed of safely, stored securely and separately, recorded and collected by the pharmacy on request.

Controlled medicines are those controlled by misuse of drugs legislation and include strong pain-killers. A locked steel cupboard was available to store controlled medicines, although none were required by people living in the home when we visited.

We saw medicine administration records (MAR) were printed and supplied by the pharmacy. These were clear and legible, included any allergies people had and photographic identification. One person had required antibiotics after a general practitioner (GP) had visited them. This had been handwritten legibly by a senior member of staff and a supply obtained on the day it was prescribed.

When people had been prescribed 'as required' medicines, information was available to help staff administer these appropriately. The reverse of the MAR sheets was used to record any exceptions, such as when a person used 'as required' medicines or had not taken a regularly prescribed medicine. This showed us staff kept accurate records of medicines. Staff understood people had the right to refuse medicines but also knew the policy of the registered provider was to inform the GP if people refused medicines for more than three days.

When people required topical treatment, lotions or creams a body map chart had been used to indicate where it should be applied and information was available so staff knew what it was for and when to apply it. One topical treatment was prescribed for a person with a specific skin condition on an 'as required' basis, when the condition became inflamed. Information was available about the condition in the person's records, along with a picture of the inflamed skin. All the topical charts we saw had been signed by staff appropriately.

When people required medication supplied in an adhesive patch, body map charts were used to mark the location the patch had been applied. We saw patches had been placed in different sites each day, in rotation in accordance with best practise guidelines.

We checked the actual count for two 'as required' medicines and a patch and they matched the expected count. We saw staff had checked the count of all PRN medicines at least twice a month. People received their medicines as prescribed at the right time. We observed two staff administer medicines at lunchtime and saw they followed a safe procedure, did not rush people to take medicines, asked if people wanted PRN medicines before preparing them and signed the MAR only after people had taken their medicines.

We saw MAR charts were checked daily by a senior carer or deputy manager and medicines management was audited each week. Staff competency had been assessed annually.

Staff told us when people were transferred to hospital or other service, a photocopy of their MAR chart accompanied them with all their medications so people's medicines remained available to people when they moved.

The service was clean and odour-free and there was a good supply of personal protective equipment, which staff used to prevent the spread of infections.

Requires Improvement

# Is the service effective?

## Our findings

Relatives told us they were confident the staff team at Knowle Court could meet their family member's needs. One relative said, "(They) love it here, (they're) a different (relative) since they came here, (my relative) loves how busy it is and eats like a horse now." Another relative said, "I wouldn't want (person) to be anywhere else but here." A third relative said, "They spoke to the family about the DoLS issues, we were all involved in the discussions."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with had a good understanding of the MCA and DoLS and they understood the concept of least restrictive methods and how people could often continue to make simple, everyday decisions even when they lacked the capacity to make complex decisions. They also discussed non-verbal communication and how people could consent or refuse without using words. One staff member said, "We help people to make their own decisions, but if they can't we do things in their best interests. People's wishes and preferences are in their care plans." A second staff member said, "Most people can make day to day decisions, but eight people have a DoLS in place so would lack capacity. If people can't communicate what they would want we would do it in their best interests. If it was a big decision we consult if they have a power of attorney or an independent advocate."

We asked the manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. Eight people were subject to DoLS authorisations, two with conditions attached, or were awaiting assessment.

The service had made improvements since our last inspection and showed us they had a clear overview of who was subject to DoLS authorisations and who had a legal representative, such as power of attorney.

The manager had taken action to incorporate DoLS conditions into care plans; however these needed to be a little clearer for one person to meet the conditions. The manager completed this action during our inspection.

Mental state and cognition care plans were detailed and person centred for example; detailing the best time of day for a person to make a decision. Some mental capacity assessments required more detail regarding the specific decision to be made in line with the MCA and guidance. We found for one person there was evidence of good practice in the assessment of mental capacity for important decisions, such as going out alone or receiving support with personal hygiene, but not for the use of a bedroom door alarm to alert staff when they left their room to reduce risks. This meant a record of the decision making and best interest process was not available to ensure the rights of the person were protected.
We found where mental capacity assessments had been completed for some people best interest discussions had not always been recorded to show the person's representative had been consulted. The registered provider told us they always discussed decisions with representatives and they completed further individual mental capacity assessments immediately after our inspection. The registered provider told us they would arrange to record best interest discussions with people's representatives as soon as possible and we asked them to send us evidence of this.

We recommend the registered provider consults best practice in this area to ensure decision specific mental capacity assessments and best interest processes are always recorded when decisions need to be made on behalf of people who lack capacity.
We found good practice guidance and information for staff was embedded in people's care records to provide guidance for staff and ensure care was provided in line with current good practice guidance. Physical, mental health and social needs had been assessed and care, treatment and support plans included print outs of information and evidence-based guidance for staff, for example advice on drinks that might tempt people who were at risk of dehydration to drink more fluids.

Assistive technology was used to maintain safety, for example, one person used a motion sensor to alert staff to their movements, and to reduce the risk of falls.

Staff were provided with training to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. This included shadowing a more experienced staff member for three shifts or more, before they were counted in the staffing numbers. Staff new to care also completed the Care Certificate, which is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. Induction also included observations of staff practice. This demonstrated new employees were supported in their role.

Staff said they had received enough training to care for the people living in the home and had different updates every month. We looked at the training records for three staff and saw training included infection prevention and control, emergency first aid, food hygiene, moving and handling, equality and diversity, the Mental Capacity Act and Deprivation of Liberty Safeguards and safeguarding adults. Staff told us they were supported to complete nationally recognised qualifications at level two and three and staff had received additional training and advice in catheter care, pressure care, diabetes, end of life care and distraction techniques. We saw from the training matrix training was up to date and further training was planned onto the rota.

Staff competence was also assessed in areas such as catheter care and moving and handling. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and had regular supervision and staff meetings. Regular supervision of staff is essential to ensure people are provided with the highest

standard of care. We looked at three staff supervision records and found staff received regular management supervision and competence assessments to monitor and improve their performance and development.

People at Knowle Court said, "They come every day and ask what we want for meals," and, "We don't get fruit everyday but we do alright, sometimes it's biscuits or cake," and, "The food is not what I'm used to but [owner] got me some beef burgers and some special K which I enjoyed."

One relative said, "(My relative) didn't eat much when they came here at first, but they provided food (my relative) liked like finger foods and now they eat normal meals."

Meals were planned around the tastes and preferences of people who used the service. People were given choices at breakfast time and received the food they wanted. People were asked what they wanted to eat at lunchtime after breakfast. We saw a menu was displayed on a notice board in the dining room, in large lettering to help people read it. The day we visited there were two choices for lunch and we observed lunch service.

A kitchen assistant served food from the kitchen. Potatoes and vegetables were served in large dishes on each table so people could help themselves, or be served by staff. This encouraged continuing independence and meant people could have the portion size they wanted. We saw one person had a small glass of sherry before lunch, which they enjoyed. This had been supplied by relatives at the person's request and was kept in the kitchen. One person had a salad.

We talked with the kitchen assistant who showed us a file containing information about people's dietary needs and preferences. Information about healthy eating and diets such as for people living with diabetes was available. We did not see information about altered food textures which might be required for people with different degrees of swallowing difficulties but staff could discuss how food was pureed or mashed so people could eat safely. Food temperatures were checked before food was served.

We saw two people supported by staff to eat pureed meals. Staff said neither person had assessed swallowing difficulties but both preferred and ate more from a soft or pureed meal. However, a person who stayed in their bedroom did have a risk of choking and had been assessed by a speech and language therapist who had prescribed thickener to be added to fluids and a soft diet.

Lunch service was not rushed, some people took longer to eat than others and staff were on hand to encourage people and give support if needed. People were offered a choice of pudding as and when they had finished their main meal. Staff said the evening meal consisted of soup and sandwiches and people chose what they wanted at the time it was served.

Where people had an assessed risk of malnutrition, food charts were completed recording both type of food and quantity eaten throughout the day. We saw that one person had been prescribed nutritional supplements due to weight loss and was slowly gaining weight through effective care and support. Other people had fluid charts if they were at risk of dehydration and staff said these were filled in throughout the day and people were encouraged to drink small frequent amounts of fluid so that a daily intake was at least 1200mls in 24 hours. They said they would inform the manager or deputy if people consistently drank less than that amount. This showed the registered provider ensured people's nutrition and hydration needs were monitored and action was taken if required.

The service had good relationships with community health services and we saw the advice of professionals was embedded in people's care plans and used to achieve best practice and help people achieve their

desired outcomes. One community professional said, "It's a good home this, one of the best around here. Staff are friendly, helpful and always available to help if we need them."

One relative said, "They call a doctor if ever (My relation) needs one and they keep us informed." Records showed people had access to external health professionals and we saw this had included GP's, psychiatrists, community nurses, chiropodists, dentists, speech and language therapists, physiotherapists, and the falls team. This showed people who used the service received additional support when required to meet their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. We saw the home was comfortably furnished and there were pictures and photographs in the communal areas. There was a large cabinet of decorative china and ornaments in the dining room which created a familiar and homely environment people may feel more comfortable with.

Most bedroom doors had numbers on them but upstairs we saw six bedroom doors had photographs and names of people on them in bright yellow frames. Staff told us these were for people who maintained their independence and helped them find their own bedroom without assistance from staff. Staff said all of the people living in bedrooms downstairs needed assistance from staff to move around the home or chose to stay in their bedrooms. Toilet seats were contrasting with the colour of the toilet to enable people with visual impairments to locate the seat and support independence. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service.

Good

# Is the service caring?

## Our findings

People and relatives told us the staff were caring. One person said, "They are very nice to us." A second person said, "We are well looked after it's very happy here."

We asked relatives if they thought staff were caring. One person's relative said, "The girls are brilliant with here." A further relative said, "It's a happy friendly atmosphere."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between people. Staff we spoke with enjoyed working at Knowle Court and supporting people who used the service. One staff member said, "The thing I like most about the job is how rewarding it is."

We observed staff speak to people gently or with appropriate humour and they were kind and compassionate. We asked staff to talk about individuals living in the home and they talked with genuine care and concern and assured us they knew people well. They used this knowledge to engage people in meaningful ways, for example, with conversations about activities or by playing music they knew the person liked. We saw people laughing and smiling with staff. One person had their pet cat living with them at the home and the service was happy to accommodate people's special pets if needed.

We observed staff anticipated people's needs and were thoughtful in small ways, for example checking if a person's drink had gone cold and offering them a fresh one. We saw a person had become emotionally distressed during our visit and saw a carer sat down and talked with them and tried to reassure them. When the person was still upset a short time later, another member of staff talked with them gently and helped them move to sit in a quieter area. We observed later the person was calmer and appeared happy talking to another person living in the home. This showed staff supported people with their emotional needs.

Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or food to support them to make every day decisions if verbal communication was limited. One staff member told us they observed a person's body language and always talked them through the support they were providing to them. Staff explained how one person living in the home communicated by facial expression to show they were in pain and if they did so, were given prescribed 'as required' pain relief medicine.

One person living with dementia sometimes exhibited behaviour that may challenge others. Staff said the person enjoyed it when they talked to them about their pet, and it made the person laugh, but at other times they would demonstrate non-verbally they did not want to listen. The carer said, "They show signs they've had enough." The carer described how the person's mood could change quickly and how important it was for carers to recognise that and respond appropriately.

People were supported to make choices and decisions about their daily lives and care records evidenced this. People told us they had a choice of meals, what time to get up or go to bed, clothing, activities, or when to have a bath or shower. People's diverse needs were respected and care plans recorded the gender of

carer they preferred to support them, as well as their religious and cultural needs.

Some people who used the service had their own bedroom door key in order to lock their room if they wished to do so and staff knocked and asked permission before entering bedrooms. Staff told us they kept people covered during personal care and ensured doors were closed. One staff member said, "I knock on the door and wait. If we need to talk confidentially move somewhere private or talk quietly to the person. Close doors and keep private." People's private information was respected and records were kept securely in a locked room.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style. The hairdresser was visiting on the day of our inspection and people were prompted and supported to use them. Everyone was wearing slippers or shoes and people were offered blankets and looked warm and comfortable.

People's individual rooms were personalised to their taste with personal items, photographs, ornaments and bedding they had chosen. Personalising bedrooms helped staff to get to know people and helped to create a sense of familiarity and make people feel more comfortable.

One person said, "I dress myself, but I can get help if I want it." People were encouraged to do things for themselves in their daily life. One staff member said, "If they can take off their own jumper give them time to do it. Give them a flannel so they can wash themselves. Encourage- don't just do it." Care plans detailed what people could do for themselves and areas where they might need support. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

We saw relatives visited the home during our inspection and they told us they were welcome to visit any time.  Staff and managers knew relatives by name and spoke to them in a friendly and welcoming way. This meant people were supported to maintain contact with people who were important to them.

Staff were aware of how to access advocacy services for people if the need arose and some people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to, or may need assistance in doing so, for themselves.

Good

# Is the service responsive?

## Our findings

Through speaking with people who used the service and their relatives we were confident people's views were taken into account in planning their care.

One relative said, "(My relation) went into hospital for six weeks, there were no issues about them coming back. We had a meeting and they just said they would check what changes were needed." A second relative said, "We had an issue about funding some pad pants, they were very helpful in resolving the problem."

Staff said they had read people's care plans and were able to tell us details about individual's care and support needs as well as information about people's personal preferences and lives before coming to live at the home. Care plans included people's personal history, individual preferences, and interests in a 'Personal Profile', which also detailed important relationships and things that mattered to the person. The staff we spoke with had read these and knew the details.

We found care plans were person-centred and explained how people liked to be supported. This is important as some of the people who used the service had memory impairments and were not always able to communicate their preferences.

Care plans included people's physical, mental, emotional and social needs. They also contained direction for staff in how to provide safe care, for example, when supporting a person to transfer from a wheel chair to an easy chair. People's needs were reviewed regularly or as soon as their situation changed. People, or those with authority to act on their behalf, were invited to attend meetings to review care plans at least every six months in order to contribute to planning people's care and support. The deputy manager showed us evidence of this and how sometimes if relatives could not attend the review, the plan was discussed by telephone and signed at a later date. Goals were set with people and these were reviewed and updated regularly. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

Daily care records were completed three times each day and although the time of writing was not recorded, staff said they were written at the end of each shift.

People were able to access activities in line with their tastes and interests. One person said, "I don't get involved that much. I like to watch the news on the telly in my room. I went the first time when they came with the snakes, but I didn't go the second time. You see one snake you have seen them all." A second person said, "I don't do the chair exercises but the others have remarked on it." A third person said, "I'm not that religious but the church come around and do services." And a fourth person said, "We do the armchair dancing, it's a bit of fun."

One relative said, "(My relative) didn't want to get involved with things at first, but they are bringing (my relative) out of (their) shell. Now (they) like sitting and chatting with the others." A second relative said, "(My relative) made a bracelet in the crafts sessions. (They) are very proud of it and show it to everybody."

In response to previous feedback about lack of activities the service now commissioned activity sessions from a local company several times a week, which included reminiscence, craft activities and armchair exercises. One of the local churches had agreed to hold services for people and people's religious and cultural needs were recorded and respected.

A sessional activities co-ordinator used information about people's preferences and interests to tailor activities. We observed a reminiscence session with four people using objects they might have used in the past to trigger memories, on the day we visited. One person had been a cook, another sewed and this information was used in conversation with people to stimulate memories and reminiscence. Records of other activities showed different people took part in different activities including walks, music quizzes, looking at photographs of local towns, sing-along sessions, pamper sessions, sewing and other arts and crafts, cooking and games.

During our inspection we saw staff spent time with people looking at photo books and talking about past times with them. Music was playing in the background which prompted discussion and some people sang along. One person told us they had asked to assist with decorating the home as they wished to keep busy. They were encouraged to do so and we were shown photographs of their work. Some people who were living with dementia held soft dolls for sensory stimulation and comfort. This meant staff supported people with their social, emotional and recreational needs.

People we spoke with told us staff were always approachable and they were able to raise any concerns. One relative said, "He's [owner] a lovely young man. You can talk to him about anything." Another relative said, "(My relative) had their own mug. It went missing so I told the staff. They searched and found it straight away."

We saw there was an easy read complaints procedure on display. Staff said they would deal with any issues or complaints if they could, would record verbal complaints on a dedicated form and would suggest people talk with, or write to the manager if they were unhappy about anything. No formal complaints had been received since our last inspection and many compliments were recorded and made available for staff to read.

People or their relatives had discussed preferences and choices for their end of life care and where they wished to die, including in relation to their spiritual and cultural needs. This was clearly recorded and kept under review, for example when a preferred funeral director had been added to a plan. This meant people's end of life wishes were clearly recorded to provide direction for staff.

Good

# Is the service well-led?

## Our findings

People and their relatives told us the home was well managed. One relative said, "I come here at all times of the day, there's no show on today, what you see is what they do every day."

Staff we spoke with were positive about the manager and the registered provider and told us the home was well-led. One staff member said, "I like working here, it's a small family run home and I know everyone here." They said the manager or deputy was always available in person or at the end of the phone and they felt well supported. They said. "Everyone (who works here) loves their job and wants what is best for the people who live here."

At the time of this inspection the service had a registered manager who was also registered as the provider of the service, which was owned by himself and his family. A manager and deputy manager were also employed.

At our last inspection the service was not meeting the regulations related to good governance because audits were taking place but were not always effective. Records were not always updated and there was a lack of management oversight and communication with regard to who had a DoLS authorised. At this inspection we found improvements had been made.

Effective systems were in place to assess, monitor and improve the quality and safety of the service. Staff and managers were clear about their role. Regular seniors' meeting were led by the registered provider and topics included; audit results, medicines incidents, staffing issues, any safeguarding concerns, DoLS, links with the Methodist Chapel, and the equality policy.

Care plans and risk assessments were reviewed and audited regularly and were up to date. Any actions required had been completed. Audits were also completed in relation to premises and equipment, such as daily bedroom audits and mattress audits. Regular checks and observations on staff competence, such as hand hygiene and policy knowledge were also completed. This showed staff compliance with the registered provider's procedures was monitored.

The registered provider had a system in place for analysing accidents and incidents to look for themes and the learning from this was implemented through staff meetings and reviewing their action plan. This demonstrated the registered provider was keeping an overview of the safety of the service.

The manager told us they wanted to achieve, "Good quality care, good care practices, good staff training. Staff to have the same goals, vision and empathies that we have. A nice happy home and a clean environment. If I have made someone smile today I have done a good job."

The manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this. The senior care staff told us they felt supported by the registered provider, and were able to contact a manager at any time for support. They said they enjoyed working for

the organisation and worked well as a team to support each other.

The management team were visible in the service and regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

Staff said they had staff meetings regularly, and talked about what was good and what could be improved. They said the management team were, "good listeners" and all of the staff were able to have their say and were listened to. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

People who used the service and their representatives were asked for their views about the service and they were acted on. A monthly residents' meeting was held and a relatives' meeting was also held every six months. Issues discussed at residents' meetings included feedback on meals and suggestions for what people might like, complaints, staffing issues, flu jabs, social activities and happiness with the environment. Any issues raised had been addressed by the registered provider.

An annual survey of relatives' and people's views was conducted and we saw action had been taken from a previous survey to improve activities at the home. The most recent survey was very positive and an action plan had been completed to address the minor issues that were raised. The results of surveys and minutes of residents' meetings, including action that had been taken, were displayed in the entrance hall. This meant people's views were taken into account and they were encouraged to provide feedback on the service provided.

We saw there were links with the local community, the church next door held services in the home and many people living in the home had lived locally and known each other before coming to live there. We found the service worked in partnership with health and social care professionals and there was no delay in involving partners to ensure the wellbeing of the people living there.

The manager and registered provider told us they attended training, managers' meetings and good practice events, and had completed nationally recognised qualifications at level five in managing health and social care. They were signed up to safety alerts and used CQC and NICE guidance to improve their practice. We saw good practice guidance was embedded in records. This meant the management team were open to new ideas and keen to promote the best outcomes for people who used the service.

The registered provider understood their responsibilities with respect to the submission of statutory notifications to CQC. Notifications for all incidents which required submission to CQC had been made.