Methodist Homes

Bradbury Grange

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 9 June 2017 and was unannounced. Bradbury Grange is a residential care home in Whitstable, Kent, purpose built in 2010. It provides accommodation and personal care for up to 50 people. The service supports older people and those who are living with dementia.

There were 39 people using the service at the time of the inspection, six of whom lived with dementia. People were able to converse with us.

At our last inspection on 6 April 2016 we issued four warning notices in relation to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regard to person centred care; consent; safe care and treatment; and governance, The registered provider sent us an action plan detailing the improvements they would make and confirmed they would be meeting the requirements of the regulations by June 2016. This inspection was carried out to follow up on compliance with these notices. At this inspection we found that the registered provider had met the requirements detailed in the warning and requirement notices and had made improvements to the culture of the service and the care people received.

There was a new manager in post since February 2017, who had registered with the Care Quality Commission (CQC) in May 2017. A registered manager is a person who has registered with the 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.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were appropriately recorded and monitored to identify how the risks of recurrence could be reduced.

People, relatives and staff told us there was a sufficient number of staff deployed to consistently meet people's needs. Staffing levels had been calculated taking into account people's specific needs and dependency levels. There were thorough recruitment procedures in place which included the checking of references and full employment history.

Medicines were stored, administered, recorded and disposed of safely. Staff were trained in the safe administration of medicines and kept relevant records that were accurate. Following an audit in medicines, the need for an improvement in the recording of PRN medicines had been identified a week prior to our inspection, and this was being addressed.

Staff knew each person well and understood how to meet their support and communication needs. Staff

communicated effectively with people and treated them with kindness and respect.

Staff had received mandatory training and were scheduled for refresher courses. All members of staff received regular one to one supervision sessions. Staff reported feeling well supported in their roles.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them. People's mental capacity was assessed when necessary about particular decisions; meetings with appropriate parties were held and recorded to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food provided and their meal times. Staff knew about and provided for people's dietary preferences and restrictions.

People's individual assessments and care plans were reviewed monthly or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors. Formal and informal complaints were appropriately documented and followed up.

People were promptly referred to health care professionals when needed. Their recommendations were acted on. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were involved in the planning of activities that responded to their individual needs. People and their relatives' feedback was sought at dedicated meetings, and through satisfaction surveys.

Staff told us they felt valued by the area manager, the new registered manager and the deputy manager, and that they had confidence in their leadership. The registered manager was open and transparent in their approach. They had driven improvements in the home and placed emphasis on continuous enhancement of the service.

There was a system of monitoring checks and audits to identify the improvements that needed to be made. The area manager and registered manager acted on the results of these checks to improve the quality of the service and care.

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

There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe.
Safe recruitment procedures were followed in practice.

Medicines were administered, stored and disposed of safely.

Staff were trained to protect people from abuse and knew the action to take if they had any concerns.
There was an appropriate system in place for the monitoring and management of accidents and incidents.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective.

Staff received appropriate mandatory training and received additional specific training to support them in their role.

Staff had a good knowledge of each person's plan of care and of how to meet their specific support needs.

A system ensured people were supported to make decisions and were asked to consent to their care and treatment. Where they were unable to make their own decisions, the principles of the Mental capacity Act were followed to protect their rights.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed. Their recommendations were implemented in practice.

Is the service caring?

Good

The service remained: Good.

The staff approach was caring and compassionate. They

communicated effectively with people and treated them with respect and kindness.
Staff promoted people's independence and encouraged them to do as much for them as they were able to.

People's dignity was respected by staff who were mindful of people's feelings.

People and visitors were provided with clear information about the service.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People, or their legal representatives, were involved with the planning and reviews of their care.
The delivery of care was in line with people's care plans and risk assessments.
People's care was personalised to reflect their wishes and what was important to them.

There was a daily activities programme that was inclusive, flexible and suitable for older people and those who lived with dementia.

Is the service well-led?

Good

The service was well-led.

The new registered manager promoted a culture that was person-centred.

People, staff and relatives welcomed the registered manager's approach, and told us they appreciated their style of leadership and support.

Emphasis was placed on continuous improvement of the service. Improvements had been made to ensure compliance with regulations and enhance people's experiences of the service.

Bradbury Grange

Detailed findings

Background to this inspection

This inspection was carried out on 9 June 2017 and was unannounced. The inspection team consisted of two inspectors and one expert by experience.

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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to check whether their action plan had been effectively implemented, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The registered manager had completed a Provider Information Return (PIR) in May 2017. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before the inspection we reviewed our previous inspection reports and the provider's action plan. We noted the records that were sent to us by the registered provider and the local authority to inform us of significant changes and events.

We looked at seven people's sets of records which included those related to care and medicines. This included assessments of needs and risks, and records of the care given. We path-tracked three care plans to check that people's care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and four staff recruitment files. We made observations of staff interaction with people, of the premises and equipment. We checked how medicines were administered and recorded. We looked at records concerning the monitoring, safety and quality of the service, the menus, the activities programme and policies and procedures.

We spoke with 20 people who lived in the service and six of their relatives, two visitors and one volunteer, to gather their feedback. We spoke with the area manager, the registered manager, the deputy manager, and five members of care staff. We also spoke with housekeeping, catering, maintenance and administration staff. We contacted an NHS Lead Clinical Nurse Specialist for Older People in Care Homes and a local authority Commissioning Officer, who recently had visited the home, to gather their impressions of the service.

At our last inspection on 6 April 2016 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service safe?

Our findings

People told us, "We most certainly are safe, I can say that for this home", "My medicines are handed to me three times a day, I don't have to worry at all" and, "At night I do feel safe knowing that this little bell is close by at all times to call for help and without fail someone comes to the rescue." Two relatives told us, "We can call for help any time of day or night, that is the main factor in making us feel safe and secure really, say my wife had a nasty fall in the night we can rest knowing that help is close at hand" and, "This is a very good place, plenty of staff to make sure the residents are safe."

At our inspection in April 2016 we found that the registered provider had not taken appropriate action in regard to the safe management of medicines. This was because some care plans lacked details relevant to blood thinning medicines, and a care plan did not provide effective guidance for staff to follow in regard to giving medicines for a person who experienced agitation. We issued a warning notice in relation to this breach of regulation. We also made a recommendation about the reviewing of homely remedies and relevant policies. At this inspection we found that action had been taken and that the required improvements had been made.

At the time of our inspection, people were not prescribed blood-thinning medicine, nor medicine to alleviate anxiety. Following an audit in medicines, the need for an improvement in the recording of PRN medicines administration had been identified a week prior to our inspection, and this was being addressed. Following our inspection, the registered manager sent us a completed action plan that confirmed remedial action had been taken. PRN protocols were appropriately in place and held with the medication records.

Senior care workers had received extended medicines management training for the administration of medicines. They wore tabards to identify they were undertaking the administration of medicines, requesting they were not disturbed during this process. Staff were heard to explain to people the purpose of their medication and gave people time to understand and give consent. One person declined to take theirs and the staff member was seen offering the medication on three separate occasions, including asking another senior member of staff to see if they could encourage them to accept. The medication administration record sheets (MAR) were appropriately completed. These included known allergies, effects and actions to be taken. The majority of medicines were supplied by the pharmacist in 'blister packs'. All other medicines were held in their original dispensed packaging. We checked a random sample of blister packs and found no discrepancies against the MAR's.

Creams which had not been prescribed for pain relief were held in a locked cabinet in the service users' bedroom. These creams were applied by care workers during personal care, who signed a separate administration sheet held in the individual service user's bedroom. Prescribed creams were also recorded and signed for by the senior care worker on the MAR. All other creams were held in the communal locked medication trollies, which were held in a dedicated locked medication store room. This store room was secure, temperature-controlled and contained separate controlled drugs (CD) and 'homely remedies' cabinets. We found the CD cabinet was fixed securely to the wall and appropriately locked. CDs were correctly stored; stocks tallied with records which were clear and legible.

The home held a small quantity of 'homely remedies' which were kept in a dedicated locked cabinet. We took a sample of these medicines and checked that the amount held in stock balanced with the amount recorded. We viewed the service's 'homely remedy' policy dated June 2016, which stated that a stock balance must be undertaken every week. On checking records we found staff were inconsistent in these balance checks as some had been undertaken weekly but most had been checked monthly. We discussed this with the registered manager who stated that he would address this with staff to ensure the policy was followed consistently. Homely remedies for each service user were discussed with the G.P who authorised their use.

At our inspection in April 2016 we found that the registered provider had not taken appropriate action to identify and reduce risks to people's safety. This was because some blood sugar levels had not been tested regularly for some people living with diabetes; guidance for staff about a person's behaviour was not detailed enough to enable them to minimise risks effectively for this person; a risk assessment had not been updated following a person's fall. We issued a warning notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made to provide a safe environment for people.

Individual risk assessments were centred on the needs of the individual. Staff were aware of the risks that related to each person. There were specific risk assessments in place for one person who displayed a behaviour that challenged, for people whose weight had decreased, and others who may be at risk of falls or pressure damage to their skin. Each risk assessment included clear measures instructing staff about how to keep people as safe as possible, taking in account people's individual circumstances and preferences. When people had been identified as being at risk of falls, comprehensive clinical risk assessments had been carried out. They stated clearly how staff were to assist the person, the equipment to use, and precautionary measures such as alert mat on the ground and/or in bed, bed rails and bumpers, and the frequency of checks. Staff helped people move around safely and people had their call bells, equipment and aids they needed within easy reach.

People who lived with diabetes had specific support plans for diabetic management. We scrutinised two of these support plans which were personalised according to people's specific needs, and included guidance for 'hypo' and 'hyper' states and information on Type 2 diabetes. They included records of regular blood sugar level tests and were reviewed and updated monthly. Staff were instructed about how to recognise the person's symptoms, how the person may communicate discomfort, and how to respond. Staff were aware of these instructions and applied them in practice. A person had been referred to a diabetic nurse when they had displayed some of the symptoms, and to a chiropodist. Care staff had received diabetes care training.

Clinical risk assessment for skin included clear guidance from district nurses and control measures such as checking specialised mattresses were set correctly, the application of topical creams for pressure area, regular repositioning of people while in bed, and regular contact with the district nurses. These measures were applied in practice and appropriately recorded.

There were sufficient care staff on duty to meet people's needs. The registered manager carried out assessments of dependency levels to ensure that there were sufficient staffing levels to meet people's individual needs. Rotas indicated that two senior care workers and five care workers were deployed during the day and evening, including one care worker at 'twilight' time. At night, one senior care worker, and three care workers remained on waking duty. We observed staff being able to provide one to one attention and care for people in a way that mattered to them. Calls for help were responded to without delay. A relative told us, "The staff are very busy but they are also calm and not rushing, they have time to talk with the residents and there are plenty of them about." Two activities coordinators ensured activities were provided

seven days a week. One chef, one cook and two kitchen assistants ensured continuity of meal provision. Two full time domestic staff and one laundry assistant ensured good standards of cleanliness and laundry management were maintained. The home was very clean throughout the premises, pleasantly fragrant and welcoming.

Additional care staff were deployed when a person needed more constant one to one attention, for example when they had an infection, when they displayed behaviour that challenged, or when they approached the end of their life. The area manager told us that staffing levels will remain in proportion to the presently reduced number of people in the home, so that staff will be increased to match any future numbers of admissions.

Accidents and incidents were being monitored daily by the registered manager to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. The registered manager had scheduled monthly audits of falls to identify any possible trends or patterns. Action was taken to minimise further risks of falls, such as the provision of pressure mats and room sensors to alert staff when people may get out of bed and needing assistance, reviews of people's medicines, and referrals to a falls clinic. Bed rails were put in place after other less restrictive options had been considered and with people's consent.

The fittings and equipment throughout the home had been checked, serviced and were scheduled for further regular checks. There were appropriate systems in place for the checking, servicing and maintenance of equipment and services such as gas, electric and water in the home. All necessary checks had been undertaken at the appropriate intervals and where defects or concerns were raised these were dealt with in a timely manner. Various sub-contractors were employed to undertake plumbing and electrical maintenance and repairs. External contractors were employed to service specialist equipment such as passenger lifts, assisted baths, hoists, profiling beds and fire systems.

There was a robust system in place for logging, carrying out and monitoring repairs throughout the home. The registered manager did a daily 'walkabout' to identify any repairs or maintenance that needed to be done and monitored these until completion. A person was showing a repair that needed to be done to the person responsible for the maintenance. They told us, "Things get done quickly, you ask and it gets done, and very politely."

People's bedrooms and communal areas were free of clutter. Equipment and wheelchairs were stored in a dedicated space when not in use and did not obstruct people's way. A security system ensured that people remained safe inside the service and people who needed assistance were accompanied by staff when they needed or wished to leave the building.

Safe recruitment practices were used to ensure staff were suitable to work with people. Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work there. Staff members had provided proof of their identity and the right to work and reside in the United Kingdom prior to starting to work at the home. References had been checked before staff were appointed and where possible references had been taken up with the previous employer. Gaps in staff employment history were explained and appropriately documented.

Staff who worked in the service were able to identify different forms of abuse and understood the procedures for reporting any concerns. There was a detailed safeguarding policy in place that reflected local authority guidance and the whistleblowing procedure. The procedures included clear information about

how to report any concerns and were displayed in corridors and on the staff notice board. Staff we spoke with told us they would not hesitate to report any suspected abuse or malpractice, and expressed confidence that any concerns would be addressed.

There were plans in place titled 'personal egress plans' that detailed how each person would be kept safe in case of an emergency. These were available to staff and emergency services and showed the level of support that people required evacuating the premises. Staff had received fire training and fire drills were regularly carried out and documented in order to ensure that staff had the skills and training to respond to an emergency.

An appropriate business contingency plan addressed possible emergencies including a relocation of people and staff in a local church. There was appropriate signage about the exits. There were regular checks of the fire warning system, fire doors, emergency exit doors, break glass points and emergency lighting.

The home was clean, tidy and well presented. Communal areas looked fresh and well maintained. In each area of the home there were hand washing facilities readily available providing personal protective equipment such as gloves and aprons for staff to use. Cleaning schedules were monitored throughout the home including the kitchen, to ensure good standards of cleanliness and infection control were maintained. A relative told us, "The cleanliness was not like this before, it has improved no end, there is always someone cleaning every time I come and visit, everywhere is spotless now." People were kept safe from the risk of infection as laundry staff segregated and processed laundry at correct temperatures. Best practice was followed and there were separate areas for clean and soiled laundry that ensured people were not at risk of cross contamination.

Good

Is the service effective?

Our findings

People said staff cared for them effectively. They told us, "All the staff know exactly what they are doing", "We get all the support we need here, from a little thing like a broken finger nail to a trip to hospital if we need it and someone [staff] will accompany us." A relative told us, "All the staff here are very efficient; they are quick to act if there are any problems."

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our inspection in April 2016 we found that the registered provider had not taken appropriate action in regard to obtaining people's consent. This was because some mental capacity assessments were not decision-specific and did not meet the requirements of the MCA; records concerning resuscitation orders contradicted the findings of the assessment; the principles of the MCA were not clearly understood and embedded in everyday practice. We issued a warning notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options to keep these people safe. Staff had received enhanced training in the principles of the MCA and the DoLS and staff we spoke with understood the five main principles of the MCA and how these related to their role.

The provider had introduced a new improved template to assess mental capacity and record decisions that were taken in people's best interests at dedicated meetings. Such a meeting had been held with appropriate parties to reach a decision in a person's best interests about placing several alarm mats in a person's bedroom. The new registered manager told us they were scheduling workshops for all care staff to ensure they knew when to carry out mental capacity assessments that were decision-specific, and how to record these in the new documentation. In the meantime, the deputy manager had completed mental capacity assessments for people in regard to their resuscitation wishes and their consent to care and treatment. All documentation regarding people's resuscitation had been reviewed and updated when necessary to ensure they were correct. Staff sought consent from people before they helped them move around or before they helped them with personal care. Their wishes and refusals were respected.

At our inspection in April 2016 we found that the registered provider had not taken appropriate action in

regard to meeting people's needs in regard to their care and treatment. This was because recommendations from a health care professional about dental review had not been acted on, and a person's continence needs had not being effectively met. We issued a warning notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made.

The registered manager had ensured that all care plans were appropriately completed and updated regularly to reflect people's change of needs. Updates were recorded in people's main care files as well as in summarised care plans. When a speech and language therapist had made recommendations, such as a special diet, a specific positioning or assistance, this was provided. A person had a catheter plan in place that had been checked by district nurses to ensure catheter care was provided effectively for the person. Following our last inspection, each person in the home who experienced difficulties with their continence had had their needs re-assessed and pads were effectively provided and used as appropriate. A member of care staff had taken the lead in continence and was the continence champion for the home, providing guidance to colleagues when necessary.

When people were identified at being at risk of skin damage, they were checked regularly, provided with specialised mattresses, and helped with adjusting their position. People were checked at hourly intervals throughout the night and these checks were appropriately recorded. Mattresses settings were checked and recorded to ensure they were appropriately adjusted for people's weight.

When people had been assessed as being at risk of malnutrition because their appetite and weights had decreased, staff completed food and fluid charts appropriately and totalled them at the end of the day. There was one person whose food and fluids intake was monitored at the time of our inspection. Fluids taken by people when taking their medicines were included, as well as gravy, ice cream and jelly. These charts were checked daily by the senior care worker then by registered manager who ensured follow up action was taken, such as referrals to a GP, speech and language therapist or a dietician. People were given fortified, pureed or soft diet according to their needs and were monitored to ensure their health improved. People were referred to other health care professionals such as district nurses, a mental health team or consultants through their GP. A person whose behaviour challenged at times had been referred to their GP for a review of their medicines and had improved considerably as a result.

People were offered routine vaccination against influenza and district nurses came to help with the administration of vaccines. A chiropodist visited upon request to provide treatment for people who wished it. A visiting optician and dental service was available although people who preferred to retain their own optician and dentist were escorted for their appointments when families were not available.

People had their breakfast as late in the morning as they preferred. We observed lunch being served in the dining area. The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were supported by staff with eating and drinking when they needed encouragement and there were enough staff to provide one to one support for people when they need it. A care worker had cut some of the food in manageable sized portions for one person who found chewing difficult. People told us they were very satisfied with the standards of meals. They told us, "Very nice food, lovely", "We have a jug of juice waiting to be drunk in all the lounges, a nice coffee bar at the front and we can just ask for any hot or cold drink and amazingly, just like in a hotel, it appears" and, "Too good actually." A relative who had shared a meal with their loved one on occasions at the home told us, "The food is surprisingly good and nicely presented." People were consulted about their preferred menus at regular residents meetings. The chef checked after lunch whether people had enjoyed their meal, and collected feedback to inform any changes to the menu.

A list of people's allergies, dislikes and preferences was displayed in the kitchen and taken into account by

the chef and the cook. People were offered a choice of two main courses and were offered alternative options if they wished. Trolleys were circulated three times a day to bring cold and hot beverages, home-made cakes, fruit, biscuits and snacks. People were encouraged to drink fluids throughout the day to promote their health and there were jugs filled with cold drinks and fruit on display in several areas for people and visitors to help themselves. A senior environmental health officer had inspected the service in December 2016 and had awarded a five star maximum rating in Food Hygiene standards to the service.

New care staff underwent a thorough induction when they started work. This included a week during which they read care plans to familiarise themselves with people's individual needs, and shadowed senior care workers. New recruits completed workbooks over a thirteen week period, that were monitored to check they were appropriately completed and their content understood. New staff worked on their own only once they could demonstrate suitable competence, and their induction period was extended if necessary. They were subject to one, three and six month probation reviews. The competency of all staff administering medicines had been assessed and documented. The 'Care Certificate' had been introduced for all new staff that had no previous experience in social care. This certificate sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold.

The registered manager and deputy manager provided individual staff supervision every three months to all staff, in line with the service's policy. Practices including the administration of medicines were discussed at care staff supervision. At these sessions, staff were encouraged to discuss any problems or difficulties they may have and gain support from the management team. One member of staff said, "We do get good support." All staff were scheduled to have an annual appraisal.

Staff received mandatory training that was essential for their roles. A computerised system was in place to monitor staff training and determine when they needed a refresher course. The monitoring system indicated a high percentage of staff were up to date with their mandatory training, which included first aid, fire safety, moving and handling, health and safety, person-centred care, equality and diversity, mental capacity and safeguarding. Staff were scheduled for training courses appropriately. Staff received additional training aimed at meeting people's specific needs such as dementia care, falls management, skin integrity, diabetes, Warfarin (a medicine that thins the blood), dignity, behaviours that challenge and end of life care. Following our last inspection, additional training including care planning and effective auditing had been introduced.

All staff were encouraged to choose and take a lead in a particular field, do research and gain further knowledge that could benefit people and the whole of the staff team. There were leads in continence, infection control, dementia and dignity, and medicines. This ensured that staff had instant access to guidance and advice in particular fields, to care for people's specific needs effectively.

Care staff were supported to study and gain qualifications for a diploma at different levels in health and social care. 37% of care staff had completed a diploma in health and social care and 18% were waiting to undertake the relevant studies programme. The registered manager had liaised with an external organisation that provided qualified assessors, training and a studies programme and had enlisted five care staff at the time of our inspection.

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was recorded appropriately. Additionally, senior care workers completed a record sheet at each day and night shifts, which reported levels of staff, the effectiveness of pagers, any system failure, and any events of significance that affected the people in the home. These

records were scrutinised by the registered manager and deputy manager. There was a communication book used by staff to record people's visits from healthcare professionals and a diary updated with people's external appointments. This system ensured effective continuity of care.

The premises were well maintained, well cleaned, welcoming, and fit for purpose. These included 50 large bedrooms en-suite with private wet rooms and toilets, wide corridors with sturdy handrails, four bathrooms, five toilets, two lounges and two dining rooms. There was appropriate signage throughout the home to help people find their way around, and people furnished memory boxes outside their bedroom doors and personalised their doors when they wished. People could bring their own furniture from their home to the service as long as they could be fitted in. Wardrobes were securely fixed, windows restrictors were in place, and a balcony railing had been enhanced with panes of glass to ensure people were safe from falling while still enjoying the views. There was a therapy room, a hairdressing salon, a garden room, a coffee room, well-maintained landscaped gardens and ample space where people or visitors could spend quiet time away from others if they wished. There were several kitchenettes where people and visitors could help themselves to hot or cold drinks and light snacks. Staff had their own staff room and a training room. A relative told us, "This place is ever so lovely, just the right environment for my mum, it has a homely feel everywhere you look."

Good

Is the service caring?

Our findings

The service continued to be caring. People told us they were very satisfied with how the staff cared for them. They said, "We know all the staff and what's more they know us and all our little foibles", "Come and join the party, that's what it's like here", "There is always someone to chat here with, I never get lonely", "No need to rush, we are never rushed which is a jolly good thing at our age", " I can honestly say there is not one member of staff who doesn't take the time to have a chat and really make sure we are all right here; they're all lovely, they're really are" and, "The girls [staff] are brilliant, we are so well looked after day and night." One person described the staff as "fantastic, always knowing the right way to do things for each of us." Relatives described the staff in very positive terms and described them as, "Really caring people."

We spent time in the communal areas and observed how people and staff interacted. Staff had time to spend one to one time with people and support them. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people. Staff treated people with kindness and addressed them respectfully by their preferred names. We observed laughter as well as gentle reassurance with appropriate body language, such as staff leading a person gently when they moved around. Staff anticipated people's needs and asked them what they would like to do next or where they would like to go, and provided the support that was required.

People's care files included clear instructions to staff about best to communicate with people. They included how people preferred to be named, whether they had hearing or visual impairment, or whether they experienced any anxieties that needed specific communication methods. A relative told us, "The staff sit down to really engage with the residents." Staff knew how to communicate with each person. They bent down so people who were seated could see them at eye level; they checked people's hearing aids regularly. Instructions were in place for staff, for example about how to interpret a person's body language and alleviate a person's anxiety. This was applied in practice. A person communicated by nodding and staff were aware of this, offering options for the person and waiting for them to nod their agreement. One person was registered blind and had hearing difficulties. The activities coordinators brought things for them to touch and smell, and helped the person join in activities. We observed how staff communicated with people when they used equipment to help them move from one place to another. The staff talked clearly to the person in a reassuring tone through each stage of the procedure, ensuring the person knew what they were going to do next.

People were assisted discreetly with their personal care needs in a way that respected their dignity. A privacy screen was used to preserve people's dignity in the lounge when lifting equipment was used to help them move around. Staff locked doors when helping people with personal care and people told us they were respectful, taking care to cover them when necessary.

Staff were mindful of respecting people's privacy. A person told us, "If I don't want to be disturbed I just close my door and they will always knock and ask before entering." Staff were attentive to people's needs and regularly checked on their wellbeing. Another person told us, "I do like a bit of privacy after lunch and they respect that by leaving me in peace when the door is closed and won't disturb me until tea time, although

they do have a check I am alright in between." Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others.

People's spiritual needs were met with the provision of religious services in the home. A chaplain visited the home every two weeks for bible reading; a catholic priest every week; and a Methodist service took place on Sunday. Volunteers joined people in morning prayers.

Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. Some people needed encouragement and this was provided. A person told us, "I do what I can and they help me with the rest, they tell me to keep myself mobile as much as I can."

People followed their preferred routine, for example some people chose to have a late breakfast, stay in bed or stay up late. One person liked to have their breakfast in bed before getting up and this was provided. Staff presented options to people so they could make informed decisions, such as what they would like to wear, to eat and to do, so that people could be in control of their day. People were enabled to maintain their independence with a positive approach to managing risk. For example several people were able to go to the local shops, and staff asked them to sign in and out to check they had returned safely. Some people used the lift by themselves; others went in the gardens independently. A person told us, "I like to help in the garden and I can still make myself a nice cup of tea if I want one." As staff encouraged people to do as much as possible for themselves, people's independence was supported.

Clear information about the service and its facilities was provided to people and their relatives. A brochure that provided information about the home, the services, the staff, activities, outings, and residential care was being updated. The current brochure was available in a large format to help people with visual impairment and included the provider's philosophy of care and the procedures to follow should anyone wish to complain. The provider maintained an informative up to date website that was easy to navigate, and this was in the process of being updated.

People were involved in their day to day care when they were able to and when they wished to be. Care plans were kept in people's bedroom in a dedicated storage box fixed to the wall, which people and their families could open. One person told us, "My care plan is in that box over there, I can always have a look if I want to." People and when applicable their legal representatives were involved in decisions about their care and in agreeing their care plans. A person told us, "My daughters both come and help with my care plan so I have no need to worry but if I ask they always explain to me what's there." A relative told us, "We look after mum's care plan with the staff here and we discuss it together with her and if we are at all worried there is always someone at the end of the phone or here who we can discuss our worries with."

Good

Is the service responsive?

Our findings

People gave us positive feedback about how the service and the staff responded to their needs. They told us, "I have to say I am pretty content really, I have all I require or need here, and more", "There is usually an activity going on somewhere, always something to do, we really don't have to get bored", "We do have lots of activities and outings, it just depends on how much you want to join in with them", "During the day we have books, people to talk to, television, activities going on, the garden, all sorts" and, "They know me well, they know what I like."

At our inspection in April 2016 we made a recommendation that responses to informal concerns be documented in order to provide a full audit trail of the complaint process. At this inspection we found that action had been taken and that the required improvements had been made.

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in communal areas and was included in the 'welcome brochure'. This was available in a format suitable for people with visual impairment. The provider had introduced a new system to record complaint and the actions that were taken as a response. A new complaint form was appropriately completed and monitored by the registered manager and the area manager to ensure any complaints, verbal and official, had been addressed as per the service's complaint policy. A relative told us, "I know who the manager is and I would talk to him, I am sure he would listen if I brought up a complaint."

A range of daily activities that were suitable for people was available. Two full time activities coordinators had devised a varied programme of activities that were suitable for older people and for people who lived with dementia. Attention had been paid to people's life stories and hobbies, what they preferred to do, and options of activities were discussed at residents meetings and relatives meetings to inform the next activities programmes. There were twenty volunteers who helped the activities coordinators with group activities, coffee mornings and daily one to one activities for people who remained in their room. Each person was encouraged to join the group activities and their wishes were respected. One person told us, "There is no pressure, but they always ask me if I'd like to join, and if I want to they take me to the lounge, and I must say I am always pleased afterwards to have made the effort, at times it is a lot of fun."

The activities programme was displayed in corridors and in each person's bedroom. The range of activities included, music, pampering quizzes, carpet boules, sing-along and karaoke, board games, card games, skittles art and crafts, reminiscence, film matinees with ice cream served, and daily armchair exercises. Some equipment and areas were adapted for people with visual impairment, such as adapted dominoes and a sensory garden area. Entertainers, performers and musicians visited the home regularly to sing and dance with people to 'old times' tunes, or play music for them.

Volunteers accompanied people in the garden. People enjoyed morning prayers with volunteers in a garden room, others enjoyed reflexology or Reiki. People had helped paint a poster to advertise a Teddy Bear Picnic planned for the home's open day. One activities coordinator told us, "We noticed how quite a few residents enjoy watching the tennis on TV, so we plan to have a Wimbledon event for the finals, with

strawberries and cream." A 'cheese and wine afternoon' where relatives were invited was scheduled. The activities department hoped to raise money for using a portable electronic device to help with bespoke one to one activities. They said, "With an [electronic device] the screen would be big enough and we could access so much on the internet directly with the person next to us; that would be wonderful; we could tap into anything they want, instantly and visually, for individual discussions, or to inform a specific activity."

People's relatives were welcome at any time and were able to stay and share a meal with them. Outings were provided to maintain links with the community and reduce social isolation. People had been escorted to the beach, to attend a spiritual retreat for the day, visit garden centres, open gardens and tea parlours. A relative had invited people to their home as they had a miniature railway in their garden. Birthdays events were planned to celebrate people's lives.

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments were comprehensive and included appraisal of people's physical wellbeing, mental state, mobility, food preferences, communication, social interests, skin integrity and risks including falls. People were encouraged to recall their history which was shared with staff. This enabled staff to gain further insight and understanding of the person's background and interests and ensures the care and support the resident received met their cultural and spiritual needs and that their lifestyle preferences were respected.

Individualised care plans about each aspect of people's care were produced within 24 hours after their admission into the service, and further developed as staff became more acquainted with people's particular needs and choices. When people had particular conditions, such as an infection, a wound, a catheter in place, breathing difficulties or when they were unwell, individual short term care plans were written in these domains to instruct staff how to care for people's individual needs. Staff we spoke with were aware of individual requirements and were able to describe to us how they cared for people. Their descriptions matched the instructions in people's care plans.

Staff promoted people's good health and encouraged them to drink plenty of fluids especially during hot weather. One person had been admitted under palliative care and had made a remarkable recovery being cared for in the service. Staff told us proudly, "He is now a picture of health."

All care plans we scrutinised had been reviewed and updated by the senior care workers on a monthly basis, or sooner when needed. Staff were made aware of any changes and updates at staff handovers. People or their legal representatives were routinely invited to be involved with the review of their care. Relatives who lived at some distance were consulted over the phone or by email. One relative had requested six monthly reviews of their loved one's care and this was carried out.

People were offered choice and their wishes about when to get up, when to go to bed, what to eat and what to do. Their preferences were considered and acted on. For example, some people liked to eat in their bedroom, others liked to eat outside. They told us they could have a bath or a shower as often as they wished as soon as staff were available, and that their refusals were respected. A person told us, "The girls always ask if I'm ready to get dressed or if I'd like a shower or a bath, it's my decision you see."

People's views were sought and acted on. Monthly residents meetings were held to which all were invited. People told us, "We do have a residents meeting about once a month; we can have a say about anything and also about the activities we'd like." These meetings were recorded and when people had made specific requests, a monitoring system ensured these had been followed up with action. For example, as a result of a recent meeting, an agency chef had not been requested to prepare food again for people and a new chef

had been actively recruited; the registered manager had observed a meal being served and action had been taken to improve food presentation and staffing levels at mealtime; a microphone was used at meetings to ensure each person could hear; and an issue about lost garments had been discussed with laundry staff.

Good

Is the service well-led?

Our findings

People, relatives and staff told us the service was well led by the new registered manager. All were complimentary about the registered manager's approach and style of leadership.

People told us, "If we need to speak to the manager of course we can, everyone is open here and if we feel lonely or need something we just have to ask" and, "I wouldn't normally bother the manager but at least I know I can if I ever should need to, he is very welcoming and approachable." Two relatives told us, "I think the staff and also the residents were a bit unsettled when the last manager left but it is settling down nicely as they get to know the new manager, these things take time but so far it is very positive" and, "I've met with the new manager, he seems very approachable; the new deputy manager is lovely, very hands on and quick to respond." A volunteer told us, "On the days I volunteer I always find the manager involved and chatting away to all the residents, a jolly and lively atmosphere; you feel life's worth living here."

Staff were positive about the support they received from the management team. They reported that they could approach any manager with concerns and that they were confident that they would be listened to and supported. A member of the care staff told us, "I like the way [the registered manager] is with staff and residents; he talks with us like he's one of us; I feel I can talk to him anytime, it is an open door policy here." The deputy manager told us, "The whole team communicates well; we talk about how they feel and about the improvements in the home, there is good leadership and staff morale is getting better, definitely."

The new registered manager had registered with the CQC in May 2017 and was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were supported by an area manager who regularly visited the service and who actively monitored the improvements to check these were appropriately implemented to achieve compliance of regulations. The area manager was supported by a regional director and an operational director. The management team had discussed the last service review from the CQC and had shared their action plan with people, relatives and other stakeholders, as well as providing regular updates on their progress. The service displayed a 'CQC corner' where a copy of the last CQC report was available, and a report from the provider titled, 'What we are doing about it'. Their action plan was also prominent in the service's website. A relative told us, "I know they have had difficulties but with all the changes this seems a different service. For example, cleanliness used to be an issue and now look, it is absolutely spotless." The registered manager told us, "This is a joint effort; we all strive to improve all the time."

At our inspection in April 2016 we found that the monitoring systems in place were not fully effective as these had not identified shortfalls relevant to assessments of risk; medicines management; mental capacity assessments; and care pans containing insufficient information for staff. We issued a warning notice in relation to this breach of regulation. The provider's action plan stated that all of these areas had been addressed following our last inspection. At this inspection we found that action had been taken by the new manager as stated in the action plan, and that the required improvements had been made.

The management team completed an appropriate range of audits to identify how to improve the service.

These included monthly audits of medicines, personal care, dining experience, falls, accidents and incidents, weighing charts, complaints, hygiene and presentation. Infection control was audited every six months. The area manager visited the service monthly and had stayed for one week at the time of our inspection, to support the registered manager implementing improvements. As a result of their visits, they produced a report based on the Health and Social care Act 2008 requirements. This report identified what action was to be taken and their level of urgency. An action plan resulted from this report, which was followed up by the registered manager and monitored by the area manager. As a result of this auditing system, sister homes' managers names had been included in safeguarding leaflets; an action plan from a staff survey had been monitored; and assessments of mental capacity had been carried out before application to the DoLS office had been considered.

Additionally, a quality team carried out monthly focussed inspections of the service. Their recent report had acknowledged what had been achieved in regard to the updating of PRN protocols and mental capacity assessments in the service; it had highlighted two care plans that needed to be signed by people or their legal representatives to evidence their involvement. The registered manager had also written an action plan following our visit that showed immediate action had been taken in response to our verbal summary, such as ensuring that home remedies were checked weekly as per the relevant policy.

The registered manager was visible in the service. They did a 'walkabout' in the service three times a day, meeting people and visitors. They met every day with the deputy manager and had held four staff meetings ensuring that all staff shifts were able to attend. Every day the registered manager consulted accidents and incidents logs, checked weighing charts and action taken when people's weight had reduced, and scrutinised two to three care plans to check they were appropriately documented. One member of staff told us, "He has done a lot since he has been there, he seems dedicated, he doesn't seem to stop."

The registered manager had monthly meetings with the managers of other homes run by the same provider, to discuss compliance with legal requirements, updates in legislation and of internal policies, budget matters, and quality of care so any lessons learned could be shared.

People had been consulted about improvements in the home. For example, they had been involved in choosing new menus; their requests at residents meetings had been acted on, such as staff serving people observing a specific rotation of tables at mealtime; and repeats of an Irish dancer performance. Attention was paid to how they wished to personalise their environment. A relative told us, "They could not have been more helpful with the decoration of the room and the chasing of the furniture [X] wanted, and pictures to be hung, to make it as personal as can be."

People had an opportunity to give their feedback about the quality of the service through annual satisfaction survey questionnaires that were audited by the registered manager. The last survey indicated that people were very satisfied with the quality of the service, the food, the staff and the activities. Comments included, "The laundry is much better that it was; the food is delicious; we enjoy all the activities and the team make sure relatives are invited to join in."

The service's policies were appropriate for the type of service and easy to understand, to help staff when they needed to refer to them. They were updated by the provider on a continual basis. Records were well organised, fit for purpose, kept securely and confidentially. Archived records were disposed of safely and appropriately according to legal requirements.