Brendoncare Foundation(The)

Brendoncare Alton

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

The inspection took place on 22 and 23 May 2017 and was unannounced.

Brendoncare Alton is registered to provide care for up to 80 people who need nursing support. There are five units: Jade, Blue and Pink units care primarily for people who are physically frail and Cedar and Oak units look after people who are living with dementia. We visited all of the units during the course of the inspection. At the time of the inspection there were 69 people using the service.

The service had a registered manager; however, they were in the process of de-registering and the new manager was in the process of registering. A registered manager is a person who has registered with the Care Quality Commission 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.

People were kept safe from the risk of abuse as relevant processes and procedures were in place. Staff were up to date with their safeguarding training and understood their role in protecting people from abuse.

People told us staff looked after them safely. Nursing staff assessed potential risks to people and people's risk management plans were reviewed on a monthly basis. Processes were in place to ensure incidents were analysed and acted upon for people's safety.

People were satisfied with the level of staffing provided and reported their call bells were responded to promptly. We observed that although staff were busy; people were not rushed with the delivery of their care. People were kept safe because the provider had robust recruitment procedures to ensure suitable staff were recruited to provide people's care.

People received their medicine from trained, competent staff. Processes were in place to ensure the safe administration and management of medicines for people.

A person told us "Staff are competent." Staff in all roles were offered training, supervision, support and development appropriate to their needs. This ensured they had the skills and knowledge to provide people's care effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they were satisfied with the food. People received the support and care they required to ensure their nutritional and fluid intake was sufficient for their needs. Staff took action to address any risks to people associated with their eating and drinking. Lunch was a pleasant experience for people and they appeared to enjoy their meal.

People were supported by staff to access health care professionals as required in response to their identified health care needs.

People reported "Staff are kind" and "Staff are so good; they make you feel as if you are at home. I feel very happy here." A staff member told us there had been a focus on recruiting "Caring staff." Staff showed an interest in the people they were caring for.

Staff understood how to communicate caringly with people. People were consulted about and involved in day to day decisions about their care. People's choices were respected. Staff understood how to uphold people's privacy and dignity and were observed to do so.

People told us their care was planned and reviewed with them and that it met their needs. People had an assessment of their care needs and preferred outcomes. Their care plans were regularly reviewed and their feedback was acted upon.

Staff were responsive to the needs of people living with dementia and understood how to meet their needs. People were provided with a variety of opportunities for social stimulation.

Processes were in place to enable people to make complaints about the service and these were used to improve the quality of the service provided.

The provider's statement of purpose outlined their philosophy of care, which was that; people should experience: care, respect, compassion, friendship and laughter, warmth and welcome. There was transparency and openness both from the provider and from within the service. The service had good external links and this enabled staff to learn about and to share good practice in order to improve the care people received.

People were satisfied with the management of the service and told us "Yes it seems well led." Staff told us they felt "Optimistic" with the new manager in place. "The service has in place a clear management structure. The new manager brought stability to the registered manager's role.

The provider was regularly supplied with information about the performance and quality of the service provided to people. The service received input and oversight from the provider's senior management team. The manager was looking at sharing responsibility for the completion of audits and action plans with staff, to create a sense of 'ownership' for the quality of the service.

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.

People were kept safe from the risk of abuse as relevant processes and procedures were in place.

Processes were in place to assess risks to people and to ensure these were managed for them safely.

There were sufficient numbers of suitable staff available to provide people's care and there were robust staff recruitment processes.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received an induction into their role, on-going relevant training and supervision of their work.

Where people lacked the mental capacity to make specific decisions, staff followed legal requirements, to ensure decisions were made in their best interests.

People were supported to eat and drink sufficient for their needs.

Staff supported people to maintain good health and to access health care services as required.

Is the service caring?

Good

The service was caring.

People experienced positive and caring relationships with the staff who provided their care.

People's views were respected and they were actively encouraged to be involved in decisions about their care.

People's privacy and dignity was upheld and promoted.

Is the service responsive?

Good

The service was responsive.

People told us their care was planned and reviewed with them and that it met their needs.

People were provided with a variety of opportunities for social stimulation.

Processes were in place to enable people to make complaints about the service and these were used to improve the quality of the service provided.

Is the service well-led?

Good

The service was well-led.

The service promoted a positive culture that was open and based on clearly defined values.

There was a clear management structure in place and the new manager brought stability to the registered manager's role for people.

Processes were in place to monitor the quality of the care provided.

Brendoncare Alton

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 comprehensive inspection took place on 22 and 23 May 2017 and was unannounced. The inspection team included two inspectors, a specialist in dementia care 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. The expert by experience had experience of caring for older people including those living with dementia.

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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received written feedback about the service from three specialist nurses, a psychiatric nurse, a representative from the ambulance service and a Social Services team manager. During the inspection we spoke with seven people, three relatives, a volunteer and a physiotherapist. We spoke with eight care staff, four nurses, an activities co-ordinator, the chef, the dementia lead, the deputy manager, the manager, the Head of Care Services and the Head of Quality and Compliance.

We reviewed records which included seven people's care plans, five staff recruitment and supervision records and records relating to the management of the service.

The service was last inspected in February 2016 and no concerns were identified.

Good

Is the service safe?

Our findings

Staff were able to describe the purpose of safeguarding, their role and the signs which might indicate a person had been abused. Staff had access to relevant safeguarding guidance and contact numbers if required. Records demonstrated that at the end of April 2017, 100% of staff were up to date with their safeguarding training. If people experienced an injury, then this was noted on a body map, a photograph was taken and the size of the injury was measured and the actions taken were noted. This ensured there was a full record of any injuries people experienced in the event they needed to be referred to safeguarding. The manager told us that any learning from safeguarding's or incidents was shared with staff through the shift handover and meetings to ensure people were protected. People were kept safe from the risk of abuse as relevant processes and procedures were in place.

People told us staff looked after them safely. One person said "There are always two staff to hoist me." People told us and we observed that their call bells were positioned within their reach, if they needed to summon assistance. A person commented "Staff always make sure it's handy."

Nursing staff had assessed the risks to people from: falling, developing pressure ulcers, becoming malnourished, choking and moving and transferring. People's risk management plans were reviewed on a monthly basis. Where people's care plans identified that they required specific equipment to enable staff to provide their care safely, this was provided. For example, hoists, slings, sensor mats and chair alarms. We observed staff were prompt to react when the alarm sounded on a person's sensor mat indicating they had stood up and may require assistance. People's records also documented the number of staff required to support them safely. Where people who were nursed in bed had been identified as at risk from developing pressure ulcers, there was written guidance in their care plans about the need to re-position them and how often. Staff spoken with were aware of who was at risk. Records showed people were regularly re-positioned to minimise this risk to them and that any topical creams required, to moisturise their skin and prevent damage, had been applied. People's re-positioning records also documented for staff which were their most vulnerable areas, which required particular care and attention to manage the risk of their skin breaking down.

Incidents were monitored both within the service by the manager and by the provider through the manager's submission to the provider of monthly and quarterly reports. Incidents were analysed for trends and lessons to be learnt. For example, data on people's falls was analysed to identify if there were any trends in the time people fell, who fell more frequently and the actions taken to reduce the risk of repetition were reviewed. The manager told us the introduction of a new incident reporting system by the provider in July 2017 would further simplify this process as the new system would flag up any trends for action by them. There was evidence staff received feedback on the measures they needed to take to ensure people's safety following incidents. Processes were in place to ensure incidents were analysed and acted upon for people's' safety.

The required checks had been completed in relation to gas, electrical, fire and water safety for the service. This ensured the building was safe for people's use. The service had a business continuity and major action

plan in the event of an emergency affecting service delivery, to ensure people would receive the care they needed.

Overall people were satisfied with the level of staffing and reported that their call bells were responded to promptly. Their comments included "It's answered promptly," "Staff come quickly" and "Oh yes, the buzzer is always answered." Some people were of the opinion that they would like to see more staff deployed; however, no-one told us that the current staffing was not sufficient to ensure their needs were met in a timely manner. One person commented "Staff move quick, I don't miss out." We observed that although staff were busy call bells did not ring for long and people were not rushed with the delivery of their care.

Staff told us that usually there were sufficient staff, however, on some occasions they were under more pressure. One staff member commented "We have to work hard to keep up." Staff told us in the afternoons there was more time to spend with people. They also reported there was a "Lot less use of agency (staff)."

Each unit was staffed according to the assessed needs of the people on that unit as determined by the provider's staffing dependency tool. In the day each unit was staffed with a registered nurse. Staffing rosters reflected the individual level of staffing for each unit described to us and additional care staff were rostered to meet the needs of those receiving one to one care. The provider was using agency staff to cover staff vacancies. However, to ensure continuity for people agency staff were now provided by a single agency.

Staff told us and records confirmed they had undergone recruitment checks as part of their application for their post and these were documented in their records. These included a full employment history, record of interview, the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment, a health declaration and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

The service had introduced an e-Mar medicines system which nurses and managers had been trained to use. All staff administrating medicines were subject to a three monthly competency assessment. The e-Mar system flagged information using a dashboard. This meant that any issues relating to missed or refused doses or late medicines were immediately flagged up. Regional managers had an overview of the system and would call the service if they saw any issues such as missed doses. For example, on the day of inspection a person had not wanted to get up and have their breakfast until later. This meant that their once daily medicine normally taken with breakfast was late; this was quickly identified and followed up by staff. We observed staff administered people's medicines safely.

Some people received 'PRN' medicines which are given 'as required.' PRN protocols were in place and alerts were automatically aligned with these on the e-MAR system. For example, where a person was given a pain killer, staff were alerted to return to assess its effectiveness within an hour of administration. Homely remedies, which are medicines available over the counter were available and regularly checked. Their use was governed by clear protocols from the person's GP.

Medicines were stored in locked cabinets in people's bedrooms. The temperatures of bedrooms were monitored to ensure people's medicines were stored safely and the manager informed us of the arrangements in place if it was noted that the temperature became too high, to ensure medicines were stored at a safe temperature. The temperature of medicines stored in the fridge were checked daily, to ensure they were stored safely.

Processes were in place to ensure controlled drugs were managed safely. Controlled medicines are medicines which require a greater level of security.

Good

Is the service effective?

Our findings

A person told us "Staff are competent." Staff told us they received sufficient support and training in their roles. We saw evidence that new staff underwent a thorough role specific induction. Staff new to care underwent the Care Certificate, which is the industry standard induction. Staff told us they shadowed other staff for two weeks when they joined the service. We observed staff on their induction were supernumerary to the staffing shift numbers and linked with a more experienced staff member to observe how they delivered people's care effectively.

The provider had a range of required training for staff. Processes were in place to monitor the level of staff compliance with training objectives. Records showed staff were up to date with the provider's required training. Staff told us the manager was in the process of arranging additional training for nurses in areas such as phlebotomy for example, to ensure their skills remained up to date. Phlebotomy is the surgical opening or puncture of a vein in order to withdraw blood. In addition to formal training; The Head of Quality and Compliance worked with individual staff on particular aspects of practice. For example, they were observed working on care plans with staff. Nursing staff told us they were supported through their re-validation, which is the process whereby nurses are required to demonstrate their on-going competence to their professional body in order to maintain their registration. There was a re-validation policy and a record was maintained of when nurses were due for re-validation to ensure appropriate support was in place for them.

Staff told us they received regular supervision and records demonstrated this was provided two monthly. Supervisions involved both one to one meetings and observation of staff's practice and competency within their role. Staff were supported within their supervision to identify their developmental needs. For example, a care staff member had been given the opportunity to mentor new staff and taken on additional roles including the training of new staff. There was evidence that staff underwent an annual appraisal when objectives were set for the coming year and progress in relation to these objectives was monitored during supervisions.

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 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 told us they had completed MCA/DoLS training, which records confirmed. Staff were able to demonstrate their understanding of the MCA and how it related to their role and work with people. Staff told us that one person made unwise food choices but that they had capacity to understand the choices they

were making and understood the associated risks. Staff understood people's rights in relation to the MCA.

Where people were able to give their signed consent to their care they had done so. People told us "Staff seek my consent."

Where people had been assessed as lacking the capacity to consent to a decision relating to the delivery of their care, relevant others had been consulted about what was in their best interests, for example, their families and GP. Some people had appointed a power of attorney for health and welfare to represent them in the event they lacked the capacity to make decisions themselves. The provider had documented this and obtained a copy to enable them to check what decisions the attorney was authorised to make on the person's behalf. People's consent for their care was sought. Where people lacked the capacity to consent to their care, legal requirements were met to ensure their human rights were protected.

Some people required bed rails for their safety; these can restrict people's movement. People or their relatives, where they lacked capacity to consent to their use, had been consulted. The Head of Quality and Compliance told us how important it was to be continually keeping any restrictions on people under review to ensure they were absolutely necessary; records confirmed these checks were made. Where restrictions upon people's' movement amounted to a deprivation of liberty the relevant application had been made, following a MCA assessment and consultation with relevant others with regards to whether the restrictions were in the person's best interests.

People told us they were satisfied with the food. Their comments included "Lunch is alright," "Yes, I enjoy the food, we get a choice." "The food is alright but not like home cooking." A relative commented "The care home serves the sort of food [resident's name] loves."

People were weighed monthly and their Malnutrition Universal Screening Tool (MUST) score calculated. MUST is a screening tool to identify adults, who are at risk from either malnourishment or from being overweight. People had nutrition care plans detailing how their dietary needs were to be met. If people were at risk from malnutrition staff monitored their intake and they were referred to the GP. People's records noted if they required assistance with their meal or equipment, such as a plate guard. At lunchtime people were provided with the support they required.

People's records showed that where they had been assessed as experiencing difficulties swallowing they had been referred to speech and language therapy (SALT). Staff followed the SALT's guidance; they knew who was on a pureed diet and who required thickener in their drinks to make them safer for them to swallow. We observed a nurse instructing care staff about the specific risks to a person from choking and these were being updated on the person's care plan to ensure there was clear written guidance for staff.

If people were identified as at risk from dehydration then they had a fluid chart in place which documented their input across the course of the day. However, people's fluid charts did not document an individual objective for their fluid intake, to enable staff to easily identify if their needs had been met. We brought this to the attention of the manager who told us this was an area they were already aware of and would be addressing for people.

Lunch was a pleasant experience for people. The dining tables were well laid and soft music played. This ensured the environment was attractive and encouraged people to want to eat in the dining rooms. The food was brought in hot trolleys for staff to serve and there was an aroma of hot food from them which provided people with sensory stimulation that it was time to eat. People were offered a choice of two hot main meals in addition to alternatives such as an omelette or salad. We observed one person had

something different, so people's individual preferences were catered for. People appeared to enjoy their lunch.

People saw a variety of health professionals. People's records showed they had seen GP's, psychiatric nurses, the SALT service, physiotherapists, palliative care team, tissue viability nurses, opticians, dentists, occupational therapists, continence service and chiropodists. People had hospital passports that documented key information hospital staff would need to be aware of in the event the person was admitted, in order to enable them to provide the person's care effectively. People's identified health care needs were met to ensure their welfare and health.

Good

Is the service caring?

Our findings

People reported that: "Staff are kind," "Staff check I am happy," "Very friendly (staff)," "Care staff are helpful." They also commented "Staff are lovely, they treat you well." "We have a laugh." "Staff are so good; they make you feel as if you are at home. I feel very happy here." Relatives told us "Staff do their best, they are very attentive." "Staff are always cheery even when people are difficult."

Feedback from nursing professionals and the ambulance service prior to the inspection was that staff were caring, sensitive and friendly towards people. A staff member told us there had been a focus on recruiting "Caring staff." The manager told us they were "Creating a caring culture by creating a team that respect each other."

Staff told us they got to know people in their care by "Spending time chatting with them." When new people moved in staff told us they were provided with information about the new person and their personal history. Staff told us they then spent time with people "Forming a bond."

People were observed to be happy and relaxed in the company of the staff who demonstrated an interest in them as individuals and concern for their welfare. Staff were observed to check on people's comfort and welfare and to ensure they had cushions in place to support them and sufficient covers for warmth. Staff had an understanding of people and their friendships. We observed an activities co-ordinator sit two people who were friends together for an activity so they could enjoy each other's company. Staff later asked one of the people what the quiz was about, taking an interest in the person and attempting to start a social discussion. Staff showed an interest in people they were caring for.

People's communication needs were noted, for example, if they had a hearing, sight or speech impairment. A person's records stated, "I need carers to give me time to express myself.' A person had a communication book to aid their communication, other people with sight impairments had been provided with large dial telephones to enable them to make telephone calls. We observed staff ensure they positioned themselves at people's level when they communicated with them. They also used touch appropriately, for example, gently touching the person's arm as they spoke to gain the person's attention. Staff understood how to communicate caringly with people.

People's records documented what decisions they could be involved with, for example, choosing their clothing. One person liked their water for washing to be quite hot so staff had noted that the person was to check if the temperature was sufficient for them. A person told us, "I tell staff what I want." Staff arrived with some freshly laundered clothes. The person told and showed them how they wanted their clothes hung. People were involved in day to day decisions about their care.

Staff were heard to explain to people what was happening as they provided their care. For example, if staff entered a person's bedroom they were heard to tell them why they were there; this provided information for people and reassurance. Staff were heard to give simple logical explanations to people to help them understand why they should drink for example. Staff provided people with relevant information about their

care at the time they needed it.

At lunchtime staff were heard to offer people a choice of drinks to have with their meal. They also asked them if the music was at the right level for them. Staff asked people if they wanted a protective cover for their clothing or if they wanted their meal cut up rather than assuming that they did. Staff consulted people about their care.

Some people liked to spend their time in their bedroom, whilst others liked to eat in the dining room and other people chose to attend the daily activities. People chose where to spend their time.

We observed people had brought items of significance for them from home such as pictures, ornaments and favourite bed covers. People had been able to personalise their bedroom to their tastes.

A person told us "Staff uphold my privacy." People had been asked for their views on what dignity meant for them and their feedback was displayed in the form of 'Dignity trees'. These were displayed around the service to remind staff what was important to each person as an individual.

Staff were up to date with their dignity training and were able to tell us the measures they took to uphold people's dignity in the provision of their personal care. These included keeping doors shut, closing the curtains and ensuring the person remained as covered as possible. Staff understood how to uphold people's privacy and dignity.

Staff were observed to knock on peoples' bedroom doors and to wait for a response before they entered. Staff spoke to people in a polite and respectful tone. They also ensured they stood close to people and spoke with them discreetly about their care.

Good

Is the service responsive?

Our findings

People told us their care was planned and reviewed with them and that it met their needs. Their comments included: "Yes, its good care," "They do things how I like," "Care planning is very good," "The care reflects my preferences," "I was consulted about my care" and "Staff review the care."

People had an assessment of their care needs and preferred outcomes. This information was then developed into their care plan. People's records noted their aspirations and what was important to them, for example, such as wearing jewellery or maintaining their mobility. It was also recorded what made a good day for the person and what made them sad. People living with dementia had the Alzheimer's Society 'This is me' document in their records, which provided details of: the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality. They also had a 'Map of Life' which showed the names of their: family, schooling and major events in the person's life. Staff were provided with information to enable them to support people as individuals.

People's records documented who was important to them and who they wanted to be involved in their care planning. This ensured people were able to choose who they wanted to be consulted about their care.

People's care plans were reviewed regularly and showed people or their relatives were consulted to ensure their care remained relevant to them. Changes were made to people's care following these reviews. For example, a relative had provided feedback about their loved ones needs at mealtimes and this had been incorporated into their care plan. Another relative told us "My mother likes lots of light and [manager] got mum a bedroom with lots of light. It overlooks the main road so she can see out of her window and look at what is happening outside. This has helped to calm her. The staff are thoughtful and intuitive." Staff responded to people's feedback.

Peoples' care records noted what aspects of their care they were independent with. For example, if they were able to contribute to their personal care. Some people chose to eat their lunch in the service's refectory and were seen to make their own way downstairs.

Staff received a handover of information at the start of each shift. This ensured they were aware of any changes to peoples' care. There was also a handover sheet which provided key information staff needed to be aware of in order to provide people's care. Staff demonstrated a good understanding of people's preferences for their breakfast and where they liked it to be served. They told us that the delivery of people's care was tailored to them. Staff were able to tell us in detail about people's diagnoses and their individual care needs.

Staff were up to date with their dementia training and also underwent training in managing behaviours which could challenge staff. They understood how best to support people living with dementia. For example, people living with dementia were given coloured cups to drink from. Research has shown that people eat and drink more if provided with brightly coloured crockery. Staff had applied the research to encourage people to eat and drink well. Oak unit had a sensory room where people could sit quietly, listen

to gentle music and watch the soft sensory light. People had memory boxes outside of their bedrooms filled with items related to their personal history to enable them to recognise which was their bedroom. There were items on Oak and Cedar units for people to pick up, touch and engage with. We observed people had been provided with items to look at and explore, such as books. Staff ensured activities were tailored to people's interest and ability, for example, a person was enjoying copying a drawing. Staff were responsive to the needs of people living with dementia.

There was a varied monthly activities schedule for the service provided by the two activities co-ordinators. People told us "Yes, there is enough to do." People were offered a range of activities including for example: church service, one to one sessions, art, craft, quizzes, pamper sessions, visits from a Pets As Therapy (Pat) dog, music, visits from a local children's nursery, exercise, gardening, cooking, films, reminiscence and speakers. An activities co-ordinator told us that they also took people out to a local supermarket for coffee and to the pub. There were also plans to further develop the sensory garden with sensory plants sculptures and a water feature to stimulate peoples' senses. People were provided with a variety of opportunities for social stimulation.

The provider held an 'Investors in Volunteers' award, which is a quality standard for good practice in volunteer management. They currently had 10 volunteers working at the service to enhance people's social stimulation. Volunteers worked with people both as part of groups and one to one; engaging people in activities such as gardening, pamper sessions and walks, for example. Volunteers were used to enrich and supplement people's experiences.

People told us "I know how to make a complaint" and "Yes, I think I would be listened to." People were provided with a copy of the complaints procedure when they moved into the service and details of how to make a complaint were displayed.

Staff understood their role in supporting people to make a complaint. Records demonstrated that where people had made a written complaint this had been logged, investigated, responded to and any required actions taken. Where required, issues had been addressed with the staff concerned. Learning from complaints had been cascaded to all staff via staff meetings. The Head of Care Services told us information about complaints received were reviewed not just within the service but also at the provider's clinical governance meeting so they could identify any trends in complaints across services. They told us that in response to complaints about agency staff only one agency was used now to provide continuity for people. People were also able to raise issues via comment forms. A person had noted that their meal had not been kept hot because the plate was too cold; as a result the chef had increased the temperature of the plate warmer. Processes were in place to enable people to make complaints about the service and these were used to improve the quality of the service provided.

Good

Is the service well-led?

Our findings

The provider's statement of purpose outlined their philosophy of care; that people should experience: care, respect, compassion, friendship and laughter, warmth and welcome. It also detailed how the philosophy would be delivered in practice to people and the aims and objectives of the service. Staff told us they learnt about the provider's values during their induction.

The provider recruited staff based on personal qualities linked to their values. They also used the 'Judgement Index', which is a process of on line testing, both during recruitment and with existing staff to provide them with information about staff's values. This information was in the process of being used to develop peer led workshops for staff, to reflect on their values and how these aligned with those of the provider. Staff told us they enjoyed this work and felt their views were sought.

There was transparency and openness both from the provider who published a news bulletin and details of the company plan and within the service through meetings. The manager had already met with people and their relatives and the staff team to introduce herself and encourage their suggestions. The manager told us they would be further strengthening people's voices within the service. A food committee had just commenced and they were in the process of setting up a resident's forum. A person told us "I am a member of the 'food committee'; we had a good meeting with the new chef last Wednesday." Processes were in place to seek people's views on the service. There were also head of department meetings, nurses meetings, carers meetings, and senior management team meetings to ensure staff had the opportunity to provide their feedback.

The service had good external links to local GP's, the hospice, local care home meetings, colleges and universities; they were members of the National Care Forum and registered with the Social Care Institute for Excellence and the Skills for Care network. This enabled staff to learn about and share good practice. For example, the activities co-ordinator told us about a project they were involved in to determine what effect music has on people who have dementia; they told us some people "Have responded well." The service was also enrolled with the 'Six Steps programme', which they had almost completed. This is a national quality programme for end of life care, designed to enhance staff knowledge of end of life care. The manager was involved with 'My Home Life' action learning sets as a development initiative for managers. This is a UK-wide initiative that promotes quality of life and delivers positive change in care homes for older people.

Nurses had attended a leadership development day in 2016 and the provider's deputy managers from across their services were invited to attend bi-monthly management workshops. We saw that care staff were thanked for their work at a recent care staff meeting. Staff's contribution to the service was also acknowledged through the provider's 'Extra Mile Awards.' Staff felt supported by management and were provided with opportunities for professional development and progression.

People were satisfied with the management of the service and told us "Yes it seems well led." Two nursing professionals told us that 'Turnover in managers has been an issue' but that the deputy manager was proactive. Staff commented, "There have been a lot of changes with a lot of home managers." Staff told us

they had met with the manager at a meeting and "She seemed to listen and take on board issues." Staff said they felt "Optimistic" with the new manager in place."

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. The service had been run by a registered manager who was one of the provider's peripatetic managers. A new manager had joined the service in October 2016, but they had then left in February 2017. One of the provider's experienced managers with a proven track record of good leadership asked to transfer to the service and became the manager on 1 April 2017. They have since submitted an application to CQC to become the registered manager. The service has had a manager in place through this period and a stable management team comprising of a clinical lead, a dementia lead and an experienced deputy manager.

The new manager told us they "Led by example" and that they believed in "Allowing staff to have input into how things are done." They were looking at staff each taking an area of responsibility within the service so that they all "Own and engage with their role." The new manager had brought both stability to the registered manager role for people and staff and a sense of 'ownership' wanting to encourage staff to be proactively involved in the service.

The manager submitted a weekly report to the provider regarding the service. This covered areas such as: people's health and welfare, safeguarding's, complaints, staff training, staffing and incidents. Where incidents had occurred, there was a record of the actions taken to ensure the person's welfare and safety. They also submitted a monthly report looking at areas such as: people's weights, people at risk from developing pressure ulcers, incidents, unexpected deaths, safeguarding's, people's behaviours which had challenged staff, care plan reviews and staff supervisions. Again there was a record of what actions had been taken in response to each incident. The provider was regularly supplied with information about the quality of the service provided.

The provider held board level clinical meetings to review the data from across their services and to identify any trends. Registered managers were periodically invited to attend to enable them to understand how information was analysed and used to drive improvements for people.

The Head of Care Services completed a monthly provider visit to the service. At each visit they reviewed a range of aspects of people's care and any actions identified were incorporated into an action plan; which was reviewed with the manager at each visit. Any visitors to the service from the provider's head office completed a visit report. This outlined the purpose of the visit, who they interacted with in terms of people or staff, the outcome from the visit and any planned actions. This demonstrated there were regular visits by, for example: the Head of Quality and Compliance, the hotel services manager and property services manager. This ensured the service received regular input and oversight from the provider's senior management team.

People had been asked for their views of the care provided during the 'Your care survey' of August-October 2016. Results showed a 93% satisfaction rate. An action plan had been devised in response to issues raised such as the re-introduction of resident's meetings which had commenced.

A range of aspects of the service were audited. These included areas such as: medicines, infection control, dignity, nutrition, catering, people's weights and care plans, for example. If actions required had been identified, then there was an action plan in place to identify what action was needed, by whom and when. Progress against actions and their completion had been noted. For example, the infection control audit had identified that there was a lack of records to demonstrate people's' slings had been laundered; this was now

in place for people. The dignity audit had identified that some staff were more task focused rather than providing person centred care to people. This had been addressed with staff through the staff meetings and we observed staff providing care tailored to people's individual needs. For example, some people had their personal care prior to breakfast whilst others preferred to have it afterwards. The manager was looking at sharing responsibility for the completion of audits and associated action plans with staff; to create a sense of 'ownership' for the quality of the service provided.