Ganymede Care Limited

The Chiswick Nursing Centre

Inspection report

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19 July 2017
21 July 2017
25 July 2017

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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 took place on 18, 19, 21 and 25 July 2017 and was unannounced on the first day. We told the registered manager we would be returning over the next three days. At the last comprehensive inspection in October 2014, with the inspection report being published in March 2015, the service was rated as 'Good'.

The Chiswick Nursing Centre is a 146 bedded care home with nursing and provides care, accommodation and support for older people and younger adults, people who are living with dementia, people with mental health needs, people with complex neurological conditions, people with physical disabilities and people with learning disabilities. At the time of our inspection 141 people were living in the home.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's risks were managed and care plans contained appropriate and detailed risk assessments which were updated regularly when people's needs changed. The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service. Recruitment was ongoing with the aim to reduce the number of agency workers.

People who required support with their medicines received them safely from staff who had completed in-depth training in the safe handling and administration of medicines, which was refreshed annually. Staff completed appropriate records when they administered medicines and these were regularly checked to minimise medicines errors.

The majority of people who used the service and their relatives told us they felt safe using the service and all staff had a good understanding of how to protect people from abuse. Staff were confident that any concerns would be investigated and dealt with. All staff had received training in safeguarding adults from abuse and had a good understanding of how to identify and report any concerns. One person felt they were at risk in relation to fire evacuation procedures because of their poor mobility. The provider had consistently reassured them that there was a plan in place to manage any emergency and their potential evacuation.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the importance of asking people for consent and the need to have best interests meetings in relation to decisions where people did not have the capacity to consent to their care. The provider was aware when people had restrictions placed upon them and notified the local authority responsible for assessment and DoLS authorisations.

Staff were aware of people's dietary needs and food preferences and provided support to those who required it during mealtimes. If people had questions or concerns about their food the provider met with

them to discuss their preferences and to find alternative options.

Registered nurses and care assistants told us they contacted other health and social care professionals, such as occupational therapists, psychiatrists and speech and language therapists, if they had any concerns about people's health. We saw evidence of these referrals in people's care records. People had regular access to a GP who visited at least three times a week, was available for emergency 'house calls' on a daily basis and was also available outside of normal surgery hours.

There was a comprehensive induction and training programme in place to support staff in meeting people's needs effectively. New staff shadowed more experienced staff and had their competency signed off by senior staff before they started to deliver personal care or support people with their medicines independently. Staff received regular supervision from management and told us they felt supported and were happy with their input during the supervision they received.

The majority of people who used the service and their relatives told us staff were kind and compassionate and knew how to provide the care and support they required. People were spoken with and treated in a respectful and kind way and staff respected their privacy and dignity, and promoted their independence.

The provider was in the initial stages of working towards accreditation in the Gold Standards Framework, which is a framework to help deliver a gold standard of care for all people as they near the end of their lives.

People were involved in planning how they were cared for and supported. An initial assessment was completed from which care plans and detailed risk assessments were developed. Care records were person centred and developed to meet people's individual needs and reviewed regularly or if there were any significant changes. People using the service and their relatives were actively encouraged to express their views and were involved in making decisions about their care and whether any changes could be made to it.

People were encouraged to take part in a range of activities and events to increase their well-being and reduce social isolation. There was evidence that people's cultural needs were considered when discussing this and making sure these needs were met. Improvements were in the process of being implemented to create a more dementia friendly environment in the suite for people living with dementia.

People using the service and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. The provider listened to all complaints and met with people to discuss their concerns. There were also meetings and surveys in place to allow people using the service and their relatives the opportunity to feedback about the care and treatment they received.

There were effective quality assurance systems in place to monitor the quality of the service provided and understand the experiences of people who used the service. The registered manager and senior management team followed a daily, weekly, monthly, quarterly and annual cycle of quality assurance activities and learning took place from the result of the audits. The registered manager was fully aware of their registration requirements regarding notifiable incidents and kept us updated with the progress of incidents and investigations.

The service promoted an open and honest culture and staff spoke highly of the atmosphere at the service and the support they received from management. Staff were confident they could raise issues or concerns at any time, knowing they would be listened to and acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Chiswick Nursing Centre

Detailed findings

Background to this inspection

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

The inspection took place on the 18, 19, 21 and 25 July 2017 and the first day of the inspection was unannounced. We told the registered manager that we would be coming back over the next three days.

The inspection team consisted of three inspectors, a specialist professional advisor in the nursing and residential care of older people and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The experts by experience had experience in the care and support of older people who use regulated services, including people living with dementia.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included statutory notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 14 and 15 October 2014, where the service was rated as 'Good'. We contacted the local authority safeguarding adults team and the Clinical Commissioning Group (CCG) and used their comments to support our planning of the inspection. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 35 people using the service, 14 relatives and 33 staff members. The senior management team included the registered manager, who was known throughout the service as the centre director, the quality and compliance director, the director of nursing, the clinical director, the human resources business partner, the training and quality assurance manager, the facilities and health and safety

manager and a senior project manager. We also spoke with nine registered nurses, five of them being the suite manager from each floor, two senior care assistants, eight care assistants, the head of catering, the head of housekeeping, the lead physiotherapist, a physiotherapist assistant and two activity coordinators. We looked at 20 people's care plans, 10 staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We carried out these observations across different floors during different parts of the day.

Good

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe living in the home and when they were receiving their care. One person told us that they felt safe as staff were available and always popped in to check on them. Other comments included, "I do feel safe here. I am very happy here and they cannot do enough for you. This is a safe place and I could not ask for more" and "Oh it's very safe, good organising here, it's very good." One person told us that they felt at risk in the event of an emergency as they were unable to evacuate themselves from the building. Most relatives we spoke with had no concerns about the safety of their family members. One relative told us they thought the service was safe and that there had been no accidents. A second relative told us that their family member had lived here for a few years and never had any concerns. A third relative told us that they felt there had been too many instances of lower quality care outcomes for their family member, however felt that the provider had responded openly with them in response to the concerns raised. The provider asked us if we could identify this person in order that further reassurances and corrective action could be taken to improve the experience of their family member. However the person had asked not to be identified and as such it was accepted that there was no follow up action that the provider could take.

There were appropriate medicines policies and procedures in place. Medicines arrived pre-packaged for each person and colour coded in relation to the time they were due to be taken. We observed medicines being administered across two floors during the inspection. The nurses administering the medicines were observed to follow accurately each step of the administration process. We saw one nurse checked a person's pulse before making a decision not to administer a specific medicine as per recorded guidance. One nurse told us that they felt confident administering people's medicines and were able to explain in detail what action to take in the event of an error. Another nurse said, "I had to take a test and the suite manager carried out observations to check on me when giving medicines, which helped with my confidence." Appropriate tabards were worn during medicines rounds which highlighted staff were not to be disturbed and we saw that medicines trollies were locked when not in use.

We checked how the service stored medicines, including controlled drugs and the safe disposal of medicines no longer required. We carried out checks of several medicines including controlled drugs that were stored in the clinical room and we found that the quantity in stock matched the records in the controlled drugs register. Records had been countersigned by two registered nurses and checked by another registered nurse from another floor. This provided additional assurance that people were receiving their controlled drug medicines as prescribed. We looked at a sample of medicine administration record (MAR) charts across one floor during this inspection. All MAR charts had the allergy status recorded and a picture of the person to assist staff in identifying them during medicines administration. There were no gaps on the MAR charts that we looked at and there were records to explain why any doses of medicines had not been administered. MAR charts were checked daily by staff involved in medicines administration and the suite manager completed a monthly medicines audit to check that medicines were being managed safely. A senior manager then carried out their own audit across each floor, providing an action plan. We saw evidence that these audits picked up medicines issues appropriately and these were addressed to ensure that people received their medicines safely.

Daily refrigeration monitoring was in place and fridge and room temperatures were between recommended temperature requirements. Medicines, including creams and eye drops were marked with opening dates to avoid the use of expired items and samples seen were within expiry dates. Where there were surplus supplies of medicines, we were told medicines were disposed of every two weeks and at times there were high quantities stored due to people arriving from hospital with their own medicines.

We found that the provider made sure the appropriate checks were undertaken before staff began work. The 10 staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place to help safeguard people. We saw evidence of photographic proof of identity and all Disclosure and Barring Service (DBS) records for staff were in date. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. There was also evidence that the personal identification code numbers of registered nurses were in date and the provider carried out monthly checks to ensure they were aware of the registration status of nursing staff. The provider asked for two references and people could not start work until they had been received. The provider had updated their application form since the previous inspection and it now included dates of previous employment, so any gaps between employment were able to be explored. The human resources business partner had a good oversight and awareness of their responsibilities in relation to safer recruitment. There was a recruitment checklist at the front of each file to make sure all relevant documents had been received before employment commenced. This meant that people were supported by staff who were suitable for their roles.

Staff had received appropriate training in safeguarding and were able to demonstrate how to keep people safe from the risk of abuse. Staff understood how to recognise the signs of abuse and told us they would speak to their suite manager or a senior member of staff if they had concerns about a person's safety and/or welfare. Staff felt confident any concerns raised would be dealt with by the provider. One care assistant said, "If concerns are raised, I'm very confident that actions will be taken." The registered manager had a detailed oversight of all current safeguarding incidents, with a central log that showed what action had been taken and the current status of investigations. We also saw correspondence that showed they were proactive in following up incidents with the relevant health and social care professionals to find out what the outcomes were. The training and quality assurance manager showed us records that staff had completed safeguarding training and that it was refreshed on an annual basis. They told us that safeguarding training was also available for relatives to give them an overview of why it is important, the types of abuse and how concerns are responded to.

The majority of people told us that they felt staffing levels were sufficient to meet their needs. One person said, "Yes, I do think there are enough staff on duty." One relative told us that they were satisfied and that staffing was not an issue. We did receive some comments where people felt staff were a bit stretched at times. One person said, "I think it is a bit short staffed, but they look after me well and I have no grumbles." A relative felt that it was due to staff having to attend training. We spoke to the registered manager about this who confirmed if staff attended training cover would always be provided. They added that they were constantly recruiting with the aim to reduce the amount of agency staff used to zero. The human resources business partner showed us that 67 permanent staff had been recruited in the past three months.

The staffing structure showed that each floor had two registered nurses, with one being the suite manager. Senior care assistants and care assistants made up a ratio of one staff member to every five people on the suite. This did not include additional support for people who required one to one support to ensure their safety. We looked at the staff rota for the previous four weeks across each suite and saw staffing levels were consistent with those as described by the registered manager and the staff we spoke with. Observations carried out throughout the inspection across different parts of the day were noted to be consistent and

adequate for the care provided. Whilst housekeeping roles had always been in place at the service, a Head of Housekeeping role had been created and recruited since the last inspection. This provided an oversight across the home and ensured that all rooms and communal areas were cleaned daily and that a rotating programme of planned deep cleansing was in place for each person's bedroom area. Each suite had its own dedicated housekeeping assistant and the registered manager felt that this was beneficial in that it enabled the care team to focus on the delivery of good, safe care.

There was a procedure to identify and manage risks associated with people's care. Before people started using the service a pre admission assessment of their care needs was carried out by a senior member of staff which identified any potential risks to providing their care and support. A range of risk assessments were completed in relation to the environment, people's mobility and personal care support needs. Dependency assessments were reviewed on a monthly basis covering areas including nutrition and individual support with feeding, continence care, skin integrity, moving and handling and social isolation. Care plans contained details about the level of support that was required and detailed information about people's health conditions. The information in these documents included practical guidance for staff in how to manage risks to people.

For example, one person had been assessed as being at risk of pressure sores, displaying behaviour that challenged and refusing personal care. We saw the relevant assessments were in place and it was observed that wound management assessments were carried out regularly, along with pictures and body maps which were uploaded to the electronic care plan. Input from health and social care professionals was available to see action taken to effectively manage the person's health conditions. We spoke with two healthcare assistants about this person, who knew about their individual risks and how to manage any moving and handling tasks safely, for the person and for the staff involved. This information was also recorded in their care plan. We saw records for three people that showed pressure ulcers which had been acquired outside of the service had healed and plans were in place for all residents at risk of developing pressure sores, to prevent them from developing. This included turning regimes, use of risk reducing specialist equipment and working in partnership with the Tissue Viability Service. We saw another person with reduced mobility was at risk of having falls. Their risk assessment highlighted what equipment was needed and that staff needed to supervise and accompany this person when mobilising from room to room to reduce the risk of them having a fall. We saw this was happening throughout the inspection and was recorded electronically in the person's daily logs.

We also saw that each person had a personal emergency evacuation plan (PEEP) in place and staff were aware of what support people would need in the event of an emergency. We saw that since a recent high profile tragedy of a fire in a London tower block, the provider had carried out a fire risk management review, which covered a number of areas including fire procedures, fire panel updates, their smoking policy and fire drills. Each person's PEEP was shared with the fire service and was available to see on every fire panel so people who needed specific support with evacuation were highlighted. We spoke with four different members of the staff team across all floors who were all able to explain to us the fire safety procedures and what to do in the event of a fire.

Infection control procedures were also observed to have been followed as we saw staff wearing personal protective equipment such as disposable gloves, aprons and hair caps during mealtimes and when carrying out personal care. Staff made sure that people's clothing was correctly labelled to minimise the risk of people's belongings getting mixed up or going missing. There were wall mounted units throughout the service containing hand sanitizing gel to help minimise the risk of infection, along with hand washing guidance posters on display. The head of housekeeping carried out a check across one suite per month with a yearly infection control audit in place, which covered nine areas including hand hygiene, the environment

and waste disposal.

Good

Is the service effective?

Our findings

The majority of people told us they were happy with the care they received from staff and felt they had the right skills and experience to meet their needs. Positive comments included, "I do feel my care needs are met yes, they are very good. The physio is excellent and has got me going up and down the corridor with a frame" and "Yes, they are pretty good." Another person said, "Oh yes, definitely", when we asked them if they thought the staff had been trained to do their job. Relatives commented that the majority of staff were able to meet their family members needs and comments included, "Some staff are brilliant but some aren't", "Some of the staff are very good and know how to manage the dementia", "Some staff are very friendly but you do see a number of different people. The nurse on today is very helpful" and "Some staff are really good, but some not so good talking to people." One relative contacted us after the inspection and felt some of the care workers were "superb". They added, "They are attentive, hardworking, sensitive and respectful but unfortunately there have been several occasions when some have seemed inexperienced or undertrained."

We spoke with the training and quality assurance manager about the induction and training programme that staff received when they started work. New starters completed a four week induction programme which covered a range of policies and procedures, training courses and direct experience across all floors under the supervision of the suite manager and senior staff. The Care Certificate was also introduced during the induction and staff were given up to 12 weeks to complete it during their probation period. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. The training and quality assurance manager provided a monthly drop in session to support staff with work related to completing the certificate. We saw completed copies in some of the staff files we viewed where direct observations had been completed and signed off, along with completed competency assessments at the mid and end stage of probation. Staff confirmed that they had completed an induction programme and had opportunities to observe more experienced staff until they felt confident. One registered nurse said, "I had a two week induction and then shadowed for two weeks when I started. If I wasn't comfortable with anything, I could always ask so that I was sure."

Where people using the service and their relatives had told us that they felt at times some of the inexperienced staff were agency staff, we spoke with the registered manager about their policy on agency staff. They told us that they only requested agency staff that had experience but if this was not possible, for example, covering a shift at short notice, an induction would be carried out at the beginning of the shift. We saw records that showed agency staff were allocated to a specific suite and an induction would be arranged before they started work.

There was a comprehensive training programme that was delivered to staff as part of the mandatory induction, which was also reviewed on an annual basis. Modules included safeguarding, health and safety, fire safety, infection control, moving and handling, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), hydration and dementia. We saw that staff also received specific training which was specific to people's individual needs and health conditions. For example, training included pressure ulcer prevention and registered nurses had specialist training in wound care management, syringe driver and tracheostomy care. There was also training for all staff on how to use the electronic care planning system.

The training and quality assurance manager showed us their staff training matrix which covered all modules and identified when training had been completed. The training programme was run throughout the year so there were always opportunities to get staff booked onto necessary training.

Staff we spoke with throughout the inspection spoke positively of the training available to them and how it improved their understanding of their role. Two care assistants told us how training on managing behaviour had been very useful and they had been able to use it to a positive effect with one person.

We saw records that showed registered nurses and care assistants had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. Items discussed included professional practice, teamwork, safeguarding, training development, people's health and well-being and the electronic care planning system. One senior care assistant told us they had brought up a concern about the moving and handling procedures for one person. They said, "We discussed it and the physio came to do a reassessment which changed the way we supported them. It made it much easier and really helped us."

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The 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 make 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). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

We discussed the requirements of the MCA with the registered manager and members of staff throughout the inspection and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records that showed best interests meetings had taken place and when mental capacity assessments had been completed. For example, we saw a best interests meeting had taken place to discuss the use of wheelchair straps for one person, and saw they were being used during the inspection. We saw a sample of DoLS applications for people who were under constant supervision and not free to leave the building for their own safety. The registered manager told us that they worked closely with the local authority and reviewing officers in order to identify any potential deprivation of liberty and we saw correspondence from the provider where applications were followed up. The registered manager had a DoLS log which highlighted applications per suite and their current status. We saw the provider had displayed the principles of the MCA on suite walls so that staff were regularly reminded of these principles and it was also discussed in monthly suite meetings.

Where appropriate, the views of people's relatives were sought, including health and social care professionals when developing care plans and making decisions about people's care. We saw people's care records and consent forms had been signed by people or their representatives to say they agreed to the care being delivered. The registered manager was able to show us records that people's representatives had the legal authority to make decisions on their behalf.

Staff told us they supported people to manage their health and well-being and would always speak with the suite manager or senior staff if they had any concerns about the person's healthcare needs. People were registered with the local GP who routinely visited the home three times a week, and was available for house

calls on a daily basis. The home had access to out of hours GPs who were called in emergencies. These visits were recorded in the electronic care planning system and staff followed up on any actions required. We observed a morning handover on the second day of the inspection and saw concerns from the night shift were discussed and whether the GP needed to be contacted. We saw information in people's care records where staff had made referrals with a number of health and social care professionals when people's health conditions had changed. This included speech and language therapists (SALT), dietitians, neurologists, tissue viability nurses and psychiatrists. One person told us that the staff helped them sort out all of their healthcare appointments. The service also benefited from their own physiotherapy team which consisted of two physiotherapists and two physiotherapist assistants. We saw people had an assessment when they moved into the home and were also reassessed if they returned from a hospital admission. The head physiotherapist told us that they identified people's mobility issues and made referrals for the necessary equipment, then designed a personalised rehabilitation programme for each person assessed. One relative said, "The excellent physios have worked really hard with my [family member] on their rehabilitation." All physiotherapy sessions and interactions were recorded on the electronic care planning system. At the time of the inspection the physiotherapy department were providing approximately 130 sessions per week to 50 people using the service.

We observed lunch over all five floors during our inspection. We observed a calm atmosphere and staff were seated when providing people with assistance to eat. People could also have lunch in their room if they wanted to. One person told us that they were able to eat with their partner and always took their tray into their room at mealtimes. There were no noisy distractions from the television or radio on the suite for people living with dementia and staff gave verbal encouragement to those who were able to eat independently. There was a selection of drinks available and alternative menu options available if people changed their minds from what they had originally ordered. The service was not rushed, people were able to eat at their own pace and those who required support from staff received it in a caring manner.

The home had been awarded a five star food hygiene rating at its most recent inspection. The top rating of five means that the home was found to have 'very good' hygiene standards. We received a mixture of positive and negative comments from people who used the service and their relatives about the quality of the food provided. Positive comments included, "I find the food excellent. I was in hospital before but it is much better here and always a good choice", "I think the food is very good, I have seen the lunch today and it looks OK" and "Very good, no complaints at all." Comments of a negative tone included, "Sometimes it's good, some days are better than others. It's just how it goes" and "On the catering side, the food can be very disappointing at times."

We spoke to the chef who showed us correspondence with people and their relatives when feedback was received about the food. The catering team had an overview of each person on each suite with information about their food preferences, allergies or specific diets, such as diabetic or soft diets. The chef would meet with people upon admission to get an overview of their food choices and this was recorded in people's files. Where we received comments of a negative nature during the inspection, when this was fed back to the provider, they showed us correspondence that the chef had met with them to discuss their concerns. One relative said, "They have worked very hard to accommodate our [family member's] complex dietary needs and the catering manager has always been prepared to talk about other options."

The provider had been a key partner in a university research project called 'I-Hydrate'. This was seen by the provider as a key way of ensuring that people were all effectively hydrated and were able to enjoy a wide range of drinks and hydrating meals to best effect. Individual assessments had been carried out and staff had received training to raise awareness about the importance of staying hydrated. Staff were seen offering tea, coffee, juices and water throughout the inspection and we saw during a morning handover it was

highlighted which member of staff was responsible for ensuring sufficient rounds of drinks throughout the day, with people's fluid intake being recorded in the electronic care planning system. The project had been successful across one of the floors and showed that hydration related infections had been significantly reduced.

Good

Is the service caring?

Our findings

People we spoke with told us they were generally happy with the care they received at the home and spoke positively about the staff who supported them. Comments from people included, "This is the best country in the world for nurses. The nurses are so good and so caring" and "I can tell you that one of the staff, they are the nicest person you will ever meet." Another person said, "Yes, absolutely, and they are amazing" when we asked them if they thought the staff were kind and respectful. The majority of relatives were positive about the attitude of the staff and comments included, "It's like another home for me. It is good here and they make me feel very welcome" and "The staff are very, very nice here, they are very good with my [family member], they are angels really." Where we received comments of a negative nature, they tended to be in relation to agency staff. For example, one relative said, "Some are brilliant, but some have no caring feelings."

Throughout the inspection we observed positive interactions between people using the service and staff. Staff were observed to be compassionate and interested in the needs of the people they supported. Whilst observing lunch on the floor for people living with dementia, one person was quite agitated and frequently shouted out disrespectful language. Staff were aware of this and responded calmly and positively, encouraging the person to focus on their meal. They also used distraction techniques in a positive manner, being aware of their interests to reduce the disruption towards other people. Whilst observing some activities people were very relaxed and comfortable with staff and we could see that people felt happy to express their wishes and felt at ease. We saw that people were encouraged to get involved and were supported by their care workers if need be. When we observed instances of people being distressed or upset, we saw staff responded in a caring manner, offering comfort and reassurance and holding their hand.

Staff we spoke with knew the people they were working with and were able to give information about people's personal histories along with how they liked to be supported. Within people's care plans we saw detailed personal information, life histories, personal preferences, interests and achievements. We spoke with two care assistants about one person they supported who displayed behaviour that challenged the service. They were able to explain in detail how they supported the person and understood that their behaviour was not personal. One of them said, "They can be very verbally aggressive and shout racist abuse at us. But because we know him/her, we understand and are here to help. Despite this, he/she is very sweet and I like them." We did observe one situation where a care assistant was providing one to one support to a person and they had to check the door for the person's name. They confirmed they were agency staff and were getting to know the person throughout the day.

We saw people's rooms were personalised and staff encouraged this to make them feel more at home. One person said, "I am happy here, it is a lovely room. All these pictures are mine, they put them up for me." People were also able to bring their own furniture to the home, depending on the size. One relative told us that the provider had supported their family member with physical adjustments to their room and furniture. We also saw one person was supported to install satellite television.

People told us staff respected their privacy and dignity. One person said, "I'm comfortable with how the staff approach me." We observed staff knocking on people's doors and announcing their presence during our visit. People were asked if they wished to speak to us and if they were happy for us to see their rooms. We saw that people's preferences were respected in relation to leaving their doors open if they wanted to. Staff we spoke with had a good understanding of the need to ensure they respected people's privacy and dignity and we saw this topic had been discussed at recent staff meetings across all floors. Meeting minutes from one suite highlighted that people's rooms were their homes and it was important to respect people's privacy. We saw that dignity in care was covered during the induction for new starters and training in this area was refreshed every year. There were reminders in people's electronic care plans to respect privacy and dignity throughout a number of areas, which included during personal care, physiotherapy sessions, change of dressings and when family and friends visited. Information from the most recent resident and relative annual survey showed that out of 120 respondents, 106 respondents felt they were always treated with dignity and respect and 13 respondents recorded mostly.

People using the service and their relatives we spoke with confirmed they were involved in making decisions about their care and were able to ask the staff for what they wanted. A registered nurse, who was also a suite manager, told us when they carried out assessments and reviews they always made sure, where appropriate, a relative was present with the person. One relative said, "I am always involved in the care planning and review meetings." We saw letters in people's records inviting relatives to review meetings every four months. A registered nurse told us that if people had no family available to attend a review, they would make contact with the relevant health and social care professionals. People also had communication care plans in place which highlighted who should be involved in care planning decisions if there were communication or capacity issues. We saw people were also supported to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. We saw records, where it was appropriate, showing that people's advocates had been contacted or updated about any changes in people's needs.

We saw that the provider had had recently signed up to the Gold Standards Framework (GSF), which was introduced to the service in May 2017, with the next training scheduled for August and a workshop scheduled for September. The Gold Standards Framework is a framework to help deliver a gold standard of care for all people as they near the end of their lives. It helps staff to identify the needs of people at each stage of their life, assess their needs, wishes and preferences, and to plan care on that basis, enabling them to live and die well with dignity. The training and quality assurance manager told us that a representative from each department would be present to help make staff more aware. We saw correspondence from the registered manager and members of the senior management team from May and June 2017 where discussions had taken place about disseminating their progress with the GSF to people using the service, relatives and staff in the August newsletters. The registered manager sent us a copy of the August newsletter after the inspection which gave an overview of the GSF programme and stated that they were now implementing advance care planning. The director of nursing told us that the training had just started and they were working towards updating end of life care plans across all of the suites. A registered nurse who was supporting a person on end of life care was able to tell us the colour coding system that was in place for the GSF, which had also been added to each suites resident list.

People who had made advanced decisions regarding end of life care had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place and this was highlighted in their care plan. People's care plans had a section about personal feelings about the future where any important information could be recorded and we saw discussions about DNACPR had taken place, including input from relatives and if funeral plans were in place. We did see one example where there was conflicting information about a person's DNACPR status

but after speaking with the registered manager about this it was rectified immediately.

Good

Is the service responsive?

Our findings

We spoke with the registered manager and clinical director about the process for accepting new referrals into the home. People had a pre admission assessment before moving in then once allocated to a suite, had a full assessment to document people's needs and complete the relevant risk assessments. At the last inspection, the provider was in the process of implementing an electronic care planning system. This system was now in place and was used for each person across all suites. It was more personalised and information could be updated in real time when staff had any interaction with a person. We observed a care assistant inputting information into the system after completing a care task for the person. Touchscreens were located in corridors across all suites where staff signed in with their own password to access each person's care record. The care assistant had supported a person with their lunch and recorded what they had and their fluid intake. They said, "We need to put everything into the system about what we have done with people." They added that after receiving training to use the system, they found it was very beneficial and less time consuming than completing paperwork. During a morning handover we observed staff being reminded about the importance of recording all activities and interactions onto the system after it had been completed rather than waiting to do it later in the day.

We saw that detailed care plans were in place which covered areas including health conditions, eating and drinking, mobility, communication, personal care, daily or weekly observations and social inclusion. The care plans were personalised and provided important details about people and what was important to them. There was reference to people's preferences and how they wanted their care needs to be met. Information about people's preferences for gender of care staff, frequency of personal care and mobility aids used could also be added onto the system. For example, we saw records where people had requested specific times of the day for when it was best to meet their personal care needs. We saw that staff had liaised with people's relatives to get as much information about them as possible to help them understand how they would like to be supported. For one person, the care plan had recorded their daily routines. They liked a hot drink before bed, liked to have a wash before having their hair brushed and liked particular copies of a daily newspaper. We saw that this had taken place through daily entries made in the system. One relative told us about a particular task that was not always completed by staff, despite it being recorded in their family member's care plan. We spoke to the registered manager about this who spoke with the relevant staff and saw that it had been updated into their care plan and made sure staff recorded it in the daily logs so it could be monitored. We saw that it had been updated in the person's care plan on the second day of the inspection and recorded when it had been completed.

There were activities coordinators allocated on each floor to support people to follow their interests, maintain relationships and take part in activities of their choosing. We spoke with two activity coordinators across two suites and observed different activities throughout the inspection. One activity coordinator said, "As the care staff have so many tasks it is really important to have a dedicated role to support people. I work with the staff to review what is best for each resident and discuss options with the suite manager, who is always very receptive and helpful."

The majority of people we spoke with were happy with the activities available. Comments included, "They

come and keep us company, they sing and dance, I love it" and "The activities manager is very nice and tends to do different stuff most days. I am not so keen but she is always trying to encourage me." Comments from relatives included, "My [family member] prefers his/her own company but staff do come and talk to them, play cards with them, get their nails painted and go to the hairdresser" and "He/she enjoys the party atmosphere."

People had information recorded in their care plans about activities they liked and these could be discussed on a monthly basis. Some of the activities offered throughout the home included arts and crafts, ball games, interactive sensory sessions, memory games, food preparation classes, arts and crafts and support with newspapers and crosswords. There were also live music events and afternoon teas available across all floors. There had been two recent summer events in the past two months and the summer fete was scheduled for the following week. One relative told us that the team had been really kind and worked hard to put on events that their family member had enjoyed. However, one relative told us that they had worked closely with staff to draw up a list of what staff could do to stimulate a cognitive response for their family member, but found that it was not always being carried out. We spoke to the registered manager about this who acknowledged this in terms of the one to one support they received and would review their records to ensure it highlighted what environment staff needed to create for that person.

We observed an art class and an interactive sensory game on two different floors and saw lots of positive and warm interactions, making sure people were involved and encouraged to take part. Pictures that had been completed were left out for their relatives and other people to see later in the day. People had access to a sensory room and an activity coordinator spoke passionately about how it had helped people with limited communication to interact, and they had noticed eye recognition, tapping and smiling that they had not seen before. The registered manager told us that they were in the process of getting hens that would be kept in the garden and people across all suites would have the opportunity to be involved in looking after them. A meeting had been scheduled for the following week where a provider from another service was coming to give a talk about the positive experience hens had for their residents. We were sent the August newsletter after the inspection which showed that their hen project was now up and running and if people wanted to get involved they could speak with their activities coordinator.

There was a garden with a wheelchair accessible greenhouse with direct access from the ground floor. There was a gardening club where people were supported to plant herbs and plants for the home, which had also been advertised in the most recent residents and relatives newsletter, which was sent to us after the inspection. One person told us how they had attended and enjoyed the cream tea and picnic event that had been held there recently. Where people told us they felt they had limited access to the garden due to mobility issues or being on another floor, we saw that the provider reassured them that they would always be supported to access the garden when they wanted.

We noticed that the suite for people living with dementia lacked a stimulating environment to make it more dementia friendly. There was a large amount of wall space that was blank where there could have been sensory of colourful wall hangings or pictures. The main lounge area also had large amounts of blank space. We spoke with the registered nurse who was the suite manager for this floor and they acknowledged that they were in the process of changing the layout to make it more suited to people living with dementia. They explained that they had been on extended leave so the plans had been put on hold, however as they were back it was up and running again. They spoke passionately about the systems and ideas that they wanted to develop, including research that had been carried out and detailed plans that were in place to create a more stimulating environment. We saw that they had worked with an external charity and a local college to source sensory kits and paintings to improve the suite environment. They added, "We are aware that there are improvements to be made but we want to make the environment as homely as possible." We saw

correspondence that showed the suite manager had been in contact with other health and social care professionals to discuss ideas and share good practice about dementia friendly environments and sessions on communication with people living with dementia.

People were also supported with their specific cultural or religious needs. One person told us that they received visits from their priest and we saw this on the second day of the inspection. We also saw records within people's care plans that allowed people to enjoy food that met their cultural needs.

People using the service and their relatives said they knew who to talk to if they had any concerns about the service. One person told us that that they were able to contact the registered manager directly and was waiting to hear about the outcome. They added, "Hopefully it will be resolved today." We saw that this had been recorded and the registered manager was in the process of responding to the person. Positive comments from relatives included, "My [family member] knows who to talk to and they have responded reasonably well" and "I think the staff are doing a reasonable job and they are friendly and helpful when you point something out." When we received comments of a negative nature, we followed this up with the registered manager and saw records and correspondence that showed every effort had been taken to meet people's needs. For example, we saw the catering manager had been to visit a person to discuss issues about the food. Temperature recordings were now recorded on a daily basis on the electronic care planning system and the provider had written to the person to discuss ways of being able to meet their dietary requests.

The service had a number of platforms available where they gave people who used the service and their relatives the opportunity to provide feedback and share experiences about the service they received. This was managed through a suggestions box in reception, resident and relative meetings, a relative forum and a director's surgery, which was held twice a year. We saw topics discussed included maintenance issues, activities, food choices and information relating to the support that people received. For example, there was information about the I-Hydrate project that was to be introduced and what the benefits would be to people. We saw that one issue had been raised about some staff not having a suitable knowledge of English. The provider had taken this on board and an English competency test was now part of the interview process. Meetings were due to be held every three months but some suites had a longer gap between meetings than others. The relative support group was designed to improve channels of communication, build relationships and provide helpful feedback. We saw that when these meetings had started to become less frequent, the provider had made contact with relatives involved to encourage them to continue.

We looked through the complaints and compliments folder and saw that complaints records included details of the event, what action had been taken, if anybody else had been notified, for example, the local authority, and the outcome. The registered manager told us that issues would normally be resolved at suite manager level but then anything more formal would be through their complaints process. Their complaints procedure was a three stage process, with an external agency being involved at the final stage if people were still unhappy. We saw evidence where complaints had led to follow up with staff members and the service acknowledged if they found standards had not met expected levels. All complaints were reviewed quarterly during a registered provider visit by the quality and compliance director. The registered manager said, "It is a good way to review all complaints and see if there is a trend or a particular area of concern." Where people who used the service or their relatives brought up an issue with us during the inspection, we discussed this with the registered manager who reacted positively about it and made plans to speak with them about it so they could find out more information and try to resolve the problem.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who had worked at the home since 2013, but had been registered with the Care Quality Commission since October 2010. He was present each day we visited the service and assisted with the inspection, along with the rest of the senior management team.

The majority of people using the service and their relatives spoke positively about the service and their day to day experiences of staff and management. People told us they felt comfortable talking with the managers and that they were approachable and listened to them. Comments included, "They are very friendly and make you feel welcome", "The manager is very nice, comes and talks to say hello and see how we are doing. The staff are good, I would say it is well organised" and "He spoke to me this morning. If I need to see him I can go downstairs and talk to him." One person told us that they had raised some issues previously and that things had improved. One relative said, "The staff always let me know what is going on and they are very approachable." Another relative told us that they felt the leadership of the home was approachable and the provider had generally responded openly and with candour in response to any concerns that had been raised. They added, "The home seems well managed and cared for and the various operational teams are led by friendly and accessible managers." A health and social care professional told us that the senior management team communicated well and followed up on any issues or concerns.

All of the staff members we spoke with told us they were well supported by their line managers and the senior management team and had positive comments about the management of the service. They felt that the provider promoted a very open and honest culture and that if they had any issues or concerns they could speak to somebody about it. A registered nurse said, "There is always somebody available. If something serious happens, then support is given." Comments from staff included, "I like working here, I receive support from a really good manager and when I refer issues to them, they are dealt with", "I can't stress enough the support I've had from everybody, it has been fantastic. Management are very supportive and I feel I'm lucky as I enjoy working here" and "I love it here. The suite manager is very approachable and offers support to staff." One member of staff, who was a new starter said, "If I have a problem or an issue, I can talk to other experienced carers and seniors and they are always helpful." A member of the senior management team told us they also felt very supported by the registered provider who had an active presence within the service. They added, "There are very clear guidelines, we have regular meetings and know what is needed to be done."

The registered manager was aware of the challenges which faced the service and looked to find ways to overcome them. One of the challenges we discussed was retaining staff and reducing the use of agency staff, to improve the continuity of care that people received. We saw that there were financial incentives for staff if they stayed with the provider for a specific period of time, along with the introduction of a staff retail discount scheme. Staff could sign up to access a number of discounts and rewards at supermarkets, restaurants and cinemas. Staff were also invited to attend a presentation ceremony to reward and acknowledge their achievements in completing the Care Certificate. We saw records of this in staff files and it had been highlighted in the most recent staff newsletter. People using the service, their relatives and

members of staff could also vote an employee of the month. One member of staff said, "I really enjoy working here, I've been here over ten years."

Accidents and incidents were recorded on each suite and reviewed daily by the senior management team. Records showed that they were then analysed by the registered manager so that any patterns could be identified and addressed, in order to reduce the likelihood of incidences reoccurring and to promote people's safety. Depending on the type of incident, there were 24 and 48 hour reviews that focused on any injuries and what action had been taken. For example, if somebody had a fall, there were also regular observations and people's vital signs were checked, with all information being recorded in people's care plans. It also recorded which agencies had been notified of the incident, including the local authority, the Health and Safety Executive or the CQC.

The provider had a comprehensive range of robust internal auditing and monitoring processes in place to assess and monitor the quality of service provided, which were carried out at daily, monthly, quarterly or yearly cycles. There were weekly heads of department meetings, with information being shared to staff at monthly suite meetings. We looked at minutes of meetings across all suites which covered topics such as the electronic care planning system and the importance of recording all care tasks, safeguarding, infection control, health concerns, people's daily routines and information about the service that had been discussed at the weekly head of department meetings. We did see that some suites meetings were more regular than others. There would then be quarterly management review meetings to discuss items such as policies and procedures, outcomes of audits and recruitment levels. We saw that fire drills had also been discussed at a recent meeting. The registered manager was also responsible for sending a weekly operational report to the board with an overview of the service, which looked at occupancy levels, staff turnover rates and their financial performance across all departments.

The registered manager had monthly meetings with the facilities and health and safety manager to review compliance across the service. They carried out regular health and safety checks of the building, including the fire alarm system, the nurse call system, water temperature checks, gas safety and electrical appliances. Regular fire drills were carried out and we saw action had been taken if procedures had not been followed accurately. The registered manager told us that the main outcome of the quality assurance system was to identify if there were failures in process or procedure and to ensure compliance and identify ways in which they could improve people's experiences. The provider carried out unannounced night visits to check that staff were following programmes of work and were available to support people. We saw that they had carried out two unannounced visits after anonymous information had been shared with us. There was also a monthly visit from the registered provider to check on the service. They sought views from people using the service, their relatives and staff, carried out observations and reviewed a number of records. This included complaints, head office audits, safeguarding incidents and the electronic care planning system.

Specific audits of recruitment records and medicines on each suite were completed on a monthly basis and reviewed by the senior management team. Yearly audits covered infection control, supervision and appraisals and a catering audit across each suite. There were also a number of spot audits, which covered care plan reviews, room temperatures, location of call bells and fluid and hydration. The service also carried out a number of 'Take 10' training sessions for staff, which were 10 minute checks with small groups of staff that could be conducted at any time to get an understanding of their knowledge on a specific topic. These provided opportunities for the provider to test and check that the specific needs of any individual person were known and understood by the staff on duty. It tested that care plans in place had been read and understood and that staff were focussed in their approach to individual people and their needs. These sessions had been expanded to include staff awareness of fire safety, safeguarding, privacy and dignity and the training manager told us that if staff responded poorly or showed lack of understanding in any of these

areas, they would receive further training.

The provider sent out an annual satisfaction survey to people who used the service and their relatives to obtain their views of the service. We saw the results from their most recent survey in February 2017 where there were 125 respondents. The information received about the service was positive and highlighted whether it had improved since the previous year. 98% of respondents said the overall opinion of the home was either good or excellent. If analysis highlighted a decrease in performance then steps were taken to address the area.

The provider held regular meetings with the Clinical Commissioning Group (CCG) and local authority who were responsible for funding approximately 70% of all placements in the service. They met with senior commissioners, safeguarding leads and continuing care assessors to provide a comprehensive overview of the service. We looked at minutes from the previous two meetings and saw a number of areas were discussed, including incidents and accidents, hospital admissions, safeguarding investigations and support available from specialist services. We saw that extra funding that had been secured for GP visits had been a factor in reducing the number of unplanned hospital admissions.