Macleod Pinsent Care Homes Ltd

Gracelands

Inspection report

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15 March 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

The inspection took place on 14 and 15 March 2017 and was an unannounced inspection.

Gracelands provides accommodation and care for up to 31 older people living with dementia. The home has 27 bedrooms, some for double occupancy. Bedrooms, bathrooms and toilets are located on both the ground and first floor of the building. There was a passenger lift to access the first floor of the building. The home offers a range of communal areas. On the ground floor there were two lounges, a dining room and access to an enclosed garden area. One person told us, "I'm quite happy because we're near to town and that's the main thing. It's easy to get there and it'll be lovely when the summer is here because we're close to the seafront too". At the time of our visit, there were 22 people living at the home.

At the last inspection, the service was rated 'Good'. At this inspection we found the service remained 'Good'.

The service has a registered manager. The registered manager was due to step down and a new manager had been appointed. They were due to start in April 2017. In the interim, the registered manager continued to run the service, with support from a representative of the provider. 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.

There was a happy and open atmosphere at the home. People and staff got along well and appeared to enjoy each other's company. Staff treated people with respect and had regard for their privacy.

People told us that they felt safe at Gracelands. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Risks to people's safety were assessed and reviewed. People received their medicines safely.

People had developed good relationships with staff and had confidence in their skills and abilities. Staff had received training in supporting people living with dementia. They were quick to support people and provide reassurance when necessary. There was an established team of staff at the home, which offered continuity of care for people. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to pursue additional training which helped them to improve the care they provided to people

People were involved in planning their care and staff understood what was important to them. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff supported people to be as independent as they were able.

People enjoyed the meals and were offered a varied menu. People had been asked for their feedback about

the food and changes had been made to the menu as a result. Staff were attentive and supported those who required assistance to eat or drink.

Staff responded to changes in people's needs and adapted care and support to suit them. We discussed with the registered manager how staff completion of some monitoring records could be improved, to ensure that any changes in people's health or support needs were reliably identified. Where appropriate, referrals were made to healthcare professionals, such as the GP or living well with dementia team, and their advice followed.

People had been asked about their hobbies and interests. Staff provided group and one to one activities in the home. Although some people enjoyed walks to the seafront, some said they would like to go out on day trips. The registered manager had arranged the use of a minibus and trips were being planned for the summer months.

There was strong leadership within the home. Suggestions on improvements to the service were welcomed and people's feedback encouraged through regular meetings and surveys. The registered manager monitored the delivery of care and had a system to review the quality of the service and make improvements where necessary.

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 said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff were confident and competent in supporting people living with dementia. Work was planned to upgrade parts of the premises and to make it more suited to the needs of those living with dementia.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared and

who knew them well.

People were involved in making decisions relating to their care and were supported to be as independent as they were able.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care was planned. Staff understood how to support people and responded quickly to any changes in their health.

People enjoyed a variety of activities but said they would like to get out more. The registered manager had arranged the use of a minibus and trips were being planned for the summer months.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager. Staff told us they were listened to and felt valued.

The registered manager and provider used a series of audits to monitor the delivery of care that people received, to ensure that it was consistently of a good standard and to make improvements.

Gracelands

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 March 2017 and was unannounced.

One inspector and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for older people.

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 any improvements they plan to make. We also reviewed three previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for five people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with seven people using the service, one relative, the registered manager, two senior care assistants, three care assistants, the kitchen assistant and the maintenance operative. Following the inspection, we contacted an admission avoidance matron, a dementia specialist nurse, a chiropodist and the local authority's care and business support team who had worked with the home. They consented to share their views in this report.

Gracelands was last inspected in November 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at Gracelands. One said, "I feel safe and secure here and everything in my room is safe". Another told us, "It is very nice and safe. They treat you very well here". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One care assistant explained safeguarding as, "Making sure people are safe. For example, if there is an incident between residents it is important to make a safeguarding and ensure it doesn't happen again". One staff member had been nominated by the home to participate in a 'person-centred safeguarding champion' programme run by the local authority. During our visit staff shared some of the new initiatives being put into place as a result of this programme (you can read more about this in the Responsive section of this report). Staff told us they felt able to approach the registered manager if they had concerns. Information about safeguarding and how to raise a concern was displayed on notice boards in the home and staff room.

Before a person moved to the home, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in using the stairs, walking outdoors, falling, or from health needs such as diabetes or epilepsy, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support people required from staff. We observed staff being vigilant to people's mobility needs, assisting them to use walking aids and safely using a stand-aid hoist for transfers. There was also guidance on the support people would require to evacuate the premises in the event of a fire or other emergency.

People were supported to take risks, for example one person had been keen to mow the lawn, despite their risk of falling. Staff assisted them to do this. Photos of the person in the garden showed they had enjoyed the task. Another person liked to go out for walks alone but was at risk of getting lost. To ensure their safety, staff ensured they had their mobile telephone with them and a staff member followed at a discreet distance.

Where people presented, on occasion, with behaviours that challenged there was guidance for staff on how to support them. We noted staff had involved healthcare professionals such as the living well with dementia team to seek advice on how best to support the person. There was information on what might cause the person to respond verbally or physically towards staff or other people living at the home, and on how staff should minimise the risk to the person and others. For one person, they found leaving the main lounge and moving to a quiet area calming for them. If this failed staff were able to administer a medicine to help relieve the person's distress. One senior carer told us, "There are other ways we manage his behaviour, rather than giving meds. It is better for (name of person)". In the care records for another person we read, 'I have been seen by the community living well team because I can get verbally aggressive at times. Since my pain relief has been changed they are happy and I seem more settled and less aggressive'.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and reduce the risk of future injury. On each occasion an incident form recorded the details such as the time, location and whether the person was injured. The registered manager checked to see if there

was any pattern in the time or location of falls. Staff had taken action to minimise future risk. For one person a sensor mat had been put in place to alert staff to when they got up, others had been treated for infections which may have contributed to their increased risk of falling. We noted that where staff used body maps to record the position of injuries, there was not always evidence that these had been reviewed or signed off. The registered manager advised that they would incorporate this into their audit.

There were enough staff to keep people safe. One person said, "I think there's enough staff here. I don't have any problems". Another told us, "I've no complaints of any kind. I'm quite happy to be here". A relative confirmed, "There's usually four or five (staff) on while I've been in. I come most days. They look after my wife very well". The registered manager explained that there were generally four or five staff on duty during the day (five to allow the senior care staff time for administration tasks) and three at night. In addition, domestic, kitchen and maintenance staff were employed. The registered manager adapted the staffing levels to suit the needs of people living at the home. She used a dependency tool to check that staffing levels were appropriate. This tool considered people's support needs with dressing, eating, personal care, mobility, sleeping and interaction. On occasions staffing had been increased if a person was unwell, at the end of their life or needed accompanying to an appointment. An admission avoidance matron told us, 'They have been responsive in terms of staffing. In the past they had two staff on at night; they were having issues with falls and admissions (to hospital) at night. They increased staffing to three at night and the falls and admission rate decreased'.

Where necessary, the service used agency staff to maintain staffing numbers. Staff told us there was good continuity in the agency staff who worked at the home, which helped as they knew people and their support preferences. Before agency staff worked in the home, their skills and experience had been checked. They had also received an induction before starting their shift. This ensured they had met people and staff, understood the fire procedures, how to respond to call bells and where to find information about people's care.

The registered manager was recruiting to fill vacant positions. At the time of our inspection there were two full time positions for day staff and four night shifts needing cover. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

People received their medicines safely. Staff who administered medicines had received training and their competency had been assessed. There were recorded details of how each person liked to receive their medicines. For example, 'Takes from spoon', 'Takes from hand' or that one person liked to remove their dentures before taking their medicine. We observed staff administering lunchtime medicines. They supported each person individually, ensured they had enough to drink and then completed the records.

Medication was stored in a locked cabinet that was clean and well organised. Medicines that needed to be kept cool were stored in a fridge and the temperature was recorded daily. Liquid medicines and creams had been dated on opening. The date of opening is important as a medicine can lose its effectiveness if stored for longer than recommended by the manufacturer.
Medication Administration Records (MAR) demonstrated that people had received their medicines as prescribed. Medicines prescribed on a variable dose were accurately recorded. There was a daily 'peer check' by a second staff member who reviewed the medicines administered and the associated records. This helped to pick up any omissions or errors in a timely way. Medicines for disposal were recorded and returned.

Although there was guidance for the use of PRN medicines this did not always include specific details on the circumstances in which the person would need the medicine. For example, we read that one person had a PRN medicine for 'acute aggression'; others were prescribed laxatives to support their bowel health. There was little information on when to give the medicines, such as how the person would present or after how many days without a bowel movement. We discussed with the registered manager how it would be useful to include this level of detail so that staff had clear guidelines and to ensure people received consistent support. Following our visit, we received updated PRN protocols which were person-specific and included detailed information when each PRN medicine should be administered.

Good

Is the service effective?

Our findings

Staff received training to enable them to provide effective care and support to people. Training made mandatory by the provider included safeguarding, moving and handling, first aid, fire safety and dementia awareness. Courses were delivered via a mix of in-house training and accessing external courses, such as via the local authority. There was also a range of posters displayed, reminding staff about moving and handling good practice, the causes of delirium and details of hypos (low blood sugar) and hypers (high blood sugar) in diabetes care. The registered manager took part in clinical meetings for care homes run by a local GP practice. These meetings covered topics such as end of life care and nutrition. Information and learning from these meetings was shared with the staff team.

There were opportunities for staff to undertake additional training such as distance learning courses or diplomas in health and social care. One care assistant told us, "I've learnt a lot since I've been here. I've done my NVQ level two and am now on level three. I've done distance learning on dementia and end of life care". A senior care assistant said, "If you request training, she (registered manager) helps and tries to get you on the training. I asked to do my NVQ level five and I'm doing it". The registered manager maintained a record of staff training and booked refresher courses as they became due. In the staff room we saw lists of forthcoming training dates, along with the names of staff booked to attend. Although staff demonstrated a good understanding of epilepsy and guidance on the actions to take in the event of a seizure were clearly detailed in individual care plans, there was no formal training in this area. We discussed this with the registered manager who advised that they would look at options to source this training.

New staff completed a period of induction, which included training and shadowing of experienced staff. This helped them to understand their role, to get to know people and their support preferences. The induction included an orientation to the home and guidance on the fire procedure, accident reporting, use of personal protective equipment (PPE) and food hygiene. As part of fire safety, staff were asked to identify the location and uses of different types of extinguisher. New staff received a 'buddy pack' which provided written guidance on key procedures such as laundry, cleaning duties and recording people's weight on a monthly basis. During their first 12 weeks of employment, all new recruits who had not previously worked in care were expected to complete the Care Certificate, which is a nationally recognised qualification. At the time of our visit, no new staff had completed the Care Certificate as they all had prior experience of working in the sector.

Staff felt supported and valued. There was a system of supervision which gave staff the opportunity to discuss their role and aspirations. One senior care assistant said, "It's a helpful opportunity to say what you feel and agree what needs to be done". Records showed that each existing staff member had received supervision in 2017 to-date. Each year, staff attended an appraisal which considered their achievements and looked ahead to the coming year. Staff were also recognised via an 'employee of the month' scheme and particular skills or interests encouraged through the appointment of 'champions' (such as for safeguarding, infection control or continence care).

The service specialised in care for people living with dementia. We observed that staff were confident in how

they supported people and quick to offer reassurance when a person appeared distressed. One care assistant told us, "Everyone is understanding of what people are living with. We try to make it nice and as normal as possible". Another care assistant said, "We try to keep a relaxed atmosphere". Staff had received training to help them understand dementia and look at different ways of supporting individuals. The home had benefited from support from the 'Care Home In-Reach Team' (CHIRT). This team is from the local NHS Trust. Staff had attended workshops and had been supported to try new approaches in people's support. The registered manager was also planning additional training in managing behaviours via a dementia nurse specialist.

Staff used various means to communicate with people. Flash cards were available if a person was struggling to understand verbal prompts or questions. These were A4 pages which included a picture. Cards included 'toilet', 'tea' and 'bed' and were used to help staff understand people's wishes. Signage was used in the home to help people orientate themselves in their environment, to find their bedrooms and the lift. Sensory materials were also used. In the activity records we read how people had appeared calm after using a sensory lamp (a light that emits a soft glow and can be calming to people). There were also materials that included pictures, sounds and smells which could be used to create seaside or garden experiences. We observed one person using a 'twiddle muff'. This was a knitted muff with fabrics of different textures and buttons attached to it. The person appeared to engage with this and was visibly soothed. In feedback from relatives gathered by an external company we read about positive experiences of dementia care at Gracelands. One comment read, 'Since moving to Gracelands Mum's mood swings have settled and her aggression has subsided. The sense of humour has returned and our spirited, wonderful Mum is back!' Another, 'He has settled very well, I know he likes it there. He can be challenging at times but the care team are all very good in dealing with him. They are led by the manager who in my opinion is a very kind, caring and respectful person, as indeed are all the team'.

The physical environment of the home was not fully adapted to meet the needs of people living with dementia. There was patterned carpet in the main lounge and corridors. Busy patterns can be distressing to people living with dementia due to changes in their visual perception. One staff member told us, "Some of them try to pick the little flowers from the carpet". The registered manager informed us that quotations had been received to replace the carpets, starting with the main lounge in April 2017. Areas of the premises would have benefited from refurbishment or attention. The path to the garden was mossy and might have presented a risk of slipping, although people were able to access the lawn area directly from the lounge in warmer weather. A relative told us, "I think the staffs' vocation is to take care of the residents. If they see marks on the paintwork they're not bothered. Cosmetic things are of no importance. You can have somewhere smarter but what's that without good care?" A care assistant said, "It's rough and ready but the care is good".

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff understood the requirements of the MCA and put this into practice. We observed staff involving people in day to day decisions, offering assistance and waiting for people to respond to questions. Records demonstrated that where people had refused support on occasions this had been respected. One person told us, "The staff are good. As far as I'm concerned there's no bullying or pushing around. I'm very happy. I find them most pleasant. There are no silly rules". A staff member said, "If they deny anything being done, we try to give them a bit of space and come back later". Where people had expressed a wish to be supported by female staff only, this was respected. A relative told us, "My wife only has female carers giving personal

care. Male carers though assist her around the home and that of course is fine".

Staff were able to describe how they would assist people with decision making and the action they would take if a person was unable to make the decision at the time it needed to be made. A senior care assistant said, "As a carer I have to act in their best interest so that no harm comes to them and to keep them safe. We work with nurses and doctors. We get them to come and assess. The families are involved as well". Staff had assessed people's capacity in relation to planning their care and being able to make financial decisions. We discussed with the registered manager how more detail on the assessment process could be helpful to demonstrate the person's involvement and how the decision was reached. For example, there was no detail on how and when the information was presented to the person or on their responses which led the staff member to determine the person lacked capacity.

Some people had appointed representatives to act on their behalf and a copy of the authorisation was generally kept on file. This would enable staff to check that the person had given authorisation to a named person to make decisions on their behalf regarding their health and/or finance in the event that they lacked capacity to do so. The registered manager informed us that they had requested copies from family members but were awaiting receipt of some.

Where restrictions were in place for people's safety, such as lap straps on wheelchairs or stair gates to prevent people from falling these had been assessed. We read, 'Stair gates in situ for safety reasons. Some residents access the stair gates independently. Staff will open gates for the residents who are unable to do so'. The main door to the home was also secured meaning people would need assistance from staff to leave the premises.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, staff had made applications on behalf of everyone living at the home. Three DoLS had been authorised and the remainder were awaiting assessment by the local authority team. One person had recently moved to the service and this application was due to be submitted. There was clear information in individual care plans as to the reason for the DoLS, the status of the application and, where appropriate, when an application to renew was required.

People enjoyed the food served. Meals were brought in from an external provider and heated up on the premises. There was a choice of two hot options at lunch and a lighter supper option, prepared by staff. One person said, "There's a good variety, plenty of it and it's all fresh. I wouldn't knock it. It's nice and clean in the dining room and I can sit where I want". Another told us, "The food is alright. There's a choice. If there wasn't anything on the menu that I liked they'd see about it and get me something else". During the morning people were asked for their lunchtime preference. Pictures of the meals were shown to those who found it difficult to choose from a written or verbal choice. The mealtime was a sociable occasion. Staff supported those who required assistance to eat or drink. Where a person appeared dissatisfied with their choice, an alternative meal was offered and served. Those who wished for an additional helping were given one. Staff in the kitchen had up-to-date information regarding people's dietary preferences and needs. This included vegetarian and vegan options.

Staff monitored people to ensure they were eating and drinking enough. Where concerns had been identified, staff maintained records of food and fluid. If a person had not been eating or drinking well, this information was handed over to staff on the next shift so that they could offer additional encouragement or snacks to the person. Drinks were readily available in the communal areas for people to help themselves

and were regularly served by staff. People were weighed monthly and staff took action to respond to any unplanned weight loss. For one person, staff had contacted the GP and requested support from the dietician. This person has since gained weight. Information on people at risk was shared with the kitchen who then fortified meals by adding cheese, extra cream and milk powder to dishes. Homemade milkshakes were also available to people on a daily basis to boost their calorie intake. Records we viewed showed staff had been proactive in managing people's risk of malnutrition and that effective steps had been taken to support people to maintain a healthy diet.

People had access to healthcare professionals and the service worked in collaboration to ensure their needs were met. One person told us, "The medical centre is close by. I can see the doctor there, but if I was ill they'd call the doctor out for me". Another said, "I've not needed a dentist or chiropodist but if I did they'd sort it out for me here". Staff monitored people and picked up on changes in their health. Records confirmed people had been supported to meet with a variety of healthcare professionals including the GP, chiropodist, dementia crisis team and optician. Healthcare professionals held the service in high regard. A chiropodist told us, "I've always found Gracelands a pleasant working environment with everyone willing to help me in my role and effective in carrying out any recommendations I have made. I visit the home every six weeks and in between times members of staff do phone me if they have any concerns". An admission avoidance matron said, 'They ring me appropriately. They take action'.

Good

Is the service caring?

Our findings

People spoke highly of the home and of the staff who supported them. We observed people relaxed in the company of staff. Some clearly had a good relationship and were able to laugh and joke together. One person said to a staff member, "You're a little devil but I like you" whilst clasping their hand and laughing. A staff member told us they found it fascinating to learn about people and their experiences. They said, "It's nice to know about their life because sometimes you can associate with that and you have a connection". They added, "If I put a smile on someone's face then that's my job done". A dementia specialist nurse said, 'Their homely approach to residents is very caring and compassionate'.

There were multiple compliments in cards received by the home and posted on an external feedback website. We read, 'You are a very special team of people', 'They are caring and kind to everybody' and 'Staff are very patient, positive, upbeat and in our experience gentle and understanding, displaying a huge amount of patience'. Another relative wrote, 'Words can never express my heartfelt thanks to each and every one of you for the amazing, exceptional care and devotion you all gave to my dear Mum in the last few weeks of her life'. We observed that all members of staff genuinely cared for people, and treated them with respect and compassion.

Each person had a key worker assigned to take responsibility for their well-being, care and support. Written information about the service explained the role as, 'The duties of the key worker are to meet the physical and emotional needs of the residents. The physical needs take the form of ensuring stock levels are maintained, that rooms are kept tidy etc. On the emotional side, key workers support and befriend the residents and their family and friends. They also provide a listening ear and support when needed'. This system appeared to work well and staff were able to tell us about specific tasks they had helped people with or activities they had supported them to participate in.

People had been involved insofar as possible in planning their care and support. Care plans included information about people's preferences and wishes on how they wanted to receive their support. A staff member said, "We ask them (for their choices). If they can't answer I read the care plan to see what the person likes and wants. All of the information is there". One person told us, "It is nice here. I can do as I please". Where people were unable to contribute directly to reviewing or making changes to their care, representatives were involved. One person had an Independent Mental Capacity Advocate (IMCA) who worked with staff to ensure the person's support was appropriate and in line with their wishes. For others, relatives were consulted. One relative told us, "I really can't fault the care. My son and I visited yesterday to discuss on-going care. (Registered manager) was very good; she listened, answered all our questions, and told us if there was anything we wanted to change to just let them know. It was a really good meeting and we left feeling much better informed".

People were supported to be as independent as they were able. One person told us, "Nobody interferes. Staff encourage me to do things for myself". In the care plans we read where people needed support from staff and about the tasks and pursuits they could manage independently. In one care plan we read, 'I am able to wash my hands/face and upper body with prompting. I do not like showers but enjoy a bath with

help from one care assistant'. We observed staff supporting one person to stand. When the person was unable, staff reassured them and said they would return shortly to try again. The person was able to stand on the second occasion which promoted their independence, rather than moving directly to using a stand-aid hoist. In feedback a relative wrote,
'Mum broke her hip and Gracelands have her back on her feet and walking quite well with a frame'.

People told us staff respected their privacy. One person said, "The staff are very caring. I look after myself. I get myself up and dressed. They knock before they come into my room and tell me what they're there for, they don't just come in to nose round my personal possessions. Nobody bothers me without good reason". Another told us, "I've found my privacy is fine, no one comes into my room without knocking". Bedrooms were fitted with a lock which people could use if they wished. Staff had means of accessing the rooms should it be required in the case of an emergency.

Staff showed respect for people and treated them with dignity. Staff called people by their preferred names and always checked with them before delivering care. One senior care assistant said, "We tell them what we are about to do and ask if that is alright". A relative had written to the registered manager saying, 'You and your wonderful staff made it very easy for him to settle in, by treating him with love, respect and dignity that continued day and night until his death. The atmosphere at Gracelands is warm, friendly and caring, everyone is accepted and treated as individuals but as part of a big, loving family'. In other relative feedback we read, 'Residents are afforded dignity in the sometimes undignified condition of dementia and old age. Dementia is tough on all concerned. Entertaining residents is very difficult indeed but Gracelands treat each resident with individual care trying to tease out those little pleasures, sometimes just a smile, that give life some meaning'.

Good

Is the service responsive?

Our findings

People received personalised care and support from staff who knew them well and understood their needs. Care plans included information about people, their background and life experiences. There was also detail on how they liked things done. In one care plan for night time we read, 'I like to have a bedside lamp on and my curtains closed'. External professionals commented on the approach of staff. A chiropodist said, 'What I love about Gracelands is that residents can be themselves as much as they can be which is such a gift to someone with dementia'. A representative of the care and business support team at the local authority wrote, 'The staff team were always seen to have warm, friendly and reassuring interactions with the people they were supporting'.

Staff were working on a number of initiatives to promote person-centred care. The staff member appointed as safeguarding champion was implementing a summary of needs to go in each person's room. This was a laminated sheet describing their key support needs and their preferences. On the front was a picture the person had chosen, meaning that their information was not readily visible, but could be referred to easily by staff. The staff member told us, "I managed to ask (name of person) all the questions. I will do it with them first and then check with the care plans. I made them so I can change it, it won't always stay the same". A representative of the care and business support team at the local authority wrote, 'The person centred safeguarding champion has been very pro-active discovering what is important to people rediscovering some 'lost' hobbies and interests and creating a 'wish book' from the dreams written on their wish tree'. We looked at this wish book and saw photos of people fulfilling their wishes. This included having a fish and chip lunch, making scones, working in the garden, dancing with a handsome man and having a new puzzle book.

Each person had a care plan which contained an assessment of their needs, risk assessments and detail on how to support them. There were sections including physical health needs, personal care, mobility and social activities. Where appropriate, specific care plans had been completed such as for diabetes care, seizures or specific behaviours towards others. Each care plan described the identified need, the aim of the support and guidance to staff on how they should assist the person. The primary records were held on an electronic system but updated print versions were available for easy reference. Key information was also presented on a white board in the staff room. This included any allergies, preferences for female-only care and information on those requiring specific monitoring such as for dietary intake or seizures. Staff had reviewed people's planned care on a regular basis to ensure that it met with their current needs and preferences.

Staff were quick to respond to changes in people's health. A senior care assistant said, "We know them and we observe them. We notice their eating and make referrals if they are losing weight or if there is a change in their behaviour". A dementia specialist nurse wrote, 'The senior staff know their residents and that really makes the difference. They react quickly to situations and are timely and responsive in contacting myself and colleagues'. A relative said, "They make sure she has a drink with every meal and keep a regular record of what she eats and drinks. They keep her turned in bed so she has no pressure sores. The staff keep me informed how my wife has been. They monitor her".

Although we did not identify any direct risk to people, we found that monitoring records were not always accurately maintained. For example, some repositioning, topical cream and bowel charts contained gaps and did not demonstrate that people had always received support as planned. There was little evidence that fluid records had been reviewed or that staff were aware of the person's target intake, although poor fluid intake had been flagged at staff handovers. The lack of complete records could make it more difficult for staff to pick up on problems in a person's health or to identify when additional support was needed. We noted that the registered manager had picked up on these issues and discussed them with staff during a staff meeting in February 2017. She told us this was an area of focus and that she would be reviewing the monitoring records on a more frequent basis.

Staff supported people to engage in activities. There was information about what each person enjoyed and their interests which helped staff to tailor activities. One person enjoyed gardening and had been supported in this; others enjoyed music and card games. Staff had made a retro sweet shop on a trolley which they took round to people. Each person was given their own purse of 'coppers' so they could purchase sweets from the cash till. Staff kept daily records of what each person had been involved in. A sample included visiting entertainers (approximately once weekly), cake making, listening to music, going for a walk with staff, one to one time and assisting with household tasks such as folding napkins. During our visit we observed staff engaging with people over puzzle books and photograph albums. They also initiated group activities such as a music quiz and a game using an inflatable ball. This appeared to be greatly enjoyed, with people commenting on how well others were managing to pat or kick the ball back to the staff member.

A few people expressed that they wished to do more by way of activity, particularly a wish to get out and about. One person said, "I just wish they'd do a few more things to entertain us. I feel I don't do enough; mind you I'm not as fit as I was. Sometimes I feel a little bored". We shared this person's suggestion for exercise to music classes with the registered manager. Another said, "I don't really go out much, my daughter has taken me out but it would be nice if they organised trips to take us out". The registered manager told us they had arranged to use the provider's minibus in the summer months to arrange trips out. She told us, "Now the better weather is coming, we'll get them out". A care assistant said, "There are plenty who would go out".

People and relatives felt confident to raise any concerns with staff. One person said, "I feel settled. I've no prejudices and no worries". A relative told us, I am satisfied that my wife is very safe here and I know that if I did have any concerns I could speak to the manager and she'd sort it out". Another relative had written, 'If I ever need to talk to the manager or under-manager they are always considerate and have time for you, for me that is important'. The registered manager held meetings for residents and for relatives. A local GP had been invited to a relatives' meeting in October 2016 to speak about, 'How dementia presents, what to look for and how to respond to different changes in personality'. These meetings provided people with a formal opportunity to raise any concerns and to share ideas about developing the service.

People knew how to make a complaint but all said they had not had cause to. One person said, "I have no complaints. I've got no grumbles at all". A relative told us, "I'm totally happy with everything here but, if I wasn't, make no bones I'd speak to the manager". Without exception, people said they would have no hesitation in speaking with the registered manager or staff. Information on how to complain was displayed in the home. This explained how to make a complaint and the anticipated timescales for response. We noted that this information did not provide information about the Local Government Ombudsman, which is where complainants can go if they remain dissatisfied with the service's response. Following our visit the registered manager sent us an updated copy of their complaints information with this contact information added. The registered manager maintained a log of any complaints received. We saw that action had been taken in a timely way and to the satisfaction of the complainant. In order to learn from complaints, the

registered manager completed a monthly review to check that necessary action had been taken.

Good

Is the service well-led?

Our findings

There was a friendly and open atmosphere at the home. In the hallway of the home there was a montage displaying photos of people and staff. There was information for people and family members about Alzheimer's disease, paying for care, along with a copy of the provider's Statement of Purpose and the rating from our last inspection. The registered manager and staff were keen to develop the service and to enhance the support they provided to people. The registered manager had recently signed up to a programme entitled 'Making it real' which looks at person-centred care. The home was also nearing completion of work to achieve the 'Social Care Commitment'. The Social Care Commitment's website describes this as, 'The sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks. Each commitment will focus on the minimum standards required when working in care'. All of the staff we spoke with said they would recommend Gracelands if they had a relative or friend needing this type of support. A chiropodist told us, 'I've always found Gracelands to be a safe and caring environment for residents. This seems to be nurtured by management and filtered through senior members of staff'. A relative wrote in their feedback, 'The staff have, in our experience, always been patient and cheerful, encouraging a positive living environment'.

The registered manager was held in high regard. She advised us, however, that she was due to step down from her post. A new manager had been appointed with a start date in April 2017. In the interim the registered manager was continuing, with support from a representative of the provider.

People and staff felt confident to approach the registered manager and told us that she took action when needed. One senior care assistant said, "I can talk to (registered manager). She does listen". A care assistant told us, "If I have a problem I can talk with her. If you need help she helps you". The registered manager was supported by a team of senior care assistants. Staff members had been appointed as champions in specific areas. There was a champion for safeguarding, continence and infection control and plans to introduce dignity and dementia care champions. In addition, staff had been allocated specific tasks such as weekly cleaning of tooth mugs, tidying of toiletry baskets and recording of monthly weights. This all helped the service to run more smoothly. One care assistant told us, "You feel valued. There's a good team ethic here, you know you've always got that support". Another said, "When you raise something, they (management) look at it. They'd always give me advice or help me".

The registered manager and provider used feedback to monitor and improve the service. Questionnaires had been sent to people and their relatives during 2016. People living at the home had also been asked for their views on the menu. The registered manager had analysed the feedback and taken action. In response to feedback that some people felt hungry in the evening we read, 'All tea and supper time menus were changed on 29/9/16 to reflect a more substantial food before bed and resident choices for teatime'. Other action included upgrades to the premises, including costing for new carpets and the employment of a new maintenance operative to address day to day issues. One person had chosen a new colour for the bedroom and their room was due to be redecorated in April 2017. The feedback about the care people received was positive. People said they found staff helpful, enjoyed the company at the home and felt safe and secure.

There were regular staff meetings, for the senior team and for all staff. We saw that in response to staff feedback, additional administrative hours had been added to the rota for senior staff, starting in January 2017. Staff had also been asked for their feedback via a questionnaire. In response to this feedback, fresh fruit salad had been added to the menu and new arm chairs purchased for the lounge.

The registered manager had a system to monitor the quality of the service and to identify improvements. We reviewed audits of infection control, accidents, falls, medication and staff files. In each case there was an evaluation which analysed the results and identified action that needed to be taken. There was clear evidence of action being taken to respond to concerns, safety issues and feedback. We reviewed checks on equipment and health and safety. These were in place, some conducted by external companies. For example a recent audit of lifting equipment (hoists, bath chairs and the passenger lift) had identified that some slings were worn. As a result these had been removed. Work was also underway to make further improvements to fire safety following an external risk assessment. The provider carried out checks on the service. We reviewed the report from a visit in February 2017. This had looked at care plans, staff files, staff supervision and appraisal, medicines and maintenance. We found that the quality processes in place had delivered improvements and ensured compliance with the regulations.