Barchester Healthcare Homes Limited

Wilsmere House

Inspection report

Wilsmere Drive
Harrow
Middlesex
HA3 6BJ

Tel: 02084207337
Website: www.barchester.com

Date of inspection visit:
26 November 2019
28 November 2019

Date of publication:
28 January 2020

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

About the service
Wilsmere House is a care home that provides personal and nursing care for people, some of whom live with dementia and/or have a physical disability. It also provides specialist support for people who have experienced a brain injury. The service is registered to provide treatment, care and support for up to 94 people. However, the service has reorganised some areas of the service, which has led to there currently being 86 beds available. Management told us that the provider would take the necessary action to have the correct bed numbers included in our records. At the time of the inspection there were 80 people using the service. Accommodation was provided within a purpose-built home, across four units, with communal areas located within each unit.

People's experience of using this service and what we found
We found some areas where the medicines management systems could be developed and improved. The service was very responsive in quickly addressing these shortfalls and making appropriate improvements.

There was a positive, open and supportive culture at the service. The registered manager and staff team were committed to ensuring people were at the heart of the service and provided with personalised care. They made sure people and where applicable people's relatives and others important to them were central to how people's care was planned and reviewed.

The service had developed links with the local community and the home provided a meeting place for carers groups. The home encouraged engagement with local community residents through activities including complimentary meals and a range of events.

There were quality assurance systems in place to identify and address any shortfalls and make improvements to the service. The registered manager and staff team were continually seeking ways to develop and improve the service for people.

People had the opportunity to participate in a broad range of social activities. They were supported to live life to the full despite many people having complex needs and sometimes life limiting medical conditions. The service provided the support people needed to fulfil their aspirations even when they were very unwell.

The service worked in partnership with external and inhouse healthcare professionals to encourage and promote people's mobility, independence, good health and well-being.

People's varied communication needs were understood by the service. A range of tools were used to support and promote people's individual ways of expressing and communicating their needs and wishes.

Staff understood and valued people's differences. They provided people with the support they needed to meet their cultural needs, follow their religious beliefs and maintain and develop relationships with friends

and family.

We saw positive engagement between staff and people. People's relatives told us they felt people were felt well looked after. They told us staff were kind and caring and provided care in a respectful and dignified manner.

Staff received the training, guidance and support they needed to do their job well and to effectively meet people's needs.

There were systems in place to safeguard people from the risk of possible harm. Staff knew what their responsibilities were in relation to keeping people safe. They knew how to recognise and report any concerns they had about people's welfare. Risk management plans were in place to protect people from harm and to support them to remain independent.

The provider had systems in place to manage and resolve complaints. People and their relatives were listened to. They had opportunities to provide feedback about the service, and action was taken to address issues they raised.

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

People benefited from living in a care home which provided effective, caring and well-led care and support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 17 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Wilsmere House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, a specialist nurse advisor, a pharmacist 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 care service.

Service and service type:
Wilsmere House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced. We informed the registered manager that the lead inspector would return to complete the second day of the inspection.

What we did before the inspection
Before the inspection we looked at information we held about the service. This information included the last inspection report and statutory notifications that the provider had sent to the CQC. Statutory notifications include information about important events which the provider is required to send us by law. The registered manager had completed a Provider Information Return [PIR]. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support

our inspections. We discussed the PIR with the registered manager during the inspection.

During the inspection
We spoke with the registered manager, non-clinical deputy manager, clinical deputy manager, divisional clinical developmental nurse, regional director, administrator, physiotherapist, physiotherapist assistant, head chef, maintenance person, laundry assistant, activities coordinator, music therapist, finance director, seven nurses, two senior care workers, five care workers, eleven people using the service, nine people's relatives, and two healthcare professionals.
We reviewed a variety of records which related to people's individual care and the running of the service. These records included care files of nine people using the service, four staff employment records, staff training records, medicines administration records and a range of quality monitoring records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at one person's medicines risk assessment, two people's medicines care plans and an action plan from the registered manager in response to the findings of our pharmacist inspector. We also obtained feedback from two more healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and a risk that people could be harmed.

Using medicines safely

● The service had a policy in place which covered the recording and safe administration of medicines. There were no gaps in people's medicines administration records (MAR). This indicated that people received their medicines as prescribed.

● Nurses and care practitioners administered medicines. These staff received medicines training and had their competence to administer people's medicines safely assessed. We saw people received the support they needed with their medicines.

● There were detailed personalised protocols for the administration of medicines that were given when needed by the person (PRN). These had been written and signed by one nurse. To reduce the risk of error and to keep people safe medicines records and administration protocols in accordance with best practice should be checked for accuracy and signed by a second trained and skilled member of staff before being first used.

● A health professional spoke positively about the service and of the engagement they had with staff about people's medicines.

● However, we found shortfalls in some areas of medicines management. These included, the administration time on one person's MAR differed slightly to the time recorded on the person's medicine pack. Two people's written profiles in their care plans indicated that they had allergies, but this information had not been recorded on their MARs, so staff administering their medicines may not have been aware of those allergies.

● The temperature of medicines fridges and clinical rooms were monitored and recorded daily, but records did not show that minimum, maximum temperatures were always recorded, and thermometers were not being reset daily to make sure they were checked for accuracy, which could mean there was a risk that medicines were not always stored and a temperature that maintained their effectiveness and safety. These issues were addressed quickly by the registered manager and/or other senior staff.

● We found no evidence during this inspection that people had been harmed by the medicines issues we found, but they indicated that some areas of medicines management could be improved. During and following the inspection, the registered manager, senior staff and healthcare professionals were very responsive in quickly addressing these shortfalls and making improvements to the home's medicines management systems.

Preventing and controlling infection

● Systems were in place to minimise the risk of infection. The home was clean and free from unpleasant odours. Domestic staff supported the staff team to ensure that the home was kept clean. Regular checks of the cleanliness of the environment were carried out. A person's relative told us, "The home is fantastic,

nicely furnished and spotless."
● Staff had received training in infection prevention and control. Protective clothing, including disposable gloves, were available to staff. Staff used these when assisting people with personal care and some other tasks. Best practice handwashing guidance was displayed within bathroom facilities of the home. We saw staff washing their hands after supporting people with personal care.

Systems and processes to safeguard people from the risk of abuse
● There was a calm environment in the home. Policies and procedures were in place to safeguard people from abuse and the risk of avoidable harm. Staff understood how to keep people safe. They demonstrated a good understanding of the indications of abuse and were clear on how to report concerns under safeguarding or whistleblowing procedures.
● People's relatives told us they felt people were safe. They did not have concerns about people's safety when they were away from the home. A relative told us, "I don't go away and worry about [Person]. [Person] is safe."
● The registered manager was aware of the need to report safeguarding concerns to the local authority and to us.

Assessing risk, safety monitoring and management
● Systems to keep people safe and manage and monitor risks were in place. Risks people faced had been identified, assessed and reviewed regularly. Risk assessments were personalised and included risks to do with falls, the use of bedrails and risks associated with people's medical conditions. For example, people who were at risk of choking had a risk assessment in place, which included guidance to keep them safe.
● Staff knew about the risks to people's safety. They knew that they needed to report any safety concerns to senior staff.
● Some people with mobility needs required mechanical equipment to help them to move. Staff had received training to use the equipment safely and risk assessments recorded the level of support each person needed. We saw staff using moving and handling equipment safely during the inspection.
● Measures were in place to help prevent people falling. When people had fallen, the incident had been reported, reviewed and investigated. Strategies were then put in place to minimise the risk of future falls and to keep the person safe. Regular analysis of falls was carried out to identify any patterns or risks and to put guidance and other suitable measures in place to protect people from future falls.
● Environmental risks were identified and managed well within the service. The service was responsive in ensuring maintenance and repairs were carried out promptly to keep people, staff and visitors safe. Service checks of the gas, electrical and fire safety systems were carried out as required.
● Regular fire drills took place. The service had a system in place that ensured each member of staff took part in a fire drill annually, so they were always familiar with fire emergency procedures. There was an up to date fire risk assessment, and each person using the service had a personal emergency evacuation plan (PEEP). These PEEPs included information that staff, and emergency services needed to support people to leave the premises in an emergency.

Staffing and recruitment
● Staff employment records showed that appropriate recruitment and selection processes had been carried out to make sure only suitable staff were employed to care for people. The service had policies and procedures to support this process.
● We observed staff worked at a relaxed pace and were available to assist people in a timely way. Staff told us they felt there were enough staff to safely meet people's needs. A nurse informed us they would speak with the registered manager if they felt that more staff were needed. They were confident that they would be listened to and any staffing shortfalls would be addressed. Two staff told us it was sometimes difficult to find

the time to spend "quality" time with people. Two people's relatives told us their loved ones received the care they needed but they felt the service could benefit from having more staff on duty.

●The service used the provider's tool (DICE) which determined the number of staff and skill mix from details of people's dependency needs. The registered manager told us that staffing in the home was responsive to people's needs and safety. Records showed that the registered manager had been responsive in providing extra staff when needed to ensure people's complex needs and safety were met by the service.

● The service has systems in place to ensure that staff covered staff absences when needed. This was to ensure people were provided with consistency of care by staff who were familiar with their needs.

Learning lessons when things go wrong

● The service had systems in place to make improvements when things went wrong. Policies and procedures were in place to ensure that accidents, incidents and complaints were responded to appropriately. Records showed that suitable action had been taken in response to incidents.

● Accidents and incidents were regularly reviewed to look for patterns and trends. Action was taken to minimise the risk of them happening again. Staff meetings, including daily meetings with heads/leads of all areas of the service, and staff supervision sessions were used to ensure lessons were learnt from incidents and shared across the whole staff team.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been fully assessed with them before they moved into the home. This was to make sure that the service could understand and meet their needs. Care and support plans were developed from the initial assessments to ensure staff knew how to provide each person with personalised care.
- Details of people's individual needs, including their daily routines, cultural, religious, dietary, relationship needs, and preferences were included in their support plans. This helped staff to fully understand people's individual needs and provide effective care.
- We noted that information about other areas of people's diversity needs including sexual orientation were not included in initial assessments. This was discussed with the registered manager and regional manager who told us they would take action to include this information in the process of initial assessment.
- Details about assessment and support people needed with their mouth care were recorded. During the staff 'handover' meeting staff shared information about meeting people's mouth care needs.
- Records of people's progress were completed by staff. Staff told us they were kept well informed about people's needs by the effective communication systems, which included detailed handovers of people's care and support needs. This helped ensure that staff always provided people with personalised effective care.

Staff support: induction, training, skills and experience

- People were supported by skilled and competent staff. Staff received an induction that included shadowing experienced staff. This helped staff learn about their role and responsibilities. A nurse spoke of having a "good, long induction", which had included being the extra nurse on duty for one week whilst shadowing other nurses. Feedback from people, relatives and care professionals informed us that they found staff to be knowledgeable about people's needs and competent in carrying out their roles and responsibilities.
- Staff had completed a range of relevant training appropriate for their job roles. This included the provider's compulsory training and training specific to people's individual needs including medical conditions. For example, most care staff working on the dementia care unit had received higher than basic level of dementia care training. Staff told us they would ask the management for further training if they felt they needed it and were confident it would be provided. The registered manager told us that there were plans to provide staff with specific learning about the needs of people who live with learning disabilities.
- Nurses spoke about the learning and training that they received which ensured they had the knowledge and skills to meet people's often complex nursing needs and maintain their nurse registration. For example, nurses had received training in nursing people who had an acquired brain injury and/or tracheostomy

(medical procedure either temporary or permanent that involves creating an opening in the person's windpipe to enable them to breathe).
● Staff were supported to complete qualifications in health and social care. The registered manager recognised the positive qualities in staff and supported them to extend and develop their roles to improve and develop the service provided to people. The provider employed a dementia specialist who supported the service in meeting people's dementia care needs.
● Staff were provided with regular supervision and appraisal of their development and performance. This and staff meetings provided staff with opportunities to discuss the service provided to people and share best practice.

Supporting people to eat and drink enough to maintain a balanced diet
● People's dietary needs were understood by the service. People's nutritional and dietary needs were assessed and monitored. Guidance had been sought from relevant healthcare professionals when required. Their recommendations and guidance were documented in people's care records.
● The chef was knowledgeable about people's preferences, cultural and other dietary needs. They knew the importance of people being provided with meals that they liked and provided us with examples of people having meals that they particularly enjoyed that had been specifically made for them. One person who lived with dementia was provided with finger food meals as they found it easier to eat using their hands.
● During breakfast we noted that the menus on the tables in one unit did not did not correspond with the meals of the day as they referred to the meals provided on the previous day, and earlier. This was mentioned to the registered manager who told us that they would ensure in future that the menus were changed before breakfast. People were asked for their feedback about the meals and the menu amended accordingly.
● Staff at the home completed regular mealtime experience assessments. Coloured plates helped make food stand out visually for people living with dementia.
● A range of refreshments that people and visitors could access at any time were available in a communal lounge. People were provided with a glass of wine if they wanted one with their meal. Relatives told us, "Food is very good" and "[Person] likes the food."
● Mealtimes were pleasant, sociable events. Dining rooms were nicely decorated, and staff provided people with the support they needed in a calm and engaging manner. People told us the food was good and there were choices available. We saw people being offered a choice of meals and drinks.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
● People accessed community healthcare services including doctors, dietitians, speech and language therapists, dentists, chiropodists, specialist nurses including tissue viability nurses and those with expertise in a range of medical conditions, and as part of preventative care and treatment. The home employed its own qualified physiotherapist and assistant physiotherapist assistant to support people's rehabilitation and mobility needs. One person's relative told us, "[Person] has physio once a week if possible, [it's] very good." One staff told us, "We work with other professionals and organisations so that residents receive the best care."
● Nurses had received support and advice about people's respiratory nursing needs from nurses based at a specialist hospital.

Adapting service, design, decoration to meet people's needs
● The premises were purpose built and appropriately designed for the people who used the service. People had access to an enclosed well-maintained garden. A person spent time in the garden during the inspection.

● Since the last inspection there had been changes made to the environment. There had been redecoration

and refurbishment of some units and a communal lounge.
● People's mobility was supported and encouraged. People walked about independently or with or with mobility aids within the units.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Care support plans included information about people's capacity to make decisions, and their communication needs.
● Staff received training in the MCA principles and DoLS. They were provided with regular updates and refresher training to ensure they had a good understanding of the legal framework for making particular decisions on behalf of people who may lack the capacity to make some decisions on their own. Staff knew that if the service was concerned about a person's capacity to make decisions they would ensure that the least restrictive option would be made in the person's best interests by those involved in their care.
● When people were unable to consent to their care and treatment in the home appropriate applications to the local authority for DoLS authorisations had been made and progress monitored.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff understood people's communication needs and engaged with people in a friendly and respectful way. Staff did not rush people when providing them with care and support. They spoke with people in a polite way, giving people time to understand and respond. Relatives told us, "They [staff] do their best I think they are kind," "Very caring [staff] here," and "The carers are kind. They look after [person] well."
- Staff had a good understanding of the importance of understanding and respecting people's differences and were knowledgeable about diversity and human rights. Staff knew how to support people's diversity needs including their religious and cultural beliefs and traditions in areas such as diet, personal care needs and language. Representatives of religious faiths regularly visited the service. Festive occasions, people's birthdays and cultural days were celebrated by the service. A person's relative told us, "[Staff] treat [person] with respect and dignity."
- Staff were aware of the family and other relationships people had. They told us, "We talk about the residents and learn about their background," and "They (people) have had a life, family and job, it is good to know what people did." A member of staff spoke of speaking in their first language with a person using the service. They told us, "When I speak to [person] in [Person's birth language], which they understand. It helps."
- Healthcare professionals spoke highly of the care people received. One healthcare professional told us staff were very knowledgeable of people's dementia care needs and supported the emotional needs of people's family members.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives told us they were fully involved in decisions about people's care and staff respected the decisions they made. A person's relative told us, "My [relative] has seen [their] care plan and [another relative] attends relatives' meetings." Relatives told us they were kept informed about any changes in people's needs.
- People had the opportunity to take part in resident and relatives' meetings. These meetings helped keep people informed of forthcoming events and gave them the opportunity to be consulted and make suggestions.
- Staff understood the importance of involving people in making decisions for themselves. They told us they always involved people in making decisions about their care where possible. Staff were seen to be respectful of people's wishes and views and we saw people were offered choices. A staff member told us, "I love to care for elderly people. I love my job."

Respecting and promoting people's privacy, dignity and independence

● Staff understood how to support people with dignity. We observed caring and positive interactions from staff who knew people well. During the inspection staff supported people in a manner that maintained their dignity. Relatives told us they felt people's dignity was upheld. They told us that staff respected people's privacy and made sure people were told about care tasks before they carried them out.

● People's care records and other personal information were stored securely. Staff were aware of the importance of confidentiality and held meetings or telephone conversations with relatives or healthcare professionals in private.

● People were able to spend time alone with their visitors should they choose to.

● Staff told us they always encouraged people to do things for themselves where possible. They told us that some people were able to do some personal care tasks such as wash their own face, and this was supported. A person's relative told us, "My [relative] has hugely improved after [they] came here."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans contained personalised information about people's care and treatment needs. They included guidance for staff on how to provide people with safe and effective care. Staff told us they read people's care plans and were kept well informed about their needs. A relative told us that their loved one received the care they needed and was monitored closely by staff.
- Staff knew people well and could tell us about people's needs including their individual likes and dislikes. Staff told us how they spoke with people and their relatives to obtain important information in relation to people's needs and preferences.
- People and relatives told us that communication with staff was good. They commented, "I know that they [staff] would call if anything happened to [person]. I speak with the nurses about [person], they are good," and "I feel fully involved."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were detailed in their care plans. Care plans included personalised details and guidance for staff to follow to meet those needs.
- Staff used a range of ways to communicate with people. Care staff told us that they showed people a choice of clothes and meals to support people to understand and make choices. Pictures, signs, an alphabet board and an eye gaze communication device were tools used to help staff communicate with people. Staff had supported one person to use an electronic tablet to help them communicate with family members.
- The registered manager provided us with examples of staff having used an electronic App (computer program application designed to run on a mobile device such as a phone or tablet) when people had difficulty in communicating in English. They told us about how one person's well-being had benefitted from staff having used the App to translate English into the language used and understood by the person. One care staff told us they had learnt some words and phrases in the language spoken by another person, which had helped them be more effective in communicating with the person.
- There were signs around the service in pictorial form to assist people to find their way around the service independently.
- A music therapist carried out assessments of people's awareness in disorders of consciousness and delivered one to one music sessions with people who lived with complex needs including sensory communication needs. The registered manager told us about one person living with a significant brain

injury who did not engage with people but had been responsive in a positive way when hearing a kind of music.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Relatives told us that they could visit anytime, and staff always made them feel welcome.

● People were provided with opportunities to take part in a range of activities. There was a weekly time table of activities. These included a range of indoor and community activities and events. We observed people taking part in a music session. People and their relatives indicated they enjoyed the session by smiling, laughing and participating in the session. One relative spoke highly about the session and of the positive impact it had on their family member. Other activities included; magician events, poetry, chair yoga, hand massage, and arts and crafts. Staff supported one person to have contact with the football team they supported. Some people had visited people who lived in another care home. Garden events including fêtes had also taken place.

● Staff supported people to maintain relationships that were important to them. The service had supported a person who was receiving end of life care to attend an important family event.

● The service had a café area, where people and their visitors could access hot and cold drinks and snacks at any time. We saw people and their visitors using this facility during the inspection. A relative spoke positively about this service.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy. When complaints had been made, they had been recorded and investigated following the provider's policy. People and their relatives knew who to contact if they had a complaint.

● The outcomes of complaints were reviewed and where possible lessons were learnt and to improve the service and minimise similar complaints being made.

● People's relatives told us that that they would not hesitate to speak up about any concerns that they had about the service. One relative told us, "I would definitely say if I wasn't happy. I know they would listen." They provided us with an example of where they had raised an issue, which had been quickly addressed by senior staff.

End of life care and support

● The service provided people with end of life care and support. Details of people's end of life wishes were included in personalised advanced care plans. These included information about whether they wanted to be cared for in hospital or in the care home at the end of their life.

● The service had worked with a local hospice to help ensure people received good palliative care. Several nurses had received palliative care training and some care staff had received end of life training. They informed us that there were plans for more staff to complete this training.

● Referrals to the palliative care team had been made when required. Staff told us they had received support from management staff during and following providing people with end of life care. The clinical manager told us that review and "debriefing" with staff after the death of a person took place and was being further developed to ensure it was standard best practice.

● DNAR (do not attempt resuscitation) forms were in place. This information had been reflected in people's care plans and recorded in care files. However, in one unit it was not clear how staff in an emergency would be able to quickly access this information as DNAR details were in people's care files located in the unit office. This could possibly lead to a delay in staff carrying out emergency resuscitation procedures. This was addressed promptly so that this information was easily accessible to staff whilst respecting people's confidentiality.

● The registered manager spoke of the importance of engaging closely with people and their relatives about people's end of life care needs and preferences. They told us that recent positive, close engagement with one person and the person's relatives had resulted in the person being cared for in the home at the end of their life, in accordance with their preferences and wishes.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Senior staff carried out a range of checks of the service to ensure care provided was safe and effective. For example, records showed that action had been taken to address shortfalls found during infection control, medicines, documentation, and nutrition and dining audits. Unannounced night and day spot checks of staff providing people with care had been carried out by management staff to check that people received effective and safe care. The service had been very responsive in addressing the medicines shortfalls we found and had put strategies in place to show lessons had been learnt and appropriate improvements made.

● Monthly quality and clinical governance meetings with senior staff ensured that clinical issues and practice were reviewed, and improvements made when needed.

●The latest CQC rating had been displayed as required, for people, relatives and visitors to view.

● All the staff we spoke with were clear about their roles and responsibilities and spoke positively about teamwork and communication between staff about the service and people's needs.

● Staff performance was monitored and supported. Staff told us the they felt supported by the nurses and management staff and were well informed about matters related to the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff promoted a person-centred approach to people's care and support. People were involved where possible in developing and reviewing their care plans.

● The atmosphere in the home was relaxed and calm, people appeared to be comfortable in the environment. They moved freely within the home.

● People and relatives relative spoke highly of the management and running of the service. They told us they had been invited to relatives' meetings and would recommend the home to others.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was an open and transparent culture within the service. When incidents and accidents had happened, the registered manager had been open and honest with people, relatives, staff and appropriate agencies including us. The registered manager had notified us of incidents as required and in a timely manner.

● There were systems in place to review, analyse, reflect, review and learn from all accidents, incidents and

complaints. The service had worked with other agencies to put strategies in place to learn lessons and reduce the risk of them happening again.

● The registered manager had an open-door policy. Relatives told us that the registered manager and other staff were very approachable. During the inspection people and their relatives spoke with the registered manager about a range of issues to do with people's care. Relatives told us, "I email the manager if I have any issue" and "Management is very good, they explain everything about the health of my husband."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were kept informed of changes within the service. People, relatives and professionals had completed surveys about the quality of the service. The results had been analysed and were available for people to view. The results had been mainly positive, where suggestions had been made, a plan had been put in place. For example, the service had been responsive to people's feedback by increasing the range of activities.

● The service had a community engagement plan which was reviewed monthly by management and the activity team. Examples of engagement with the local community included events where local police had visited the service to meet staff and people using the service and provided information and advice. Pupils from local schools had visited the service and spent time engaging with people by singing, playing a piano, and talking with them. People had been invited to a festive party held at a local school. Regular outings to places of local interest such as museums took place regularly.

● To provide support to people who were socially isolated the service had invited older people living in the local community to join them for a meal in the home.

● A Multiple Sclerosis (MS) carers group regularly met at the home as a support group and engaged with people living in the home who lived with MS. The registered manager spoke of plans to offer the home as a venue for other similar carers groups.

● The service had worked closely with a local hospice that had supported nurses to receive palliative care training.

● The registered manager attended local forums to keep up to date with changes within social care. They received updates from national organisations including Skills for Care.

● Feedback from healthcare professionals was positive about the service. They told us that staff knew people well, treated people with respect and followed their instructions/advice regarding people's care and treatment.