Jesyem Medicare Limited

Hendford Nursing Home

Inspection report

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Date of inspection visit:
25 October 2016
27 October 2016

Date of publication:
25 November 2016

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 25 and 27 October 2016. The first day of our inspection was unannounced and we told the provider we would be returning on 27 October to complete our inspection. The service was last inspected on 7 January 2014 and at the time was found to be meeting all the regulations we looked at.

Hendford Nursing Home provides accommodation for up to 34 older people who require nursing or personal care, and those living with the experience of dementia. At the time of our inspection, 24 people were living at the service. This was because the whole of the first floor was being refurbished and new admissions were being restricted until the completion of the work. A new extension had been completed at the time of our inspection and we saw that this provided a comfortable living space for people.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission 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.

The provider had systems in place for the management of people's medicines and staff had received training in the administration of medicines. However, in some cases, the amount of boxed medicines did not correspond with the medicines administration record (MAR) charts.

The risks to people's safety were identified and managed appropriately and people were cared for safely.

There were regular health and safety audits which indicated that all areas of the home were checked for safety and any areas requiring maintenance were identified.

There were enough staff on duty to keep people safe and meet their needs in a timely manner, and the provider had contingency plans in place in the event of staff absence.

There were appropriate procedures in place for the safeguarding of vulnerable people and these were being followed.

People's nutritional and healthcare needs had been assessed and were met.

People who used the service were cared for by staff who were suitably trained, supervised and appraised. The registered manager sought guidance and support from other healthcare professionals and attended workshops and conferences in order to cascade important information to staff, thus ensuring that the staff team were well informed and trained to deliver effective support to people.

The provider acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's capacity was assessed and they, or their representatives, had consented to their care

and support. Processes were being followed to ensure people were deprived of their liberty lawfully.

Staff were caring, treated people with dignity and respect and took into account their human rights and diverse needs. People and relatives told us that people were safe and happy at the service.

Assessments were carried out before support began to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly. These were clear and comprehensive and written in a way to address each person's individual needs, including what was important to them and how they wanted their care to be provided.

There was a complaints procedure in place and people and their relatives knew how to make a complaint. They felt confident that their concerns would be addressed. Relatives were sent questionnaires to gain their feedback on the quality of the care provided.

A range of activities was provided which included regular outings. These were varied and took into account people's likes and dislikes, their backgrounds and any particular interest they had.

People, relatives and professionals we spoke with thought the home was well-led. The staff told us they felt supported by the registered manager and there was a family atmosphere and a culture of openness and transparency within the service.

The provider had effective systems in place to monitor the quality of the service to ensure that areas for improvement were identified and addressed.

We made a recommendation in relation to the safe management of medicines.

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.

The provider had systems in place for the management of people's medicines. However, in some cases, the amount of boxed medicines did not correspond with the medicines administration record (MAR) charts.

The risks to people's safety were identified and managed appropriately and people were cared for safely.

There were enough staff on duty to keep people safe and meet their needs in a timely manner, and the provider had contingency plans in place in the event of staff absence.

There were appropriate procedures in place for the safeguarding of vulnerable people and these were being followed.

Is the service effective?

Good

The service was effective.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional and healthcare needs had been assessed and were met.

People were cared for by staff who were suitably trained, supervised and appraised.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a kind and respectful way. People said they were well cared for and had good and caring relationships with all the staff. Relatives and professionals felt that people using the service were well cared for.

Care plans contained people's likes and dislikes and identified

the activities they enjoyed, people who were important to them, their cultural and religious needs, and needs relating to their identity. People were supported by caring staff who respected their dignity, human rights and diverse needs.

Is the service responsive?

Good

The service was responsive.

Assessments were carried out before support began to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

People and relatives were sent questionnaires to ask their views in relation to the quality of the care provided.

A range of activities was provided which included regular outings. These were varied and took into account people's likes and dislikes, their backgrounds and any particular interest they had.

Is the service well-led?

Good

The service was well-led.

At the time of our inspection, the service employed a registered manager.

People, relatives and professionals we spoke with thought the home was well-led and that the staff and management team were approachable and worked well as a team.

The staff told us they felt supported by the registered manager and there was a culture of openness and transparency within the service.

There were regular staff meetings which encouraged openness and the sharing of information.

There were systems in place to assess and monitor the quality of the service.

Hendford Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 27 October 2016. The first day of our inspection was unannounced and we told the provider we would be returning two days later to complete our inspection.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert for this inspection had experience of 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 improvements they plan to make. We reviewed the information we held about the service including notifications of significant events, safeguarding alerts and the findings of previous inspections.

During the inspection, we spoke with seven people who used the service, two relatives, a visiting friend, nine staff members, including the provider, the registered manager, the secretary, the nurse advisor, two registered nurses, two care workers and a cook. We also spoke with a visiting activities coordinator.

We observed how people were being cared for and supported. Our observations included a Short Observational Framework Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. The expert-by-experience observed people being supported to have their lunch in their own bedrooms. We looked at the environment. We checked how medicines were managed including administration, storage, disposal, records and policies. We looked at the care records for five people. We looked at the staff recruitment records for four members of staff, staff training, support and supervision records and records of staff meetings, communication, rotas and allocations. We also looked at other records the provider used for managing the service, which included records of complaints, compliments, audits and other quality monitoring checks.

Following our visit, we spoke with a three healthcare professionals to obtain their feedback about the service.

Good

Is the service safe?

Our findings

Medicines policies and procedures were in place and senior staff demonstrated a good understanding of the procedures they followed when they supported people with their medicines. We checked the medicines administration records (MAR) charts for six people who lived at the service which had been completed over a month. They showed no gaps in signatures indicating that people had received their medicines as prescribed. However, the amount of tablets in three of the boxed medicines we checked did not match the amount of signatures on their corresponded MAR charts. The nurses in charge on the day of our inspection were unable to explain the reason for this. We informed the registered manager who told us that this would be addressed without delay. We saw on the second day of our inspection that they had addressed this with staff and were ensuring that systems were immediately being put in place, and audits were increased to daily.

We also noticed that one medicine's dosage had been increased by the GP half-way through the month, but staff had continued to record the administration of this medicine on the same MAR chart instead of starting a new record. However, we checked the amount of tablets given since the increase, and the amount remaining in the pack and found this to be correct, indicating that this medicine had been given correctly but the recording of this was confusing. The nurse in charge told us that they were taking this on board and would ensure that new MAR charts are completed when changes are made in future.

Senior staff carried out regular audits, however, after discussion about the shortfalls we identified, they informed us that they would increase these to include daily checks in order to identify errors and address them without delay.

Arrangements were in place for the management of people's medicines and all medicines were stored securely in a locked medicines trolley. Staff were trained in the administration of medicines and received yearly updates.

There were protocols used for the administration of medicines that were taken 'as required' (PRN). Whilst some people were able to request PRN medicines, the registered manager had put in place pain assessment tools to help them make a judgment where people may need medicines for pain relief and were unable to ask for these. This meant that people were protected from the risk of suffering unnecessary pain.

Controlled drugs (CD) were stored in a double locked CD cabinet. We saw that balance checks were completed regularly. Random checks of several CDs were carried out during this inspection. The quantity of CDs in stock matched the quantity recorded in the CD registers. This indicated that people were getting these medicines as prescribed.

We recommend that the provider seeks relevant guidance in relation to the management of medicines, such as the Royal Pharmaceutical Society guidance for care homes.

People and relatives we spoke with indicated that the service was safe. Some of their comments included, "I

feel it is as good as it could get for the kind of care that's needed and if I had concerns I feel I could voice them", "The carers seem to know what they are doing", "Staff are very nice and friendly. I'm content here" and "Yes, I feel she is safe here." People and relatives confirmed they would know who to contact if they had any concerns, and added they did not have any concerns about the service. Staff received training in safeguarding adults and training records confirmed this. The service had a safeguarding policy and procedure and a whistleblowing policy in place and staff had access to these. This indicated that people were protected from the risk of abuse.

The provider had procedures for safeguarding people. All staff had received training in this area, and demonstrated a good understanding of what constituted abuse and what they would do if they suspected someone was at risk of or being abused. One staff member told us, "We keep people safe, and save them from abuse and neglect and any avoidable harm. If I was worried, I would tell the manager straight away. I know they would act."

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. Risks identified were rated low, medium or high and included falling, skin integrity, choking and social isolation. Risk assessments showed a thorough understanding of each person's physical and mental health conditions and included guidance for staff to follow to enable them to care for people in a safe way. We saw that staff were instructed to "promote privacy and dignity" and "to observe and monitor skin condition every time when washed and changed" for a person who had been assessed at risk of skin deterioration because they were unable to maintain their own personal hygiene. We also saw a moving and handling assessment for a person which was thorough and included the person's medical condition, history of falls, what specialist equipment was needed and how much support the person required from staff.

There were protocols in place to respond to any medical emergencies or significant changes in a person's wellbeing. Emergency contact numbers were accessible.

Incidents and accidents were recorded and analysed by the registered manager and included an action plan to address any issues or trends identified. We saw evidence that incidents and accidents were responded to appropriately. This included an examination by the GP and close staff observations for a person who had been found to have an unexplained bruise.

The provider had a health and safety policy in place, and this was made accessible to staff and people living at the service. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and workplace safety. We saw evidence that all areas were regularly checked and any requirements were actioned appropriately. We saw that weekly safety checks were undertaken by senior staff. These included checks of all mobility aids, call bells, fire doors and kitchen appliances. We saw that any identified issues were addressed without delay. We saw that all Control of Substances Hazardous to Health (COSHH) products were stored safely on the day of our inspection. All upstairs windows were fitted with window restrictors to prevent the risk of people falling from heights and records indicated that these were regularly checked. The home was clean and well maintained. We saw cleaning schedules in place for different areas such as the kitchen and the laundry room.

The service had taken steps to protect people in the event of a fire, and we saw that a general fire risk assessment was in place and this was reviewed regularly. We saw evidence that checks of all fire safety equipment were carried out regularly. These included the fire alarm system, door guards and fire

extinguishers. The service carried out regular fire drills and fire alarm tests and staff were aware of the fire procedure. People's records contained personal emergency evacuation plans (PEEPS). These included appropriate action to be taken in the event of a fire according to people's abilities and needs.

The staffing records we viewed confirmed there were always enough staff on duty at any one time to provide care and support to people. The registered manager told us they occasionally needed to use agency staff but had a good relationship with a local agency who tried to supply regular staff to ensure continuity. In addition we were told that the service employed a pool of bank staff which were available to cover staff absence at short notice. Staff we spoke with told us they worked as a team and the registered manager was always available to lend a hand.

Recruitment practices ensured staff were suitable to support people. This included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working at the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) check were completed.

The home was undergoing significant renovation and the first floor was not in use at the time of our inspection. The provider had put in place risk assessments with regards to hazards and noise and had sent the relevant notification to the Care Quality Commission (CQC). They had organised the home to minimise disruption to people who used the service. For example, the builders accessed the first floor via an external fire escape, and the lift was placed out of use to ensure that people did not go upstairs by mistake.

Good

Is the service effective?

Our findings

Decisions about care had been made by the person or in their best interests by people who knew them well. People told us they had been consulted about their care and had agreed to this.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider understood the principles of the MCA and had followed its requirements. The registered manager had identified people for which restrictions had to be put in place and had taken appropriate action to make sure these were in people's best interest and were authorised by the local authority as the Supervisory Body. This included an authorisation for a person for whom bedrails were being used. All staff employed at the service had received training in MCA and DoLS and demonstrated a fairly good understanding of this.

Some of the care records we checked contained 'Do Not Attempt Resuscitation' (DNAR) forms. These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if they stopped breathing. These were authorised by the GP and people or their representatives had been involved in this decision. The registered manager told us that many people living at the service lacked capacity. This meant that people were being appropriately supported when decisions about their care were made.

During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us and we saw evidence that they received regular supervision meetings from their line manager. The registered manager told us that this provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and their line manager to reflect on their performance and to identify any training needs or career aspirations.

People were supported by staff who had appropriate skills and experience. Staff told us they had received an induction when they started to work for the service. This included training and working alongside other staff members. Staff told us they were able to access the training they needed to care for people using the service. Their comments included, "I got a really good induction when I started", "My induction left no stone unturned", "The training has made us understand people better" and "We get a lot of frequent training, like

dignity and respect training. It has taught me to be a good carer, treat people with respect and understand the people we care for." Staff also received training specific to the needs of the people who used the service, such as MCA, palliative care and dementia awareness. The service had integrated the Care Certificate into their staff induction process. The Care Certificate is a nationally recognised set of standards that give staff an introduction to their roles and responsibilities within a care setting. Training records confirmed that staff training was delivered regularly and refreshed annually.

Care files contained a section dedicated to eating and drinking which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. Malnutrition Universal Screening Tool (MUST) scores were in place and used where there were concerns about people's nutrition. We saw that people's weight was monitored and recorded monthly. We checked the records for five people using the service and saw that people's weight was stable. This indicated that people were receiving adequate amounts of food to keep them healthy.

People told us the food was good at the home. One person said, "The food is very good." We observed people during lunch time. People chose where they wanted to eat. We saw that where two people had chosen to eat in their bedroom, their choice was respected. Some people chose to sit in the dining room, and some people chose to eat in the lounge. People had a choice of food at each meal. There were pictorial menus displayed in the dining room. This meant that people who may have had difficulties identifying what was written on the menus could still choose their meals. We saw that people who needed assistance were assisted in a calm and kind manner. One person kept getting up to go for a walk. The member of staff embraced this and went for a walk with them, calmly guiding them back to their seat where they encouraged them to continue with their meal. There were nice interactions between staff and people, and people were able to enjoy their meals in an unrushed manner.

We spoke with the cook who was aware of individual people's dietary needs. They told us that the staff were very good at keeping them informed of people's changing needs. They said, "I ask people what they want for their meals. They have two choices" and "The staff inform me of their dietary needs. One has a fortified diet so I make sure I adapt their meals." They told us that if people wanted something different, they would go and cook it for them. We viewed all menus for the week and saw that they changed daily and were rotated across the month. People had adequate amounts to drink. Tea and coffee was served mid-morning and mid-afternoon and jugs of juice, water and fruit were available in the lounge throughout the day. People were also served hot or cold drinks on request. This meant that the service recognised the importance of food, nutrition, hydration and a healthy diet for people's wellbeing generally, and as part of their daily life.

The service was responsive to people's health needs. A healthcare professional told us that the service was very good at calling them whenever a person required their services. They said, "It's a very good service. I have been visiting for many years and have never had a concern. They respond to people's needs and call me when someone needs treatment. I can only praise them." Records showed that people's health needs were monitored and any concerns were recorded and followed up. Staff were able to tell us what they would do if they thought somebody was unwell. One staff member said, "I observe people, I know them well. Whenever I think someone is unwell, I report it to the nurse in charge. They always call the doctor" and another told us, "I am observant. I know when someone is unwell, such as a high temperature." Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This showed that the service was meeting people's health needs effectively.

Good

Is the service caring?

Our findings

People and relatives were complimentary about the care and support they received. Some of their comments included, "My [family member] is very comfortable here, as comfortable as she can be", "It's very nice here. Calm, warm and very friendly", "There are regular outings in the summer", "I am happy that the staff tried their best to get her to go into the lounge, but it's not for her, she prefers to be in her room", "They brought her fruit to encourage her to eat, she doesn't eat much at meal times"

The staff and the registered manager spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. Their comments included, "The residents are like our family" and "I treat people with respect. We understand them, how to speak to them nicely. We sing to them. Some just want to see you smile." Staff we spoke with knew people well and were able to tell us their likes and dislikes.

All staff displayed a gentle and patient approach to caring throughout the day when caring for people in the home. We observed that staff interacted with people kindly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. People and relatives told us that staff were respectful, valued them and met their physical and emotional needs. Healthcare professionals we spoke with echoed this.

Staff were clearly aware of people's needs, routines and behaviour and were able to explain how they supported different people. We saw evidence of kind and empathetic care.

We observed interactions between people and staff throughout the day. There was a relaxed and unrushed atmosphere and staff appeared to have a very good rapport with all the people who used the service. We observed several members of staff taking it in turns to walk with a person whenever they were restless and chose to get up. We saw that this activity was met with patience and kindness by all the staff.

During lunch, we observed a member of staff supporting a person to eat their meal. This was done in a caring and kind manner, while talking to them calmly and gently wiping the person's chin to protect their dignity. We also observed a care worker supporting a person who was bed bound to eat their meal. They took their time and paused between mouthfuls to ensure that they were given enough time. One staff member told us, "For people who can't tell you, we observe their body language to inform us. For example, if someone doesn't open their mouth, we try other food."

The service received regular compliments from relatives. We viewed a sample of these. Comments included, "[Family member] was treated with such respect and dignity and we thank you so much for that", "A big heartfelt thank you for the wonderful care and comfort you provided for my mother" and "You are a fantastic team. Kind, compassionate and very hardworking, with a sense of humour she greatly enjoyed."

The provider was developing the environment to suit the needs of people living with the experience of dementia. This included some sensory equipment in the lounge, and the use of colours to help people

differentiate between different areas of the home. They also used colourful cutlery and crockery, which appeared to be well received by people. One person commented on this and said, "Oh, the food looks clean."
The provider told us they ensured that all staff understood and worked to the "6 Cs principles". These included Care, Compassion, Competence, Communication, Courage and Commitment.

Good

Is the service responsive?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that where people were able, they had been involved in discussions about their care, support and any risks that were involved in managing their needs. The registered manager told us that some people were referred from the local authority and they had obtained relevant information from them. This included background information for most people which helped staff understand each person and their individual needs. One healthcare professional told us that the staff team provided a service according to people's individual needs.

The deputy manager met with the GP every Monday. They told us that they worked together to review people's needs, and where possible, reduced the use of medicines. They also identified the need to work with people who displayed behaviours that challenged the service in a holistic way. For example, where a person was admitted with the label of 'challenging behaviour', they explained that with patience, and calm conversations, they began to understand what was creating anxiety for the person using the service, and helped them take control of this with the help of their relative. They told us, "Now [person] trusts us and we get on well. It makes me happy."

The care plans we viewed were comprehensive and contained detailed information to know what the care needs were for each person and how to meet them. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences, areas of risk and what was needed to keep the person safe. Care plans included people's assessed needs, interventions and outcomes. These were written in the person's perspective and included sections such as, 'What I find difficult', 'What I can still do', 'What upsets me', 'My personality' and 'My physical health'. Staff we spoke with were able to describe people's individual needs and how they met these. Some relatives we spoke with confirmed that regular reviews were organised but added they had not participated in these as they were happy with the care their family members were receiving.

Staff told us they encouraged and supported people to undertake activities of interest to them, and included regular outings. One relative told us, "Someone will come and sit with [family member] and do the crosswords with her, which she likes" and a person's friend said, "Outings happen regularly and I have seen them putting people on the bus. My friend has been out on bus trips but doesn't always want to go." They also added, "One lady comes around every week to spend time with [friend]. And a lady brings her guitar and talks to my friend." We noticed that after lunch, some of the chairs in the lounge were re-arranged so people could sit in a small group and watch the news together, whilst a care worker sat with another person to quietly read a book with them.

Care plans included a person-specific social profile section. This gave a history of the person's past. The registered manager told us that this enabled staff to develop a therapeutic relationship by offering meaningful activities based on people's interests or their past occupations. This included supplying people with newspapers of their choice, encouraging people to watch sport and other programmes of interest with staff, and involving people with news and political events, such as the recent referendum and voting.

The service employed an activities coordinator, who was a former member of the nursing team. They worked on a part time basis to support the social needs of people, based on their social profiles. They worked with individual people to develop a person-centred programme of activities. These included playing games and puzzles, inviting drama groups and entertainers, and the use of dolls for some of people living with advanced dementia, who appeared to gain comfort from these. The activities coordinator kept records of all activities undertaken with people. We viewed a range of these records and saw that activities were varied and took into account people's interests and choices on the day. For example, the activity coordinator had brought a 1959 newspaper to a person who had been involved in this particular publication in their younger days. This had jogged their memory and prompted them to go and retrieve some paperwork about particular events of their younger days from their room. This showed that activities were meaningful and delivered with the person in mind.

A variety of materials were purchased for people with particular interests. These included books about railway and steam engines, football and particular musical artists. There were handbags, mirrors and scarves available, and we saw a person using the mirror on several occasions to look at themselves. Some people chose to wear colourful beads, and enjoyed an aromatherapy session, hand massage and having their nails painted by staff. There was a piano available in the lounge. We were told that this was used regularly by staff and visitors. The registered manager told us they encouraged children and families to visit anytime they liked and bring their pets. We were told that relatives had developed positive relationships with other people who used the service and enjoyed interacting with them.

The home had good links with the local community. This included frequent visits from local school children who were studying for a project in dementia. The registered manager told us that the children were keen to interact with people who used the service and often 'queued up' to play dominoes with one person who has a particular interest in this. They added that this person has remained unbeaten by them. We were also told that one person using the service was a head teacher and enjoyed chatting about their experiences with the visiting school children.

Pastoral helpers and a Minister from the local church were frequent visitors, and involved people in various activities throughout the year. These included singing hymns, listening to readings or poems, and celebrating events such as Easter and Christmas. We saw photographs of events celebrated in the home, which included people's birthdays and parties where friends and relatives were also invited.

The service also employed the services of an external healthcare professional once a week to carry out one to one activities with people. They told us they organised small meaningful activities such as bringing a musical instrument, or just chatting. They said, "Once, we just talked about the leaves outside looking like butterflies in the wind. Her face just lit up."

The service had a complaints procedure in place. This was available to people who used the service. Where complaints had been received, we saw that they had been investigated and the complainants responded to in accordance with the complaints procedure. This included a complaint where the dignity of a person who used the service had been compromised. We saw evidence that the manager had initiated a staff meeting to discuss dignity and respect and had sourced a suitable training programme for all staff. One staff member told us, "The training helped me understand people better, be a better carer and respect people at all times." This indicated that the service was responsive to complaints and ensured that improvements were made as a result of these.

Most people who used the service were living with the experience of dementia and were unable to complete quality questionnaires. However, regular feedback was obtained from their relatives. Questionnaires

included questions relating to how people felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and social needs. We viewed a range of questionnaires and saw that the results showed an overall high level of satisfaction. There was evidence from the comments we saw, that staff met people's individual needs, including their cultural needs. One comment said, "Although my [relative] does not speak English, staff have always been able to communicate and cater for her needs using gesture, picture cards etc. and they are always patient with her." We were also told that a care worker who spoke the same language as a person who used the service frequently spent time with that person to chat in their language.

Good

Is the service well-led?

Our findings

The management team consisted of a provider and a registered manager. They worked closely together to provide care and support to people who used the service and were supported by a deputy manager who was a registered nurse, a team of qualified nurses and care workers. There was a secretary employed at the service who provided administrative support to the registered manager. The registered manager had been in post for 10 years, and held a National Vocational Qualification (NVQ) Level 4 in Leadership and Management.

People were cared for in a well-managed service. People and their relatives were complimentary about the registered manager and the provider and told us they were approachable. One person confirmed they knew who the manager was and that they would be "Ok to raise any issues to her" if they had any. One relative told us, "I feel like it is well led and well run" and "I absolutely feel I could complain if I wanted to, feels like it's an open door."

Staff commented that they felt supported by senior staff and the registered manager. They told us the registered manager was "hands on" and "always available". Their comments included, "The manager is supportive. If I need any help, she is always ready. We work as a team", "The manager always makes sure we are ok and calls at weekends. She is good", "It's a well led service. The manager listens, always, and values my opinion", "If I say, I think a person needs a recliner chair, the manager agrees and we get one. Nobody has pressure sores here because we have the right equipment", "The manager is very nice and supportive" and "The manager is good. She is happy when things are done right. When it is not, she makes sure it gets better. She is all over the place helping, and on our neck. It's a good thing."

People could be confident that there were systems to monitor the quality of the service and make improvements. The registered manager had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks, health and safety checks and care records. Audits were evaluated and when necessary, actions plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were thorough and regular. This meant that the registered manager would be able to address any areas of concern promptly.

The registered manager told us they held team meetings monthly and we saw records of these. Items discussed included any issue about people who used the service, person centred care and dignity, environment and health and safety issues, policies and procedures, training needs and complaints. Staff we spoke with confirmed that meetings were regular. Outcomes of audits, complaints, incidents and accidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. Memos were regularly issued to staff to inform them of anything relevant. These included a fire rescue service audit taking place and notices of upcoming training.

The provider told us they met with the registered manager weekly to discuss any current issues or concerns and regular meetings took place to discuss future plans for the service. These had included discussions

about the current refurbishment which was taking place at the time of our inspection.

The registered manager ensured they attended all training important to their post. They also attended the Nursing Home Association roadshows and conferences, the Dementia Matters conferences, provider forums and other meetings organised by the local authority. They told us they found these useful and informative. They also maintained their knowledge of social care by consulting the Care Quality Commission (CQC) website.

The registered manager had sought 'Responsive Behaviour and Step Inside' training from the Alzheimer's Society for all the staff working at the service. This training also included personal counselling sessions with all the nursing staff to help them understand and discuss individual needs of people living with the experience of dementia. The nurse in charge on the day of our inspection told us that these sessions had helped shift the culture of the home from a nursing model to a model of empathy, care and support. Another member of staff told us, "I feel more confident to work with dementia because of all the training, and the one to one sessions we got by the person from the Alzheimer's Society." The staff we spoke with told us they were all 'Dementia Friends'. The registered manager told us that they had made positive changes following the training. This included introducing colourful T shirts for care workers and ancillary staff instead of uniforms.

The service worked closely with healthcare and social care professionals who provided support and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff. One healthcare professional told us the service was "very good and well managed" and another said, "The management is very responsive and takes on our recommendations."

The provider was in the process of developing a 'Friends of Hendford' forum. They were hopeful that this would encourage communication with friends and relatives, and help develop the service for the benefit of people who used the service.