Windmill Care Limited

Osbourne Court

Inspection report

North Road
Stoke Gifford
Bristol
BS34 8PE

Tel: 01179448700
Website: www.windmillcare.com

Date of inspection visit:
22 March 2016
23 March 2016

Date of publication:
15 April 2016

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

The inspection took place on 22 and 23 March 2016. Osbourne Court provides accommodation and personal care and support for up to 58 older people. Many of the people accommodated were living with dementia. This was an unannounced inspection, which meant the staff and provider did not know we would be visiting. The previous inspection was completed in May 2014 there were no breaches of regulation at that time.

The registered manager had recently resigned. The deputy had been appointed to manage the service. They confirmed they would be submitting an application but had only been in their new role for seven days. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were receiving care that was responsive and effective and tailored to their needs. Care plans were in place that clearly described how each person would like to be supported. People had been consulted about their care and support. The care plans provided staff with information to support the person effectively. Other health and social professionals were involved in the care of the people. The staff and the GP were working closing in promoting healthy eating and reducing falls. Safe systems were in place to ensure that people received their medicines as prescribed. However, not all medicines given had been signed for. The manager promptly devised an action plan once checking people's medicines records.

People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow the procedures. Systems were in place to ensure people were safe including risk management. We found that not all staff had gone through a safe recruitment process. By day two of the inspection the new manager had organised a review of all recruitment files. This included organising the information more logically with an index showing what records were in place.

Staff were caring and supportive and demonstrated a good understanding of their roles in supporting people living with dementia. Staff received training and support that was relevant to their roles. Systems were in place to ensure open communication including team meetings and one to one meetings with their manager.

People's rights were upheld, consent was always sought before any support was given. Staff were aware of the legislation that ensured people were protected in respect of decision making and any restrictions and how this impacted on their day to day roles.

People's views were sought through care reviews, meetings and acted upon. Systems were in place to ensure that complaints were responded to and, learnt from to improve the service provided.

The service was committed to involve relatives in aspects of running the service. Friends and family meetings were organised. The provider and the manager had organised external speakers including the local GP who provided an insight into the dementia pathway and about healthy eating and how this was being promoted within the home. Social gatherings were organised so family and friends could visit the services. Relatives told us they were made to feel welcome and there were no restrictions on visiting times.

People were provided with a safe, effective, caring and responsive service that was well led. The organisation's values and philosophy were clearly explained to staff. The registered provider was aware of the importance of reviewing the quality of the service and was aware of the improvements that were needed to enhance the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Improvements were required to ensure people were safe. This was because not all medicines that had been given had been signed for. Not all checks had been completed in respect of the recruitment of new staff.

People were safe from harm because staff reported any concerns and were aware of their responsibilities to keep people safe.

There were sufficient staff to keep people safe.

People were kept safe as risks had been identified and were well managed.

Is the service effective?

Good

The service was effective.

People could be confident that their healthcare needs were monitored involving other health and social care professionals. Good relationships had been built with the local surgery.

People were supported by staff who knew them well and had received the appropriate training. People's freedom and rights were respected by staff who acted within the requirements of the law.

Staff had a good understanding of people's care and support needs. People were supported by staff that had the necessary skills and knowledge.
People's nutritional needs were met and this was kept under review to ensure people were having enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were caring, polite and friendly in their approach to people living in the home and their families.

Staff knew people well and were able to tell us how people liked to receive their care.

People and their relatives were supported to express their views and be involved in making decisions about the care.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs. People were involved in developing and reviewing these plans.

People were supported to take part in regular activities in the home and the community.

There was a complaints policy and procedure in place. People and their relatives knew how to make a complaint if needed and complaints had been responded to.

Is the service well-led?

Good

The service was well led.

Staff felt supported and worked well as a team. The manager and provider worked alongside the staff team to deliver and monitor the quality of the care to people. People, their relatives and staff spoke positively about the leadership of the home and felt listened too.

Systems were in place to review and improve the quality of the service. This included seeking the views of people who used the service, their relatives and staff on the running of the service and day to day care. They were committed to providing a home for people living with dementia where they were recognised as individuals.

Osbourne Court

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 was an unannounced inspection which was completed on 22 and 23 March 2016. The inspection was completed by two inspectors. The previous inspection was completed in May 2014 there were no breaches of regulation at that time.

Before the inspection, we asked the provider to complete 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 planned to make.

We reviewed the information included in the PIR along with information we held about the home. This included notifications, which is information about important events which the service is required to send us by law.

We contacted two health and social care professionals to obtain their views on the service and how it was being managed. You can see what they said about the service in the main body of the report.

During the inspection we conducted a Short Observational Framework for Inspection (SOFI 2) assessments. SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves.

We looked at eight people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included staff rotas, training records and audits that had been completed.

We spoke with the manager, six care staff, six people who used the service, five relatives and the operations manager.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Relatives confirmed they felt their loved ones were safe in the care of the staff at Osbourne Court. One relative told us they had visited six other care homes and were really pleased their mother had been accepted to live at Osbourne Court. They told us, "It was the best outcome for mum as she was no longer safe at her previous care home". They told us, "this has given us peace of mind, as mum is well cared for and is no longer in any danger".

Other comments included, "I know my mum is safe, all the staff are kind and considerate and take a real interest in her". Another relative told us, "It was a difficult decision for us as a family when we knew we could no longer cope at home, my wife was not safe at home, I can sleep well at night knowing she is not only safe but well cared for". Another relative told us, "Mum is happy here, she is safe and always wants to return when we have been out for the day". They told us there was a situation at night where they had been contacted by the care staff. They told us they were concerned but this was alleviated as they were able to stay throughout the night which assisted in reducing their anxiety and provide continual reassurance to their relative. They told us the safeguards the staff had put in place provided assurances their relative was safe.

The provider had not always followed safe recruitment practices. We looked at the recruitment files for five members of staff and found not all the appropriate pre-employment checks had been completed. All members of staff had received a Disclosure and Barring (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. However, for two staff there was only one reference. The new manager was aware that two references must be obtained prior to staff working. In response, on the second day of our inspection the administrator had started to audit all recruitment information and was following up any missing information. A checklist had been introduced which recorded when information had been received. Assurances were given that staff would not commence in post until two references had been obtained.

Sufficient staff were supporting people. This was confirmed in the staff rotas. Staff told us any shortfalls were covered by the team and the manager. The manager told us it was important that people were supported by familiar staff and agency staff were rarely used. The manager told us they were recruiting to two care staff vacancies and the deputy post. The manager told us there was very little staff turnover and there was a stable team. This was confirmed when talking with staff and relatives.

A member of staff told us they felt at times on the first floor it could be rushed. They were concerned because a person's care needs had increased and they felt this was impacting on the other people as they could not spend as much time with them. The manager told us staffing was planned using a dependency tool and confirmed additional staff could be employed where people's needs had changed or if a person was unsettled. They told us they kept this under review and staff from downstairs could be called upon to assist upstairs.

People told us they had keys to their bedrooms and we observed people using these. Where people lacked the capacity or the dexterity to use a key. Staff had consulted with the person on whether they wanted their

bedroom door locked or unlocked. Relatives had been involved in this decision. Staff were observed unlocking bedroom doors for those people who had choose to lock their bedroom door but were unable to use a key. This enabled people to keep their possessions safe and afforded them privacy. One person told us they liked to lock their bedroom door at night and staff had recently showed them how to do this to keep them safe. Occasionally one person became confused about where there bedroom was, they had clear signage on their bedroom door. This assisted them with finding their bedroom. This kept them and others safe as it had improved orientation for the person.

Medicines policies and procedures were in place. Not all medicines had been signed for when given to people. There were gaps in the medicine record for some people. It was evident the medicine had been given as it was no longer in the blister pack. The manager had completed an audit by day two of the inspection and was following this up with the staff involved. They confirmed that where staff had not followed the correct procedure for signing, their competence would be checked using a new medicine competency check list. The manager told us previously competence was checked by completing an observation of the staff members practice. This was recorded in their supervision record but there was no formal tool for detailing what was checked.

We had received information prior to this inspection that not all staff had been trained in the safe handling of medicines. We checked training records for staff who were responsible for administering medicines. One member staff did not have a record of receiving this training. The manager checked with the staff member who said they had evidence they had completed distance learning course and would make sure this was brought in for them to view. The manager told us all staff had completed distance learning or training from the local pharmacist on the safe administration of medicines. The manager told us the new medicine competency checklist would be rolled out to all staff who give medicines to people.

Appropriate action had been taken when staff had noted a medicine error including contacting the person's GP and South Gloucestershire Council who commissioned the service. Appropriate action had been taken to reduce further occurrence and ensure people were safe in relation to the administration of medicines.

Some people were prescribed medicines to be given 'when required'. We heard staff asking people if they needed these medicines. We saw protocol's in place for these medicines which gave staff additional information to help them give medicines in a safe and consistent way. A relative told us, "Mum is often asked if she is in any pain, when we visit especially if staff were assisting with any personal care". They also told us the staff were very good at recognising if their mum was in pain by facial expressions and they were confident this was continually monitored.

People received a safe service because risks to their health and safety were being well managed. Care records included risk assessments about keeping people safe. These covered all aspects of daily living. Risk assessments included the action staff must take to keep people safe. These had been kept under review and other professionals such as occupational therapists and physiotherapists had been involved in advising on safe practices and equipment required.

Where people were at risk of developing a pressure wound and required support with changing position, records were maintained of the support provided. Staff were aware of the risk assessments to keep people safe in this area. However, we saw there were some gaps for one person. Staff told us they had not had time to complete the records on the morning of the inspection but all care had been carried out in respect of this area. The manager told us there were two places where staff were expected to record this information and felt that staff may have got a bit confused. We checked again on the second day for this person and another who was being supported in bed. Staff had clearly recorded all positional changes throughout the day and

night.

The manager told us that there were movement sensors in 12 of the 58 bedrooms that could be activated where a person was at risk of falls. The manager told us the sensors were only used when a person was at risk. There was a policy in place guiding staff when these should be used and that the person must be involved in the decision process. Staff told us regular checks were completed on people who choose to remain in their bedroom during the day and throughout the night. There was clear guidance for staff should a person have frequent falls. This included reviewing the person's medicines and checking the environment for any risks. The manager told us about how this had been effective in keeping people safe and there had been a reduction in falls.

People were kept safe by staff who understood what abuse meant and what to look out for. Staff confirmed they were trained and knew the signs to look out for in respect of an allegation of abuse. Safeguarding procedures were available for staff to follow with contact information for the local authority safeguarding team. Staff told us they had confidence in the manager to respond to any concerns appropriately. The service had reported to the local safeguarding team any allegations of abuse and taken action to safeguard people. We were also being notified of any allegations of abuse. In the last 12 months the number of incidents had reduced. The manager and the operations manager told us this was due to changing the lay out of the four lounges to make smaller sitting areas rather than people being sat round in a circle. The moving of the chairs had meant that people were not congregated in one small area. One staff member said that they understood the term safeguarding and said "If I felt someone was being neglected then I would call for assistance straight away and speak to my manager".

Environmental risk assessments had been completed, so any hazards were identified and the risk to people removed or reduced. Staff showed they had a good awareness of risks and knew what action to take to ensure people's safety. There were arrangements in place to deal with foreseeable emergencies.

Other checks were completed on the environment including moving and handling equipment, checking sensory alarms (which alerted staff if a person had fallen) were working correctly and routine checks on the lift, electrical and gas appliances. Certificates and records were maintained of these checks.

The home had been assessed in October 2015 by the local Council in respect of food hygiene practices and had been awarded a five star. This is the highest rating a service could achieve. This was clearly displayed in the hallway of the home.

People and their relatives told us their bedrooms were cleaned daily and they always found the home to be clean and free from odour. Housekeeping staff explained their roles and confirmed they had sufficient equipment. We observed the housekeeping staff engaged in their duties and found the home was clean and free from odour.

Staff told us they had attended training in infection control. Staff were wearing protective clothing such as aprons and gloves when completing personal care or handling food. A member of staff was asked by a person for assistance, the member of staff politely explained they would be one minute as they needed to change their apron before assisting them. The staff returned promptly and it was evident they had changed their apron and had a fresh pair of gloves on before they assisted the person. The service had an infection control lead who told us they had recently introduced hand washing audits as part of their role. This meant people could be confident the risks in respect of cross infection was minimised affording their safety in this area.

Good

Is the service effective?

Our findings

People and their relatives told us they liked the staff that supported them and felt their health care needs were being met. A relative told us, "It's is lovely here, you cannot fault the staff, it is home from home". Relatives confirmed they were kept informed about any changes and were involved in regular care reviews. One relative told us they were meeting with some health professionals and the manager to discuss some changes that had recently taken place with the care of their parent.

People had access to other health and social care professionals. Staff told us the GP visited every Friday. The GP provided feedback that the staff were well prepared for their visits with clear information about each person that required their attention. This was faxed to the GP before the planned visit. Another health care professional told us the staff were very good at reviewing any physical causes for psychiatric symptoms such as urinary and chest infections. They told us, "They are keen to provide input into our assessments and have very good knowledge of their residents".

District nurses visited the home to provide support with any nursing care needs such as wound care management or medicines for diabetes. The manager told us there was one person who had a pressure wound but this had now healed. Where people were at risk of developing pressure wounds a care plan was in place describing how the person should be supported. This included any specialist equipment such as pressure cushions or an air mattress that should be in place to minimise any risks. There were also body maps to record any wounds and information about how staff should support the person with positional changes. District nurses maintained their own records of the treatment and healing process.

Other health and social care professionals were involved in supporting people. They included dieticians, physiotherapists, occupational and speech and language therapists and the mental health team. Their advice had been included in the plan of care and acted upon. Staff and the manager told us people were supported to see a dentist, optician and a chiropodist. Where people had been seen by a visiting health care professional staff had recorded any treatment or follow up required.

People were asked what meals they preferred and this was incorporated into the menu planning. Information was available to the cook on any specialist diets and if anyone required fortified meals because of weight loss. Care staff confirmed that they were aware of this information and were knowledgeable about the dietary needs of people. There was a menu board outside the kitchen so that people could see what was available. In addition care staff asked people what they would like each day for lunch and tea. People told us they enjoyed the food. The staff were working closely with the GP on monitoring weight gain and loss and the promotion of healthy eating. Where people were at risk, staff were recording what meals people had eaten and any refusals. The service was promoting 'food first' and working closely with other professionals and families. Families had been invited to a meeting to discuss what this meant for their relative in keeping them healthy.

People told us they enjoyed the food. A relative told us they were impressed with the food provided and they were often invited to stay for lunch and offered refreshments. They told us that for special occasions

refreshments and cake was provided such as birthdays.

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 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.

The manager told us they had submitted applications in respect of Deprivation of Liberty Safeguards (DoLS) for many of the people living at Osbourne Court but was waiting for the local authority to visit and authorise these. The manager had a system to monitor and keep under review each authorisation ensuring where this needed to be renewed this was completed in a timely manner. This information was shared with the visiting GP. Relatives had been involved and kept informed about the outcome.

Each person had been assessed to determine whether an application for DoLS should be made. The manager had notified us about the outcome of the authorisations. Information about these safeguards were clearly described in the person's care plan and the reasons for the authorisation. This was because many of the people were unable to make a decision on whether to live at Osbourne Court due to their dementia and required constant supervision to keep them safe.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. Whilst staff acknowledged how important it was to involve people in making decisions some decisions may be too complex for a person living with dementia. Where decisions were more complex meetings were held so that decisions could be made which were in people's best interests involving other health and social care professionals and relatives where relevant. Records were maintained of these discussions, who was involved and the outcome. Best interest meetings had been held in respect of a person's ability to keep their bedroom locked during the day. Some relatives had asked for this to happen as some people will unknowly wander into other people's bedrooms. Other decisions included end of end of life care and health care treatment. All relatives we spoke with confirmed they had been asked about how their relative would like to be cared for and were kept informed about any changes in care. One relative told us, "oh yes, they are very good and do ask us for our opinions".

Staff had received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty safeguards (DoLS) and there was a MCA and DOLS assessment and referral policy.

The manager was able to demonstrate new staff were supported through a formal induction. Staff completed the Care Certificate that was introduced in April 2015. There is an expectation that all new staff working in the care industry should complete this induction during their first three months. New staff members were subject to a probationary period at the end of which their competence and suitability was assessed. The manager said with the appointment of a deputy this would assist in making improvements in this area. They told us they were not quite completing this within the three month timescale. New staff worked alongside more experienced staff and were not counted in the staff numbers. This enabled them to

gain confidence and get to know the people they were supporting.

Individual staff training records and an overview of staff training was maintained. The manager was able to demonstrate staff had completed health and safety, fire, first aid, moving and handling, safeguarding, MCA and DoLS training. A training plan was in place to ensure staff received regular training updates. Staff told us the training they had received, had equipped them for their roles. A member of staff said, "You only need to ask for some training and the manager and the provider are supportive, you cannot fault the training". Some of the staff had completed a Health and Social Care Diploma in supporting people with dementia. Staff were knowledgeable about the effects that dementia could have on the person and their family. Another member of staff told us training was always taking place and this was advertised in the staff room on the notice board.

Osbourne Court is a purpose built property to provide accommodation and personal care to 58 older people. The accommodation is arranged over two floors. There is a lift to enable people to access the first floor. The home was decorated to a good standard and comfortably furnished. Pictures and photographs were displayed throughout the home. Comfortably seating was available along the corridors for people to sit and rest or watch the coming and goings in the home. There was outside space which people could access independently.

There was a key code on the main entrance which restricted people from leaving the building independently. People were reliant on staff or their visitors to support them in this area. People could move freely around the whole home visiting people on either floor. We saw people from upstairs visiting people downstairs and taking part in some activities.

All bedrooms were ensuite and single occupancy. People were supported to personalise their bedrooms including bringing in their own furniture. People had been supported to put photographs or an aid to their memory in a box on their bedroom door to assist with orientation.

The first floor had a variety of areas that people living with dementia could busy themselves including work benches with switches, wheels and cogs that could be turned. In addition there was an area with items of interest for keen gardeners, a coat stand containing hats and coats and other dress up items which people could use.

Since the last inspection the provider had changed the layout of the dining areas and lounges on both floors. This was so people could sit and eat in smaller groups. Each area had been arranged in small cosy seating areas rather than everyone seating in a big circle. The provider and the manager had spoken positively on how this had impacted on people's relationships with each other. Staff told us all the lounges were now used rather than everyone congregating in one area on each floor. They told us there had been a notable reduction in people experiencing aggression from another person.

Good

Is the service caring?

Our findings

One relative fedback to us prior to the inspection, "My mother-in-law has been at Osbourne Court for several months now. When she first arrived she was extremely disorientated and upset. This made her angry, uncooperative and difficult to work with. I have been so impressed with the patient, professional and very kindly attitude of the care staff who have gradually won her trust and helped her to settle in her new home". Another relative told us, "Friendly homely atmosphere, very caring and attentive. Managers (very 'hands-on') and carers work together as a team. Carers always show my mother respect, and are very supportive of family members in distress. We should love my mother to be able to stay here for the rest of her days". Another relative told us, "They are all very caring, even the younger staff, not only to mum, but towards us as a family". One person told us, "it's lovely here, I have made new friends and the staff are really kind". People confirmed the staff were polite to them. One person told us, "it is lovely here, I keep myself busy, there is no nonsense and I am very happy".

People told us they liked the staff that supported them. Throughout the day we observed all staff, from housekeeping staff, to the cook, to the care staff spending time with people engaged in conversations or taking part in activities. People were offered a daily newspaper and a small shop was organised selling sweets. No payment was exchanged for the sweets it was evident people enjoyed the activity and were taking an interest in the old fashioned scales that were used to weigh the sweets. There was a sense of fun which the staff were promoting for people.

Staff knew they needed to spend time with people to be caring and have concern for their wellbeing. Staff told us they was sufficient staff to enable them to spend time on a one to one basis with people. Staff told us personal care was not rushed enabling staff to spend quality time with people. However, one member of staff was concerned that they felt torn sometimes when some people required more support which meant they may not spend as much time with others who may be quieter.

We observed staff knocking on doors and waiting for people to confirm they could enter. Staff closed bedroom doors when supporting people with personal care. Staff were heard asking permission to assist people, offering reassurance and explaining to them what they were doing. Relatives confirmed that when personal care was delivered this was completed in a way that maintained their relative's privacy and dignity. This demonstrated staff respected the person's rights to privacy and their involvement.

We observed the lunch time meal. Staff were engaged with people explaining what they were eating and providing encouragement in a sensitive manner. One person was upset because they had to wear an apron. A member of staff attended to this person by telling them "everyone else is wearing an apron". This was not the case and the person continued to try and take the apron off. Three times the member of staff went over to tell the person to wear the apron. This action showed little understanding of the person's discomfort and was not treating them in a person centred way. In addition this member of staff stood and assisted a number of people during the course of the lunch time. This was fed back to the manager. Other members of staff sat down and gently encouraged people. This showed a more person centred approach.

People told us they could get up and go to bed when they wanted. Care records included information about people's personal routines including their preferences in relation to getting up, how they liked to spend their day and when they wanted to go to bed. Daily records confirmed that where people could not communicate their choice, this was done in accordance with their care plan. Staff described to us how people were supported in an individual way promoting choice on when they wanted support and assistance.

We observed staff asking people if they would like assistance and their wishes were respected. Where people had declined personal care we observed staff returning later in the morning to offer help with getting up and dressed. This meant people were supported to make day to day choices on when they would like to receive care and these were respected.

People looked well cared for. This included ensuring people had their glasses, some ladies had painted nails and others had jewellery that matched their outfits and people's hair looked clean and groomed. People's care plans included what was important to them. For example one person care plan stated 'Please ensure I always wear my necklace and ring'. One relative said, "The staff are very attentive, they recently painted my mother's nails and she was really pleased". They told us, "The staff are all kind and gentle with mum, they explain what they are doing and offer reassurance when assisting with any personal care".

Staff described people in a positive manner and they were knowledgeable about people's life histories and important family contacts. We spent some time in the lounge and dining areas observing interactions between staff and people. Staff were respectful and spoke to people kindly and with consideration. Staff were unrushed and caring in their attitude towards people.

Relatives confirmed they were made to feel welcome and could visit whenever. They told us they were able to have meals with their relative including at Christmas and special occasions.

Relatives told us about meetings they were invited to attend which were held regularly for people and their relatives. Relatives told us the provider had recently introduced a 'Friends and Family' meeting. They told us outside speakers had been invited including the GP who talked to them about the dementia pathway and healthy eating. From talking with the manager and the provider it was evident they wanted to support relatives coming to terms with their loved one who were living with dementia and how this impacted on them.

In addition there was a quarterly newsletter for people, their relatives and friends which kept them informed of activities, social events, staff changes and success stories such as staff completing training.

People had been asked about their end of life wishes and how they wanted to be supported and who needed to be contacted. We were told relatives could stay and visit for as long as they wished during this period. The staff would liaise with other professionals including palliative care specialists, district nurses and the person's GP to ensure all equipment and appropriate pain relief was in place to support the person.

Some staff had completed training in palliative care. A health professional told us the staff will ask for assistance promptly and appropriately. The GP confirmed they were involved in discussions about end of life care which would include close family members in relation to end of life care.

People were supported to make advance decisions to refuse treatment or appoint someone with lasting powers of attorney, if they wished to do so. Information in people's care plans clearly recorded who they had appointed where relevant and their legal responsibilities in respect of what decisions they could be involved with. The manager had obtained copies of the documentation and was aware of their responsibility to

include the person's representative in any decision making.

Good

Is the service responsive?

Our findings

We observed staff organising activities including a ball game and the use of a parachute which was being used to encourage gentle exercise. People were also enjoying a word proverb game where people would finish off the sentences. This activity was calm and relaxed and people took part if they wished. The manager told us they were looking to organise more one to one activities for people based on their interests and hobbies. They were also exploring the interests of staff so these could be mapped to the people living in the home. The manager recognised that if a member of staff had a particular hobby or interest they would be more enthusiastic about sharing this with people.

Other activities included, film evenings, coffee mornings, bingo, pamper sessions, discussion groups to aid memory, quizzes, baking, gardening and arts and crafts. There was also the daily sparkle newsletter which encouraged people living with dementia to reminisce. People were actively reading the information and then discussing the contents with each other and staff. One relative commented positively on the information in the daily sparkle and how it had assisted in a conversation. They said this was really positive as recently their relative had been withdrawn and showed no interest in anything.

Staff told us trips were organised for people to the local garden centre, places of interest, trips to the local cafe and a trip to the Zoo. We were also told external entertainers visited every four weeks. Photographs were displayed throughout the home of the activities and trips organised. Last summer the staff organised a 'day at the beach' at Osbourne Court. There was a punch and judy show visiting and a fish and chip lunch. They organised some donkeys to visit the service. Staff said this had been successful with many people enjoying the experience.

The local church visited the home regularly to assist in meeting people's spiritual needs. People's cultural and religious needs were recorded in their care plan. One person's care plan stated they regularly visited the local church prior to moving to Osbourne Court and it was good they were able to keep in touch with the congregation and the local vicar. A mobile library visited the home every fortnight and an area in the main hallway provided people with a small library of books they could borrow. A visiting hairdresser visited three days per week. There was a designated area which had been set up as a hair salon. Staff were heard complimenting people after they had been to the hairdresser.

Some people were observed using twiddle muffs. Twiddle muffs are a knitted muffle mitt that contain different items sown on to them to enable the person to get a sensory experience. People were observed using these and taking an active interest in the items. Displayed in hallways were trees with knitted baskets and small chickens in preparation for Easter. One lady was particularly taking an interest in these items. We were told a relative had made these items that were displayed.

The care staff were responsible for organising the activities. Staff confirmed they organised daily activities either in small groups or on a one to one basis. Records were maintained of the activities that people had participated in. The manager told us that it was everyone's role to plan and organise activities. They felt if there was a named member of staff who completed this role then when they were not working in the home,

activities would not take place.

People's needs were assessed before they moved to Osbourne Court. This enabled the staff to plan with the person how they wanted to be supported enabling them to respond to their care needs. From the assessment, care plans had been developed detailing how the staff should support people. The person, their relatives and health and social care professionals where relevant had been involved in providing information to inform the assessment. The GP told us the staff ensured all new people were seen by the GP within the first week. The staff ensured all appropriate records such as hospital discharge letters and information from the person's previous GP was available. The GP said this was important as many of the people were living with dementia and may not recall this information. This meant the GP and the staff could respond promptly to the person's health care needs.

People had a care plan covering all areas of daily living. This included personal care, eating and drinking, sleep, hobbies, preferred daily routines and interests. There were risk assessments detailing any risks associated with their care or medical conditions. The care documentation included how the individual wanted to be supported. For example, when they wanted to get up, their likes and dislikes and important people in their life. These had been reviewed regularly and as people's needs had changed. We did note that one person's care plan about communication stated that there were no concerns. However, we found this was not case as the person was unable to understand what we were saying either due to a hearing loss or their dementia. The manager agreed this would be reviewed and updated

Care plans were tailored to the person and included information to enable the staff to monitor people's well-being. Where a person's mental or physical health presentation had changed it was evident staff worked with other professionals including the community mental health team and the GP.

Relatives had been involved in sharing life histories to enable staff to get to know the person. This enabled staff to respond to people living with dementia who may not recall all their life histories and aid conversation with the person.

Daily handovers were taking place between staff. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. For example, if a person refused personal care this was shared with other colleagues so this could be offered at a more convenient time to the person. During the handover the morning staff had reported that a person had been upset when family had left and asked the afternoon staff to complete regular checks. This showed that important information was shared to ensure staff were providing a consistent approach that was responsive to their needs.

People had access to call bells to summon assistance from staff. These call bells were linked to pagers carried by staff and a visual display which told staff where the call was coming from. During our inspection call bells were answered promptly. Where people had chosen to remain in their bedroom call bells were close to hand. Staff said for those people who were unable to use their call bell regular visual checks of people were completed. The manager and a member of staff told us regular checks were completed at night. The times of the checks were variable taking into consideration the well-being of the person. People and their relatives had been consulted about their preferences in respect of the nightly checks. One person had requested they were only checked once as they found the staff entering their room had disturbed their sleep pattern. This was clearly recorded in the plan of care. Staff said this would be reviewed if the person was unwell.

Staff were working closely with other health and social care professionals in minimising the risks relating to

falls. Staff told us where a person had fallen this was discussed with the GP in relation to their medicines and a review of their general health. The manager completed an audit on all falls to ensure appropriate action had been taken and to look at any themes in relation to place and time. We were told about a person who had fallen on a number of occasions as they were entering their bedroom door. The manager told us in response the person had moved bedrooms and their no longer wore their door key around their neck which appeared to have reduced the amount of falls. This was confirmed in the records we viewed and showed how the staff had responded to people's changing needs. We observed staff reminding people to use their walking aids where they had forgotten to take it with them. This was done sensitively.

A visiting healthcare professional told us the staff were adaptable and provided suitable levels of observation as well as ad hoc one to one time when a person was acutely distressed. Staff were aware of the people that required this additional support. For example, one person became angry during our visit. Staff were observed promptly de-escalating the situation and speaking in a calm manner trying to resolve why the person was upset. This person quickly calmed in response to the actions of the staff. A relative said staff always intervene when people get upset and manage to calm the situation down really quickly. The manager and staff told us there was always a staff presence in the lounge areas especially on the first floor to ensure people's needs were responded to promptly. The staff member was expected to sit with people and organise activities. This was so the monitoring could be done discreetly.

There was a complaints policy and procedure. The policy outlined how people could make a complaint with a timescale of when people could expect their complaint to be addressed. Complaints and concerns were taken seriously and used as an opportunity to improve the service. The themes of the complaints had been discussed at the 'friends and family' meetings such as making improvements to the laundry.

There had been three complaints since our last inspection and these had been investigated thoroughly with feedback given to the complainant. Relatives told us they had no reason to complain but would know how to if necessary. They said they were confident if they had a complaint it would be dealt with appropriately by the management team. Relatives told us both the manager and the provider were approachable and had an open door policy.

Good

Is the service well-led?

Our findings

There had been a recent management change within the service. The registered manager had resigned in March 2016. The deputy manager had been successfully appointed to this role seven days prior to this inspection. They confirmed they would be submitting an application to register with the Care Quality Commission. They said they were actively trying to recruit a new deputy to assist in the running of the service. The provider had kept us informed about the management changes.

Staff spoke positively about the team and the leadership in the home. They described the manager and the operations manager as being approachable. Staff told us they could always contact the manager or the provider for advice and support. Relatives knew who the manager was and confirmed they were approachable. One relative provided feedback prior to our inspection stating, "The management of the home is good with any issues quickly discussed and addressed. I do definitely feel that at this home staff really do care about the residents and want them to be happy in their home and for families to enjoy visiting their loved ones".

Staff described a positive culture in the home, including a team that worked together to meet people's needs. Staff told us the manager was open and transparent and worked alongside them. A member of staff said, "The manager will always come and help and if you have any query or concern, you know it be will be dealt with there and then". A visitor told us, "The new manager is passionate and caring; she was previously the deputy and is now the manager". We observed visitors and people actively seeking out the manager and the operations manager and spending time with them.

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a senior care worker and a floor lead on duty to guide the care staff. Staff had signed contracts in their files along with job descriptions on what was expected of them.

Some staff had designated responsibilities such as a dignity or dementia champions, nutritional and infection control leads. Regular meetings were organised with the leads to drive up quality. Action plans were drawn up to improve the service. For example the lead on nutrition was working with the staff to increase their knowledge on portion sizes with smaller plates being used for those people who were reducing their weight for health reasons. The leads were responsible to lead by example and support and train staff. The dignity and dementia champions attended meetings with the local council and we were told best practice was shared during these meetings.

Staff told us meetings were regularly taking place and they were able to participate in discussions about the running of the service and the care and welfare of people living at Osbourne Court. Staff told us any changes to the care practice, the running of the home and key policies were discussed. They confirmed the meetings ensured staff were kept informed about the service and their individual responsibilities. Staff told us that daily handovers took place including a written record, which enabled them to keep up to date when they had been away from the home for a few days. Staff were receiving regular supervision on a six to eight weekly basis with a line manager. Supervisions were used to discuss the staff member's role, training needs

and any concerns about the care delivered.

A relative told us they had found the 'family and friends' meeting really useful in gaining knowledge about the dementia pathway and how care was funded. Part of the meeting was led by the provider or the manager. Then a relative would chair the remainder. The minutes of these meetings showed that relatives and friends could discuss areas for improvement. We saw the relatives had raised some minor concerns about laundry, activities, staff identity and key workers during a meeting in September 2015. The minutes stressed that the relatives that attended were very happy with the care provided and that the suggestions made by the group were not intended to be critical or negative of the care being delivered. The group felt that the suggestions would enhance the lives of people living at Osbourne Court.

The areas for improvement were followed up at a recent meeting in February 2016. It was noted there was an improvement in staff wearing their name badges although the name board in the reception area was not always updated in the afternoons as part of the handover. In respect of the key worker role families did not always know who this was. This had recently been discussed at a team meeting and key workers were expected to make contact with relatives introducing themselves by the end of March 2016. It was evident the manager and the provider were committed to making improvements to the service based on the suggestions from this group.

The service had received many compliments around the care delivery, directly from families, the friends and family group and from visiting health care professionals. This was fed back to the staff team. The manager told us they were planning to introduce an employer of the month. This would be a member of staff that had gone the extra mile. The manager said this would drive up good practice in the home.

Systems were in place to review the quality of the service. These were completed by either the manager, a named member of staff or the provider. They included audits of health and safety, medicines, care planning, training, supervisions, appraisals, nutritional and infection control. It was noted from the medicines audit the manager had picked up there were gaps in staff signing for medicines. So whilst the audit had picked this up it would appear that there had been no improvement in this area. This was because we had seen that whilst people had been given their medicines staff had not always signed. The manager had completed a check on this by second day of the inspection and devised a plan of action to address the shortfall.

The provider submitted the Provider Information Return (PIR) prior to this inspection. This clearly described the service and improvements they wanted to put in place to enhance the service. The manager told us they wanted to continue to develop the friends and family support group and the quality assurance review team. They wanted to promote an open culture so people could feel valued and voice their opinions through regular residents meetings. They wanted complaints to continue to be seen as a means to improve, not as a criticism.

The manager told us they had recently attended training on the butterfly approach with two other staff. The butterfly approach is used as a model of care for supporting people living with dementia. The focus is on the person, their emotions and people feeling valued. The manager told us they were looking to use many of the aspects of the model to improve the experience of people living at Osbourne Court. For example, freeing up staff to spend time with people, to ensure care was tailored to the person and provide meaningful activities for each people. The manager told us some of these had already taken place such as exploring activities and interests of staff and making areas of the home more homely with people not congregating in one area. They were also asking relatives and friends to volunteer in the home bringing in their interests and hobbies and supporting people with activities.

The registered provider and the manager were part of a number of networks that they told us were very useful in keeping themselves and staff up to date. This included a care provider forum organised by the local Council for residential care providers. In addition the dignity champions attended meetings with other staff across the local area.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incident reports were produced by staff and reviewed by the manager. From the incident and accident reports we could see that the manager had sent us appropriate notifications. A notification is information about important events which the service is required to send us by law.