Danaz Healthcare Limited

# Pax Hill Nursing Home

## Inspection report

Pax Hill
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Outstanding |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Pax Hill Nursing Home is a 98-bed nursing home registered to provide care for older people and younger adults. The service is registered to provide care for people who experience physical or mental health conditions including dementia. Care is provided on three separate floors. Balmoral unit provides residential care; Montgomery unit provides nursing care for people living with dementia or with a diagnosis of mental illness and Windsor unit provides nursing care. At the time of the inspection there were 73 people accommodated.

At our last inspection we rated the service good overall and requires improvement in well-led with no breaches of the regulations. The service was rated as requires improvement in this key area, as the provider had not always consistently created an open and transparent culture within the service.

The service had an experienced registered manager. 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's needs were holistically assessed and their preferences about how they wanted their care provided were considered. There was a strong focus on providing individualised care to people living with dementia, which enhanced their experience of the care provided. Staff had been supported by their dementia care consultant to develop their skills, knowledge and confidence when working with people with dementia.

Staff were highly skilled at responding rapidly to a deterioration in people's health and providing the correct interventions to enable them to receive their care, including end of life care where they chose, at Pax Hill. Staff had been trained to provide Namaste care to people living with dementia when approaching the end of their life which provided comfort and connectivity for people.

Social activities provision was exceptional. The activities which were planned with people where possible, enabled them to try new things, to contribute to society and to feel a sense of self-worth. Staff had built strong links with the local community for peoples' benefit, with both members of the community coming in to the service and people going out regularly.

The service was well-led, with enthusiastic and motivated leadership which kept people at the heart of everything they did. There was a very positive and forward-thinking culture underpinned by a desire to drive service improvements for people.

Rigorous and constructive challenge was welcomed and used to improve the service for people and had been used to find innovative and empowering solutions to issues for people. The views of people were sought in a variety of ways. Processes were in place to continually audit and evaluate the service provided.

The service was a role model for other services. They worked in partnership with others, they shared their ideas and practice to ensure good experiences and outcomes for people across services.

People were kept safe from the risk of abuse through the robust training and processes to prompt staff to consider if a safeguarding referral was required to keep people safe following any incidents. There were processes in place to ensure staff felt able to report any concerns and to ensure relevant actions were taken for people's safety.

Risk assessments had been completed in relation to all aspects of people's care and for peoples and staff's safety within the service. Relevant checks had been made in relation to fire, equipment and utilities safety. People received their medicines safely from trained, competent staff. Processes were in place to protect people from the risk of acquiring an infection.

There were sufficient suitable staff to meet people's needs. Recruitment safety checks had been completed and the registered manager took swift action during the inspection to ensure that any staff without the required full employment history provided this information as legally required.

People's needs were effectively assessed and their care and support was delivered in line with current legislation and recognised good practice guidance. Staff had the skills, knowledge and experience to provide people with effective care. Staff received regular support and supervision of their work.

People were very positive about the quality of the meals provided. People were offered both a range of nutritious meals to meet their dietary requirements and the level of staff support they required to eat their meals.

Staff worked effectively together to ensure people's needs were identified and they were referred promptly to other services as required. People were supported to access the healthcare services they required.

People's individual needs were met by the design and decoration of the service, particularly on the dementia unit, where people experienced a relaxed and stimulating environment.

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

There was a person-centred culture. Staff consistently treated people in a kind and compassionate manner. There was written information for staff about people's communication needs and how to meet them. Staff asked people for their views and respected them. Staff ensured people's privacy and dignity were upheld during the provision of their care.

Further information is in the detailed findings below

## 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 remains Good.

The open culture, robust staff training and processes in relation to the identification and reporting of potential safeguarding concerns ensured people's safety.

Risks to people had been assessed and managed to ensure their safety and freedom were respected. Processes were in place to protect people from the risk of acquiring and infection.

Processes and procedures were in place to ensure people received their medicines as prescribed and safely.

### Is the service effective?

Good

The service remains Good.

Staff were provided with a variety of training to support their professional development and to ensure they had the skills to meet people's needs effectively.

Staff supported to eat and drink sufficient for their needs. Any risks to people associated with eating or drinking had been assessed and managed effectively.

People's individual needs were by the design and decoration of the service.

### Is the service caring?

Good

The service remains Good.

There was a person-centred culture. Staff treated people with kindness and compassion.

Staff asked for people's views and respected them.

Staff ensured people's privacy and dignity were upheld during the provision of their care.

### Is the service responsive?

Outstanding

The service has improved to Outstanding.

There was a strong focus on meeting the needs of those living with dementia. Staff skills in supporting these people had been enhanced through the recruitment of a dementia specialist, resulting in the achievement of exceptional outcomes.

Activities, driven by people, were rewarding and made them feel part of their community and valued.

Staff were trained and skilled at responding to a deterioration in people's health and were able to support people to receive end of life care at Pax Hill as per their wishes.

## Is the service well-led?

Good

The service has improved to Good.

The service was well-led. It was forward thinking and highly inclusive of both people and staff.

Rigorous and constructive challenge was welcomed and used as an opportunity to reflect and improve the service for people.

The service was a role model for other services. They worked in partnership with others, to ensure good experiences and outcomes for people across services.

# Pax Hill 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 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 comprehensive inspection took place on 5 and 6 November 2018 and was unannounced. The inspection team included two inspectors and an expert by experience on the first day and an inspector and an expert by experience on the second day. 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 by experience 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 included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received feedback from a specialist nurse and a GP, both were very positive about the care people received at the service. During the inspection we spoke with 16 people and three people's relatives. As people who lived on Montgomery unit experienced dementia and could not all speak with us, we used the Short Observational Framework for Inspection (SOFI) to enable us to understand their experience of the care provided. We also spoke with the provider, the registered manager and 13 staff, including three care staff, four nurses, the head of housekeeping and the chef.

We reviewed records which included seven people's care plans, five staff recruitment and supervision records and records relating to the management of the service.

The service was last inspected on 4 and 5 July 2016 and no concerns were identified.

Good

# Is the service safe?

## Our findings

There was an open culture where staff felt able to report any concerns, without concern for the consequences. Staff had undertaken safeguarding training and those we spoke with were confident in their safeguarding knowledge. Staff had been appointed as, 'safeguarding champions' to promote good practice, such as the completion of the provider's safeguarding concerns log. This was a record staff were required to complete to explore the possible causes for example, of any bruises and to prompt them to consider whether a safeguarding alert was required. Where people had experienced an injury, there were photographs, a body map and a treatment plan to ensure there was a record of the injury and the actions taken. Nurses informed us they had also attended additional training, in relation to their role when completing safeguarding investigations under the instruction of the local authority as the lead agency. A person told us, "I feel very safe here." People were kept safe by robust processes and staff who had received relevant training.

Processes were in place to ensure all incidents were documented, reviewed and evaluated to identify if any changes were required in people's care or if any learning was required to prevent the risk of repetition for people.

Risk assessments had been completed both in relation to all aspects of people's care and for people and staff's safety within the service. The service had a business continuity plan in the event of an emergency. Relevant safety checks had been completed in relation to fire safety, water, electricity, gas and equipment to ensure peoples' safety.

Risks to people associated with transferring had been assessed. Where people required assistance, people's records documented the equipment to be used, such as a hoist, the type of sling and the number of staff required to transfer the person safely. Staff were observed to transfer people safely, in a dignified manner and to constantly speak with people to provide reassurance whist they were assisted. Risks to people from falling had been assessed and relevant measures taken to reduce the risk for them. Staff had identified what equipment people required to keep them safe, through the provision of items such as sensory mats to alert them when people had got out of bed, and pressure relieving equipment. We saw these items had been provided as required for people's use. Where staff had assessed people as requiring bedrails to reduce the risk of them falling from bed, legal requirements had been followed to ensure this was in their best interests and did not restrict their freedom. Where people had been identified as unable to use a call bell, staff were instructed to check upon their welfare regularly across the course of the day, which we saw they did. Staff received regular updates on changes to risks to people at the staff shift handovers and through the information provide on their 'handover' sheets. Risks to people had been assessed and managed to ensure both their safety and freedom were respected.

Staffing levels were calculated using a recognised tool and we found the service to be well staffed on all three units. People told us, "They (staff) come when I ring the bell." People's care was not rushed, and people did not have to wait long for their care to be provided. There was good mixture of skills, knowledge and competence amongst the staff on each floor, with a mix of nurses, senior care staff, care staff and

activity staff to meet people's needs. There was a mixture of male and female staff of different ages, to reflect people's different needs and preferences. There was a high degree of stability and retention within the staff team with no use of agency staff. People, especially those living with dementia benefited from the consistency this provided. Shifts were always led by an appropriately qualified nurse or senior care staff, to ensure staff were guided and directed in their work with people.

Staff recruitment checks had been completed. These included, proof of the applicant's identity, references, fitness to work and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had previously changed their application form to require potential applicants to provide their full employment history from when they finished full time education rather than the past ten years as they had previously required. However, two of the five staff recruitment files we reviewed contained the old application form and these two staff had not provided a full employment history. We brought this to the registered managers attention who took immediate action to address this and to identify any other staff this impacted upon. By the end of the inspection these staff had been identified and their employment history obtained to ensure this information was available as required.

Staff who were responsible for administering people's medicines had undertaken relevant training which they updated regularly and their practical competency at administering medicines was assessed annually as required. Staff had access to up to date medicines guidance for reference.
Processes were in place to ensure people's medicines were ordered, stored, administered and disposed of safely. Processes were in place to ensure the safe management of 'controlled' medicines which require a greater degree of security. Where people had been assessed as requiring their medicines to be administered covertly the correct legal process had been followed. People's medicines were reviewed regularly by their GP. Staff were observed to take their time administering people's medicines before completing their medicines administration record to document the medicines they had given. Processes were in place to ensure there was guidance for staff in in relation to medicines people took as required. Staff used tools to enable them to assess if people might be in pain who could not articulate this. People received their medicines safely.

Processes were in place to protect people from the risk of acquiring an infection. Staff had undertaken relevant infection control training and had access to relevant guidance. Staff had plentiful access to personal protective equipment which they used in the provision of people's care to reduce the risk of cross-infection. The environment was clean and fresh and there were sufficient housekeeping staff deployed to maintain a clean environment for people.

Good

# Is the service effective?

## Our findings

People's needs were assessed prior to their admission to ensure staff could meet them. People's full care plan covering all aspects of their care needs was then devised with their input or that of their representative.

The providers polices were up to date and referenced legislation and good practice guidance, such as that published by the National Institute for Health and Care Excellence and local guidance. The registered manager and staff ensured their knowledge remained up to date through their attendance at local care forums and working with other providers and the local Clinical Commissioning Group (CCG) on the development of staff 'champion' roles to improve safety for people and by the development of resource folders to inform and guide staff. The registered manager ensured they remained up to date with new initiatives and that this information was disseminated to staff to constantly improve practice for people.

All staff received an induction to their role and those care staff who were new to social care were required to complete the Care Certificate which is the industry standard induction. Staff were required to complete 15 mandatory courses, in addition to English lessons if required. In addition, staff accessed further training in areas relevant to their role and people's needs such as, falls prevention, tissue viability, nutrition, catheterisation, percutaneous endoscopic gastrostomy feeding where a person is fed through a tube, communication, team leading and risk assessments. A staff member told us, "Training is excellent, and opportunities are encouraged." We observed staff were very competent and knowledgeable. Staff received three supervisions per year and one annual appraisal, to reflect upon their achievements across the year and their developmental goals for the coming year. Staff were provided with a variety of training to support their professional development and to ensure they had the skills to meet people's needs effectively.

When people moved into Pax Hill the chef was provided with information about their dietary requirements. The menus were planned with input from people and staff. People's feedback on the meals was sought via the resident's unit meetings and the focused group and changes to the menus were made in response to peoples' feedback.

People were offered a choice of whether they wanted a hot breakfast. At lunch and tea there was a choice of three main items in addition to alternatives. People provided positive feedback on the quality of the meals provided. Their comments included, "The food is excellent" and "The rice pudding is delicious, I don't know how they do it!"

We observed lunch on all floors reflected the needs of the people accommodated. For example, the chef served the lunches to people living on the dementia unit to provide a visual reminder to them that it was lunchtime. Staff supported those who needed assistance to eat their meal. Whilst on the Balmoral unit where people were very independent, staff had a discreet presence and assisted people as required.

Risk to people associated with choking or malnutrition had been identified and assessed and there were 'nutrition' champions' who audited people's nutritional requirements and ensured people received the nutrients and fluids they required. Where people were at risk from weight loss, staff followed the local CCG

guidance and provided people with fortified foods and fluids and food 'toppers,' which are foods designed to add calories to a meal such as grated cheese. Risks to people associated with malnutrition and dehydration were well managed.

Staff worked effectively together to ensure people's needs were identified and they were referred promptly to other services as required. A local GP held a weekly clinic for people and visited in between if required. People were also able to access chiropody, eye care, audiology, speech and language therapy, psychiatric nurses, Parkinson's nurses, tissue viability expertise and dental care as required. The registered manager had ensured that any issues with accessing external services for people had been promptly identified and appropriately escalated on behalf of people. The service had also recruited their own dementia specialist/occupational therapist to work with them for one day a week and had access to a private physiotherapist.

The environment had been improved in response to people's needs. Improvements had included the purchase of blue toilet seats as these were replaced, to provide a colour contrast for people. Lighting had been improved in the lounge to provide a softer and more ambient experience for people in the evenings. There was clear signage for people to orientate themselves. These improvements had benefited people as they experienced a relaxed, environment which was both stimulating and clutter free.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

People signed their consent to the care they received where they had the capacity to make this decision. Where people lacked the capacity to consent to their care, staff had completed a MCA assessment with relevant others to determine if receiving the care was in the person's best interests. They had also identified any restrictions in place upon the person and whether these amounted to a deprivation of liberty, which required legal authority. Staff had completed MCA and Deprivation of Liberty Safeguards training and understood who was subject to a Deprivation of Liberty Safeguards authorisation.

Good

# Is the service caring?

## Our findings

There was a very person-centred culture. A person told us, "I'm quite happy, everyone is nice here. I don't see how anyone could dislike it here. I think it's a very comfortable, happy place." Another said, "Here all the staff always say, 'all we want is to make you happy' they're so caring and loving."

Staff were highly motivated to offer kind and compassionate care. We observed acts of kindness across all three floors. We saw staff supporting a person to walk who showed signs of distress, staff were patient with them, saying, "Take your time darling" and progressed at the person's pace there was no sense of rushing them. On the dementia nursing unit at lunchtime we observed staff helping people with their meals or just generally taking the time to chat or hold their hands or rubbing their back reassuringly whilst gently encouraging them to eat. A nurse was sat next to a person who aggressively pulled at their apron. They responded very gently with, 'You don't like my apron? Ok, no problem we can take it off," gently rubbing the person's arm as they were speaking. The person calmed at the interaction. The nurse later commented, "I love the residents and working with them, they're like family." We observed a person refuse all food, four members of staff intervened at different points. The person was later seen drinking tea, with staff chatting to them about a magazine they were looking at. The person was smiling contentedly.

People told us they felt cared for and listened to. One person commented to another when asked, "They look after us, don't they dear." Another person said, "They're all so kind and lovely here. I have my own chair outside the garden doors, especially for me!" A third person told us how sensitive staff had been to their situation and how they had supported them to cope recently at a difficult time in their life. Staff cared about people and their welfare and treated them kindly.

There was information for staff about people's communication needs and how to meet them. One person it was noted called out often, which is a form of communication. Staff were instructed to go in and provide reassurance regularly whether they had called out or not, to give the person the sense that staff were there and that they did not only come when called. Another person's plan instructed staff to explain all procedures clearly so the person could understand. We observed staff bending down to people's level when they communicated with them, this ensured they were not bending over the person and facilitated level eye contact with the person.

People were actively involved in decisions about their care wherever possible. For example, at lunchtime on the dementia nursing unit staff used 'show' plates so people could see and understand what the meal choices were and to support them with making their choice. When people asked for an alternative pudding such as ice-cream, staff listened and responded immediately so people could see their views were acted upon by staff.

The information in people's care plans demonstrated their views about their care had been sought. We heard people exercising choices throughout the inspection. A person commented, "I'm going downstairs for lunch, I prefer it down there." We observed a member of staff ask a person, "Can I help you with your wheelchair?" the person replied: "No it's fine, I need the exercise" and carried on pushing their wheelchair.

Staff continued to accompany the person chatting as they went. Staff asked people's views and respected them.

Staff ensured people's privacy and dignity were upheld during the provision of their care. At a recent residents meeting, staff had sought people's views about how they wanted to be collectively referred to and people had expressed the view they wanted to be referred to as residents. We observed staff knocked on people's bedroom doors before they entered. Personal care was provided in private with the door shut. Staff were sensitive to people's need for dignity. We heard staff discreetly ask a person if they would like to go and change their clothes.

Staff recognized the importance of family contacts for people. A relative told us, "I'm always made to feel welcome.  It's a very good home here." Staff also emailed people's relatives to provide updates on their wellbeing and promote their participation.

Outstanding ☆

# Is the service responsive?

## Our findings

Professionals told us the service was focused on providing person-centred care and support and achieved exceptional results. A specialist nurse told us, "They are amazing." Recent written feedback from another specialist nurse to the registered manager stated about staff, "Their enthusiasm and passion was an inspiration." Professionals feedback was reflected by a person who told us, "I've got everything I want" and another who commented, "Here all the staff always say is 'all we want is to make you happy'."

There was a strong focus within the service on meeting the individual needs of those living with dementia and a determination to see them as a person with a history and not a diagnosis. The service had recruited a consultant in dementia care for one day a week to provide, 'dementia care mapping' which is a recognised approach to achieving care focused on the experiences of the individual and enabling staff to understand their lived experiences. For example, one of the consultant's reports explained to staff why the person exhibited certain behaviours and identified the person's strengths and instructed staff to focus on these when working with the person and provided techniques they should use to work with them in an individual and person-centred manner. Staff spoken with understood this guidance which they had applied, this had resulted in the person being calmer during the provision of their care. Another person's records explained why due to their employment history, the person might feel threatened and lash out if staff were to approach them from behind. In addition to providing information about the person's type and stage of dementia and how this personally impacted upon them. These reports had developed staff's understanding of the person and helped staff to see them as an individual with a history and not just a person with a diagnosis of dementia. The reports provided staff with individualised, practical strategies and guidance they used when working with each person to ensure they had a more positive and personal experience of the care provided.

The service had taken extensive and innovative steps to meet the behavioural and communication needs of people living with dementia. Staff had been provided with comprehensive training in dementia care and support by their consultant, on areas such as communication, why people living with dementia may not like bathing, understanding aggression, reducing the use of antipsychotics in dementia care, role play on working with people with dementia and communication. This work had enabled staff to better understand people's experience of these aspects of their care and to provide alternatives, such as a wash if people did not want to bathe or identifying times when the person was more likely to want to bathe. We saw the consultant working with an individual and they explained how they would then share this work with staff to enhance their understanding of that person and their history. The impact of this work was to give staff greater confidence and awareness of the needs of people living with dementia and how to support them effectively. For example, we observed a person was distressed, a nurse attended and spent 50 minutes with them, not leaving until they were satisfied the person's distress had been alleviated. Staff had the confidence to spend time with the person rather than being focused on the next 'task.' The registered manager told us they did a project 'changing times' to teach staff not to focus on schedules and to not be afraid of walking away and coming back when the person was ready to receive care.

We noted there was a very 'calm' and unrushed atmosphere throughout the service, people were relaxed

and content, especially on the dementia unit. Staff had been empowered by the training they had received and now had the skills, confidence and understanding to provide people living with dementia with individualised care that made them feel calmer and less fearful.

The service ensured that people had access to the information they needed in a way they could understand it and complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Staff had undertaken training in Namaste Care and there was a dedicated Namaste room. Namaste Care is about connecting with people in the end stage of dementia through comfort, sensory stimulation, and often, staff just, 'being present.' We noted a person entered the room for the session, visibly confused. A staff member sat with them continually chatting, talking about the person's family with them and then proceeded to show them photographs of their family, reminding them in detail who the members were. The person's mood visibly 'lifted' and they began to chat in response. The provision of this therapy had enabled the person to make a connection with staff and had positively affected their mood. Staff also recognised people's emotional needs when they lost friends they had made at the service and a person told us how sensitive and respectful staff had been of their wishes at this time.

Staff had exceptional skills in identifying and responding to changes in people's health and wellbeing when receiving care at the end of their life. Staff had received end of life care training in line with the 'Six Steps programme'. This is a nationally recognised best practice approach to delivering responsive and empathic end of life care. This helped to ensure they had the skills and knowledge to respond to people's changing needs.

Staff also completed a, 'Future Wishes' document with people which clearly recorded their wishes about their preferences and priorities in the event of a deterioration in their health and their wishes about their care at the end of their life. Staff were highly skilled at identifying and responding to changes in people's care needs when their health deteriorated and in subsequently providing their end of life care in the place of their choosing, at Pax Hill. This was in accordance with good practice guidance in enabling all people including those living with dementia to receive their end of life care in the place they chose. These measures had led to a significant reduction in the figures for GP out of hours call outs, 999 call outs, hospital admissions and deaths in hospital since 2016. Staff had the knowledge and skills to be exceptionally responsive to changes in peoples' healthcare and this had dramatically reduced the likelihood of people requiring healthcare input in an emergency and subsequently finding themselves in hospital, which was often not in accordance with their wishes.

The provider took a highly individualised approach to activities to help ensure people lived as full a life as possible. The activities staff on all floors demonstrated an ability to communicate with people both on an individual and group level and were highly attentive to each person. The four activities co-coordinators were allocated to different floors but also worked together as a team. Different activities were provided across each floor and in the community with the use of the service's minibus to meet people's individual needs and preferences. People were taken out to a variety of places, including local exhibitions. A person told us, "We went to Devil's Dyke, someone pushed me all the way to the top to see the stone!" However, people were also welcomed to attend activities on whichever floor they wished. Activities were suggested by people wherever possible. For example, one person wanted to play bridge and the local bridge club had been invited to come in to teach people to play. We noted that particularly on the residential unit where people were most able to contribute their ideas, there was a true sense of equality, partnership and joint enterprise between people and staff in the planning of their activities.

There were a vast range of activities arranged, many of which reflected the time of the year, which is important when people may have forgotten the season or the month, to assist their recollection. For example, during the week of the inspection there was an Armistice day talk, Remembrance service, fireworks display and Diwali celebration.

People had been involved in making a mosaic to publicly display in the newly refurbished residential dementia service next door. People's feedback on this project included, "Yes it was 12ft long! Joint effort. Yes, I'd never done anything like that before" and, "Oh yes, that was lovely, it was lovely doing something new." The activities provided had a beneficial impact upon people's sense of well-being. A person told us, about doing activities, "Yes, it makes us feel better." Staff provided both traditional and new experiences for people to try, they recognised that just because people were older it did not mean they did not want to do new and interesting things.

The provider encouraged people to make sustained and meaningful links with their local community to give them a sense of comfort, connectivity and purpose. For example, on Balmoral unit, people chose charities to support and items they made were sold both in the reception and at Christmas and summer fairs to raise funds for their chosen charities. This gave people a sense of achievement, self-worth and value. People had also chosen to make knitted hats for a premature baby charity and had received photos of babies wearing them which clearly gave them pleasure. Staff had arranged a talk by a local charity that people had raised money for recently, thus inviting the community in and enabling people to hear first-hand about the work being done with the money they had raised. An activities co-ordinator told us, "Everything we do, it is always for a purpose."

People were also involved in an art exhibition in the community where their work was to be displayed, enabling them to have community presence. The local church and schools were regularly invited into the service and contact had been made with the local nursery group, to enable people to interact with the children. People were both able to attend church services in the community and local ministers held religious services on-site for those unable to go out. There were strong links with the local community which enhanced people's life experiences.

The activities staff arranged activities that met each person's needs, and which validated people's efforts wherever possible and had a real meaning for them, rather than just filling time. People felt worth something and that they were still able to be creative, experience new things and to contribute to society.

People and or their representatives where applicable were consulted by staff about the planning of their care and their preferences about how they wanted their care delivered. People's care plans fully reflected their physical, mental and social needs and any needs on the grounds of their protected characteristics as defined by the Equality Act, such as age or gender, for example. People's care plans were regularly reviewed to ensure they were up to date. A GP told us, "They are good at speaking to relatives and seeking their views."

People were provided with information about how to make a complaint if required and processes were in place to investigate any complaints received. People spoken with felt able to raise any issues but had not felt the need to. The one complaint received in the past year, had been investigated and resolved.

Good

# Is the service well-led?

## Our findings

The service motto 'Our residents do not live in our home, we work in their home' was distinctive and encapsulated the provider's approach in putting people at the heart of the service, recognising that it was their home first and foremost. Staff were extremely motivated by and proud of their work with people. A staff member told us, "I love it – this job. Coming to work is a pleasure, it doesn't seem like work." A person said to us, "Everything is wonderful here, couldn't have chosen a better home." Another said, "I so admire the proprietor here, what they've done. People are queuing up to come here."

The service was now very well-led. The service was family run and since the last inspection the provider no longer had an active role, another member of the family had taken this on. They were motivated and 'hands on,' they worked at the service several days a week. They had sought to develop their own knowledge and skills in dementia care since taking on their role, to enable them to better understand people's needs.

The provider's representative and the experienced registered manager had worked together with staff to develop an open, dynamic and transparent culture for people, focused on improvement and delivering high quality care. A specialist nurse confirmed, "They want to continuously improve and build" and, "From the top down there have been improvements." Staff felt inspired across the service to drive improvements, for example, the chef had researched food moulds to improve the presentation of pureed vegetables for those who required their meals pureed and was looking at changing the plates to 'freedom plates' which were deeper, with bright colours and easier for people to use for themselves.

There was a clearly defined management structure and the registered manager had very good oversight of the service. The unit managers had been enrolled on and supported to attend a management training course, to ensure the future managers of the service were identified and developed for people's benefit. A focused feedback had been completed on all managers including the provider's representative to identify areas for improvement and as a result a session on supervision of staff skills had been booked to further build their confidence and skills.

Staff had received training from the 'Virtual Dementia Tour Bus,' which provides staff with experiential training to help them understand what it feels like to be a person living with dementia. We saw that as a result, staff now had a greater understanding of people's lived experiences. We saw at lunchtime on the dementia unit, staff were sensitive to people's needs and always on hand to help where necessary, going from table to table, chopping food or offering just a few kind words.

There had been innovation for people in the way the corridors on the dementia unit were decorated. The walls were three dimensionally decorated in themed zones, using items donated by people, which gave them a stake in their environment. The walls reflected the age and life experiences of the people cared for, with themes such as the war, seaside, outdoors and music. The zoning of the corridor, enabled people to both locate their rooms as they could associate their room with a particular 'zone' and provided both visual and sensory stimulation. As people could look at the displays and staff and their relatives could use them as a focus for discussion and people could touch the items. We spoke with an activities staff member who told

us, "The whole corridor I'm responsible for. Everyone recognises where they are. There's different colours and themes, they know where their room is." Staff's creativity had provided an enriching and stimulating environment for people which we saw staff using with people as a source of conversation as they walked with them.

There was a focus on on-going investment for people, with the recent installation of a water 'bore hole' to ensure that there would be sufficient water pressure for people, following the increase in demand with the re-development of their residential dementia service which was located on the same site. There had also been an investment in technology, to ensure the IT capacity of the service could meet the growth in demand from both people and systems. In recognition of the fact that more people wanted to use their IT to stay connected with family and the outside world.

There was a strong commitment towards ensuring equality and inclusion across the service for both people and staff. For example, there was a firework display on the ground floor unit on the first day of the inspection to celebrate bonfire night. We saw staff ensured people were asked if they would like to go down and watch. Those who could not or did not want to be were enabled to watch from the lounge on each floor to ensure all could participate in this whole service social event. Staff had organised a Diwali celebration on the second day of the inspection to which all people were invited and staff from other ethnic backgrounds also participated. This was organised by a member of the housekeeping staff who told us how they worked collaboratively with their activities colleagues to organise this and other celebrations for people across the year for example, at the summer fair, when they celebrated the different cultures, food and music which represented the diversity of staff's cultural backgrounds. We saw the room was packed for the celebration many relatives and visitors also attended, and were observed sitting alongside their relative, joining in with the music and clapping. A person commented, "Oh, I really enjoyed that." People and staff felt part of and derived great pleasure from the festival.

People and staff's views were sought on the service in a variety of ways. In addition to surveys and suggestions boxes, each floor held their own residents meeting to ensure it reflected the agenda and needs of the people accommodated on that floor. The provider had recently also introduced a service wide, 'Focus group' to encourage innovation and ideas from people that could benefit everyone across the service. For example, ideas were being progressed to improve the garden and to provide 'hot trolleys' to transport meals to people in their bedrooms. Because of feedback on the call bells being intrusive, hand held devices had just been introduced to reduce the noise for people. The provider's representative told us they were consulting people about how they wanted the exterior of the new minibus 'branded.' They told us that as people used the bus to access the community for trips, it was important that they were consulted about the exterior of the bus to ensure it reflected how they wanted to be seen in the community. Staff also reported feeling involved in decisions.

The service welcomed rigorous and constructive challenge. Healthwatch, the consumer champion for health and care had inspected the service in October 2017 and provided feedback within their report on potential areas for improvement. Management had used the report to critically reflect on the service provided. In response they had produced an action plan which outlined the work they planned to undertake and how they would measure success. One area highlighted for improvement had been the use of 'protective covers' to protect people's clothing whilst they ate. Staff had researched the alternatives and identified 'dignity scarves' as a more personalised option. These are 'scarves' which are placed over the person's shoulders. However, staff felt they could improve on what they found, and had designed and made their own for people's use. We noted the scarves were so dignified and discreet that they appeared to be part of the person's dress at lunch. People did not mind staff asking them if they would like to use one and we observed people with dementia liked the feel of them and touched and stroked them. This intervention

had increased people's dignity and experience at lunch. Feedback had been used positively to drive improvements in the service for people.

Processes were in place to audit the quality of the service, both internally with audits that regularly reviewed all aspects of people's care from their experiences to the records and external audits by the provider's pharmacist. There was a clear bi-annual service improvement plan which set out what areas they wished to address, what action was required by whom and how success would be measured. The service also used their dementia specialist to enable them to audit and measure peoples' experiences, especially those of people living with dementia. They had asked the dementia specialist to audit people's lunchtime experience. All aspects of the service were audited from people's entering the dining room to leaving. Because of the recommendations made, several changes had been made to improve both the environment, such as clearer information for people about the options available and dining experience, with staff ensuring that no notes were made in the dining room of what people had eaten, to ensure their dignity.

The service was a role model for other services. They were involved in a number of 'Champions' groups that had been set up with local homes and the local Clinical Commissioning Group. The role of the staff champions was to promote good practice and they ran focus weeks on their area of expertise, such as falls and infection control. A specialist nurse told us they had supported staff with their infection control week, to enable them to understand the importance of hand hygiene in reducing the risk of cross-infection for people. The annual infection control statement showed that although the rate of infections had already been low in 2016, work across 2017 by the champions in promoting good infection control practice had led to a further reduction in the level of infections for people.

The registered manager had recently received excellent written feedback from a professional about staff's contribution and the sharing of good practice and ideas at a care home forum, where local providers meet to update themselves on current practice. The professional had particularly commended the use of the dignity scarves as an example to other services. We saw they had been asked to provide information on their work on infection control and the dignity scarves for dissemination to other homes. Another professional confirmed they had "Formed links with other homes in the area on areas of practice such as infection control. They are looking at what is good practice and developing guidelines to share." The registered manager told us that they were often approached by other homes asking if their staff could come and visit the activities co-ordinators, due to their local reputation for providing high quality person centred and meaningful activities. They worked in partnership with others to ensure good experiences and outcomes for people across services, not just their own. Staff had also been nominated for a social care award in recognition of their work.