Premier Care Homes Limited

Picktree Court Care Home

Inspection report

Picktree Lane
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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Outstanding** ☆
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

This inspection took place on 28 November and 4 December 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Picktree Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Picktree Court Care Home accommodates up to 88 people in a purpose built, five storey building. Accommodation is provided across three separate floors. During our inspection there were 80 people using the service. Some of the people had nursing care needs and some people were living with a dementia type illness.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in March 2015 and rated the service as 'Good.' At this inspection we found the service had improved to 'Outstanding' and met all the fundamental standards we inspected against.

The service was exceptional at supporting people with their dietary needs. A healthcare professional described the service as "outstanding" and "highly proactive in managing swallowing difficulties."

The Provider had a holistic approach to assessing, planning and delivering care and support. They were instrumental in the development of a monthly multi-disciplinary team meeting between the home, the GP practice and the local mental health team. This was established to support people at the home with the most complex needs, such as dementia.

There was a strong, visible, person-centred culture at the home. Without exception, people who used the service and family members told us staff were very caring. Staff treated people with dignity and respect, and enabled people to maintain and regain their independence. Thank you cards sent to the home provided evidence of the kind and caring nature of staff.

Positive comments about the service had been posted on the NHS choices website feedback page. These included, "I can give nothing but five stars, more if I could to this wonderful care home", "I will always feel and know that I made the right decision in choosing Picktree Court for my mum to be cared for", "If you are looking for a Care Home for a loved one, look no further than Picktree Court. You won't be disappointed" and "Picktree Court Care Home is a fabulous example of what a care home should offer."

Staffing rotas were specifically formulated to ensure people's needs were met and staffing levels varied depending on the needs of the people who used the service. Records showed that staffing levels consistently exceeded the number of staff required as per the provider's dependency tool and we saw there were sufficient numbers of staff on duty during our inspection visit to keep people safe and engage in activities.

The registered manager and staff understood their responsibilities with regard to safeguarding and staff had been trained in the protection of vulnerable adults. The service has implemented the use of the 'Herbert Protocol'. The Herbert Protocol is a national scheme which encourages carers to compile useful information that can be used in the event of a vulnerable person going missing.

Systems were in place to create a safer environment for people who used the service, visitors and staff, and helped to determine how improvements could be made following incidents.

Medicines were safely stored and administered. The administration and recording of medicines was carried out using an electronic, hand held device that used a barcode scanning system. This reduced the risk of medicines errors.

The home was very clean. People, family members and visitors commented on the cleanliness of the home stating it was "spotless" and "immaculately clean". Staff had received training in infection prevention and control, and a variety of infection control and cleanliness related checks and audits were carried out.

Accidents were appropriately recorded and analysed to identify any trends, and risk assessments were in place for people who used the service.

People who used the service received effective care and support from well trained and well supported staff. The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff.

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. Where people lacked capacity to make decisions mental capacity assessments and best interest decisions had been carried out and were recorded.

The provider had a thorough approach to planning and coordinating people's admission to the service. Care records were regularly reviewed and evaluated. Records were person-centred and had been written in consultation with the person who used the service and their family members.

None of the people using the service at the time of the inspection were receiving end of life care however people had end of life care plans in place. These described people's preferences for their care at this important time.

The provider protected people from social isolation and a variety of activities were on offer at the home. These included dementia themed activities and a 'making memories' project. Individual monthly planners and daily activity logs recorded activities people had taken part in.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint. None of the people or family members we spoke with had any complaints about the service.

People and family members we spoke with were positive about the management and atmosphere in the home, and staff felt supported by the management team. The provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Records showed that staffing levels consistently exceeded the number of staff required as per the provider's dependency tool.

The home was very clean, and a variety of infection control and cleanliness related checks and audits were carried out.

The registered manager and staff were aware of their responsibilities with regards to safeguarding vulnerable adults, and accidents and incidents were appropriately recorded and investigated.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Outstanding

The service was extremely effective.

The service provided outstanding support for people with dietary needs.

The Provider led on the development of a multi-disciplinary approach to support people at the home with the most complex needs.

Admissions to the service were thoroughly planned and coordinated.

Is the service caring?

Outstanding

The service was extremely caring.

People and family members told us staff were exceptionally caring and had gone the "extra mile" to provide outstanding care.

The service enabled people to maintain and regain their independence.

Respect for privacy and dignity was embedded in the service.

Is the service responsive?

Good

The service was responsive.

Care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account.

The home had a full programme of activities in place to ensure people who used the service were protected from social isolation.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role. Staff were regularly consulted and kept up to date with information about the home and the provider.

Picktree Court Care 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 inspection took place on 28 November and 4 December 2017 and was unannounced. One adult social care inspector, a specialist advisor in nursing and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 11 people who used the service, eight family members or visitors, and two visiting healthcare professionals. We also spoke with the provider, registered manager, assistant manager, care delivery manager and seven members of staff.

We looked at the care records of eight people who used the service and observed how people were being cared for. We also looked at the personnel files for five members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Picktree Court Care Home. A person told us, "I feel safe, it feels like being at home here." Another person told us, "I feel safe, the staff here are wonderful." We saw a thank you card from a family member that stated, "What we would like to highlight is our appreciation of the way in which all of the staff made her feel safe and, in a surprisingly short time, at home here."

The home was a large, five storey building set in its own grounds. Access to the home was restricted for security purposes and visitors were required to sign in and out. Staff used a fingerprint recognition system to enter the premises and a key card system was in use for moving around the home. Each key card had its own staff identification, with different security access levels depending on the role of the staff member. For additional security, CCTV monitoring was in place in all external areas, access areas and 'non-resident' areas such as care stations and medicine administration and trolley storage areas. This helped to create a safer environment for people who used the service, visitors and staff, and helped to determine how improvements could be made following incidents.

We discussed staffing levels with the provider and registered manager and looked at staff rotas. A dependency tool was used to calculate the number of staff required on duty. Records showed that staffing levels consistently exceeded the number of staff required as per the provider's dependency tool. The provider believed this enabled the delivery of more effective care and enabled staff to be more involved in training and development. Staffing rotas were specifically formulated to ensure people's needs were met and staffing levels varied depending on the needs of the people who used the service. The provider had tools in place that monitored staff turnover and staff sickness/absence. The registered manager told us agency staff had been used in the past but any absences in the last three months had been covered by the home's permanent staff. Staff and people who used the service did not raise any concerns regarding staffing levels at the home. We saw there were sufficient numbers of staff on duty during our inspection visit to keep people safe and engage in activities and off-site appointments.

The nurse call system was computer controlled. This enabled the provider to monitor response times to improve care, safety and wellbeing. When a person pressed the nurse call, it had to be cancelled by staff at the point of call meaning staff could not cancel without attending the person's location. This prevented staff from failing or delaying to attend to a person's needs. There was also a public address system in place which the provider said allowed for more prompt action to be taken.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Nurse registration checks were also carried out regularly to ensure nurses were registered with their governing body.

The home was very clean. A person who used the service told us, "My room is always clean and as soon as anything is spilt the staff are there straight away" and "The premises are kept spotless." Another person told us, "The premises are very clean and my room is beautiful." A family member told us, "The rooms and environment at the home are of the highest standard, everything is always immaculate and the cleaners work very hard indeed." Comments on the NHS choices website feedback page included, "It is a beautiful, comfortable, immaculately clean and friendly environment" and "Picktree Court Care Home is immaculately clean." We saw a copy of an email from a family member that stated, "Your nursing/care home is always spotless." A visiting healthcare professional told us, "It looks like a hotel. It's always getting cleaned."

The home's laundry facilities were in the basement of the premises. Laundry was bagged and sent to the laundry room via a chute, reducing the risk of infection. There were separate, areas for soiled and clean laundry. The laundry area was very large and clean.

A variety of infection control and cleanliness related checks and audits were carried out. These included domestic cleaning schedules for each area of the home, carpet, mattress and wheelchair cleaning logs, regular bedroom checks by allocated key workers, kitchen audits to ensure the environment was clean, safe and policies and procedures were being followed, and colour coded cleaning equipment was in use. The provider had a food hygiene rating score of five, which is the highest that can be achieved. Food was delivered from the kitchen to the dining rooms via a dedicated lift, reducing the risk of contamination.

Staff had received training in infection prevention and control, there was an infection control champion in place to monitor and improve standards, and attend local infection prevention and control meetings. We observed staff using appropriate personal protective equipment (PPE) that was available in the home. We saw a recent infection control audit had been carried out by the local infection prevention and control team. There was only one minor action from this audit.

Accidents and incidents were appropriately recorded and analysed to identify any trends. For example, following every fall a 'Post fall huddle' took place within 15-30 minutes where staff on the floor came together to document the fall, how it occurred, what could be done to prevent it from happening again and any other recommendations. Not all the records included recommendations however where they did they included the use of monitoring equipment such as sensor pads, referrals to the falls team or increased observations. Monthly falls statistics were analysed and actions were recorded. The risk of falls in the home was reduced as people could not independently access staircases.

The service has implemented the use of the 'Herbert Protocol'. The Herbert Protocol is a national scheme which encourages carers to compile useful information that can be used in the event of a vulnerable person going missing. The provider told us the local police force praised the service's proactive use of this recommended document, which supported the police in responding promptly and successfully when a person left the home unsupervised.

Risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. They included kitchen, bed rails, falling from heights, generic utilities, disposal of medicines, safe temperatures, moving and handling, fire and clinical waste. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

The registered manager conducted a health and safety audit every six months, which checked the interior and exterior of the premises, laundry, kitchen, cleaning and domestic duties, infection control, and staff awareness of health and safety. There were no actions from the most recent audit in September 2017.

Hot water temperature checks had been carried out for all rooms and bathrooms. Some of the temperatures recorded over the previous three months exceeded the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). We brought this to the attention of the registered manager who agreed to action it straight away. On our second visit we saw this had been actioned and all temperatures were within the recommended levels.

Equipment was in place to meet people's needs and where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed. For example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. The provider told us the home was covered by a fire protection mist suppression system. We spoke to a fire officer who confirmed that the mist suppression system used in the home was very good and not seen in many homes. The provider told us the system ensured safety to all rooms and was especially important given the high dependency levels of people in the home. The risk of burns to people was reduced as the home had a ceiling mounted heating system. People who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation.

The provider's safeguarding adults procedure provided information on the procedure for staff to follow in relation to keeping people safe from abuse or harm. The procedure defined the different types of abuse and the responsibilities of staff. Staff had been appropriately trained in how to protect vulnerable people. A safeguarding referral log included details of any incident reported to the local authority and whether family members and CQC had been notified. This confirmed incidents of abuse, or allegations of abuse, had been appropriately reported and dealt with.

The provider had a whistleblowing policy to encourage the reporting to management of any concerns involving a member of staff. The policy included the contact details for the local authority and CQC.

We found appropriate arrangements were in place for the safe administration and storage of medicines. Medicines were administered and recorded using an electronic, hand held device that used a barcode scanning system. For each person, the system included their name, a photograph, whether the person had any allergies, details of the person's GP, medical history and reason for prescribing. The system enabled staff to be informed when medicines were due and indicated when medicines had been given. It also included details of stock levels. Daily management reports could be generated from the system and monthly audits took place. The provider told us the implementation of the electronic system had meant more staff time could be utilised providing resident care. The electronic system also reduced the risk of medicines errors. However, if errors did occur staff told us about the system that was in place for reporting and actioning errors.

We observed a medicines round and found it was unhurried and there were positive interactions with people. For example, the member of staff administered medicines to a person who was in bed. They sat down at the person's bedside and asked if the person was comfortable. They placed the medicine on a spoon, offering a drink of water afterwards.

Competency checks were carried out for staff who administered medicines. Medicines were appropriately stored in locked trollies in a locked room. Room and refrigerator temperatures, for those medicines that

required cold storage, were recorded and within recommended levels.

Outstanding ☆

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A person who used the service told us, "The girls [staff] are good, nothing is too much trouble to them. They are good lasses." Another person told us, "They [staff] all look after me very well" and "They [staff] are all good." A family member told us, "I would just like to say how very happy I am with the care [name] is receiving at the home." Another family member told us, "I have no reason to doubt that staff have the necessary skills, they are all very patient with them, they are brilliant." A visiting healthcare professional told us, "The girls [staff] are really good. There's a lot of documentation for a care home but they are very spot on."

The service was exceptional at supporting people with their dietary needs. Where appropriate, referrals were made to speech and language therapists (SALT) and their guidance was included in people's care records. A letter we received from a speech and language therapist involved with the home stated, "I would rate this care home as outstanding in all areas. The care home are highly proactive in managing swallowing difficulties as evident by the referrals we receive in to our service for residents who they have identified as having warning signs of swallowing difficulty." They stated the service was "proactive in seeking guidance", "flexible with appointments" and "the care staff and nurses seem to really know the residents". They also provided an example of how through joint working between the SALT and the service, a person who was admitted to the home with swallowing and feeding difficulties had improved to a normal diet, had put on a significant amount of weight and had become fully mobile.

Malnutrition Universal Screening Tools were used to identify people at risk of malnutrition, people's weights were recorded regularly, and food and fluid intake records were in place where required. We saw records for two people who had been at risk of malnutrition. MUST and weight records showed these people had steadily gained weight, reducing their risk.

The provider told us the home offered a choice of mealtimes to suit dependency levels. This ensured people could sit with like-minded people who had similar abilities and interests, creating a more sociable meal time. We carried out observations of the lunch time period. A choice of drinks was offered and dining areas were clean, nicely decorated. There was sufficient staff to ensure there was a calm atmosphere and people had a good experience. We saw staff were patient with people and offered alternatives for anyone who did not want to eat the main choices that were available. The provider told us menus were based on the NHS 'Focus on undernutrition standards' and were changed to reflect Winter and Summer nutritional intake. 'Kitchen contact' records were in place for people and recorded people's preferences, dietary needs and other comments regarding food and drink. People's individual dietary needs were recorded on the kitchen notice board. A trolley service was offered between meals, serving hot and cold drinks and snacks.

People we spoke with were positive about the food served at the home. Comments included, "Staff always ask what you want and ask if you want alternatives", "They know I don't like fish and they offer me something else", "Staff come around the day before with the menu and there are three choices" and "There is plenty of variety."

People's needs were assessed before they started using the service and continually evaluated in order to develop care plans. The provider had a thorough approach to planning and coordinating people's admission to the service. We saw a copy of an email from family members complimenting the provider and registered manager for spending time with them and their relative, talking about the home and answering any questions. This ensured everyone had as much available information as possible to enable them to make an informed decision.

We saw another email from a family member thanking the provider and registered manager for the support they provided regarding an appeal the family had made against a decision by social services for their relative to remain at home rather than in full time care. The family member stated, "They [provider and registered manager] provided us with a lot of helpful and useful information and advised us of all the information we needed to collate the required letter necessary regarding our appeal." The family member went on to say that following admission to the home, their relative's weight increased and they became more independent. The family member stated this was, "All down to the amazing care he is receiving in Picktree Court."

The provider had good links with the local GP practice, who had over 90% of the people who used the service on their records. These links had established a process between the home, the practice and the pharmacy to streamline the repeat ordering of medicines to reduce waste and minimise the risks of errors. GPs from the practice visited the home once per week to carry out a "ward round". A GP from the practice confirmed the weekly ward round approach for people at the service was "working well" and had "significantly reduced hospital admissions."

The Provider had a holistic approach to assessing, planning and delivering care and support. They had excellent links with health and social care services, and were instrumental in the development of a monthly multi-disciplinary team (MDT) meeting between the home, the GP practice and the local mental health team (MHT). This was established to support people at the home with the most complex needs, such as dementia. The MDT enabled discussion and early intervention for people who had not yet been referred to the MHT because their needs fell below the threshold for referral but allowed support and advice to be shared and earlier intervention by the MHT if required. This enabled people to be better supported and achieve better outcomes due to early diagnosis and implementation of appropriate support. The MHT confirmed that since the implementation of the MDT, there had been a reduction in calls for their service from the home. Although similar MDT meetings took place at other care homes, the MHT stated Picktree Court Care Home was the only home to have GP attendance at the clinics.

Visiting GPs and NHS staff were able to use the home's secure Wifi network system to access people's records and share information whilst on the home's premises. This eliminated any delays in being aware of people's medical history and enabled informed and effective medical support to people who used the service.

People were supported to attend appointments to hospital or other healthcare services. A person who used the service described how when they had visited the hospital for an appointment, the consultant was pleased to find an improvement in their condition whilst they had been a resident at Picktree Court Care Home.

Staff were supported in their role and received regular supervisions and an annual appraisal. All staff appraisals were up to date. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. A supervision matrix was in place that recorded when supervisions and appraisals had taken place, and the topic of the supervision. Supervisions were a two way process and topics of conversation included mealtimes,

medication, care plans, infection control, and moving and handling. The provider told us that several staff, as a result of support and development, had been promoted to more senior roles within the home.

New staff received an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Mandatory training is training that the provider deems necessary to support people safely. This included fire safety, person centred care, mental capacity, control of substances hazardous to health (COSHH), dementia, food hygiene, challenging behaviour, health and safety, equality and diversity, infection control, moving and handling, and safeguarding. The provider's human resources department produced an electronic training matrix, which informed the registered manager of any due or overdue training. We saw where training was due, it had been identified and the staff member informed.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the requirements of the DoLS had been followed. DoLS files included details of when they had been applied for, when authorised, expiry dates and whether CQC had been notified. Where people lacked capacity to make decisions mental capacity assessments and best interest decisions had been carried out and were recorded. The registered manager and staff we spoke with had a good understanding of mental capacity and had received appropriate training.

Consent was documented in care records. For example, consent for taking a person out into the local community. People told us staff obtained consent before delivering care or support. Where people were unable to provide consent, family members had been consulted and these were recorded. One person told us, "They ask for consent and they always tell me." A family member told us, "They will ask [name] or ring me at home."

Some of the people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service had been involved in the decision making process. Emergency healthcare plans (EHCP) were in place for some of the people. EHCPs help make communication easier in the event of an emergency and inform healthcare professionals of people's wishes with regard to any treatment they should receive.

The service had 'champions' within the home. These were staff members responsible for health and safety, dignity, safeguarding and infection control. The provider told us the champions actively supported staff to make sure people experienced good healthcare outcomes.

Some of the people who used the service were living with a dementia type illness. People and family members were consulted about the design of the premises and all areas were maintained and decorated to

a high standard. Some people had chosen to have their names put on their bedroom doors. None of the family members we spoke with raised any concerns about the design of the premises. We spoke with the activities coordinator, who told us they had downloaded dementia activities packs from the Internet, had started making some dementia friendly rummage boxes for the lounges and had placed 'dementia dolls' around the home. They had also made use of the reminiscence boxes available from Beamish Museum. These encouraged older people with memory problems to trigger their memories and stimulate conversation.

Outstanding ☆

Is the service caring?

Our findings

There was a strong, visible, person-centred culture at the home. Without exception, people who used the service and family members told us staff were very caring. A person who used the service told us, "Staff are kind, they are wonderful." Another person told us, "Staff are kind and they are always having a joke with you." Another person told us, "The staff are so kind, all of the girls and even [registered manager] pops in for a chat." A family member told us, "They [staff] are kind." Another family member told us, "[Staff] are always caring towards [name] even when [name] is difficult." Another family member told us, "I am definitely happy with the care [name] receives. The staff are always caring and kind and they treat them so nice."

The kind and caring nature of staff was evidenced in thank you cards that family members had sent to the home. Comments included, "Your staff are truly caring and attentive", "I was so relieved when you offered my mother a place, and send many thanks to you and all your staff for being so caring and compassionate", "You all work with your hearts and that shows", "Your care for mam could not have been better" and "I would like to thank you for all the care and kindness you showed to [name] over the last three years. Not just with her daily needs but in the simplest of gestures that make you all so proficient in your jobs. Like a warm smile, a gentle hug, a kind word, the little sing songs, all these gestures were greatly appreciated." Another family member had written to the home to thank staff for arranging a 100th birthday party for their relative and said, "I'm sure she will treasure the day for the rest of her days."

Written feedback from visiting professionals included, "Very good care given to residents", "Very caring staff with residents' needs always prioritised", "Provide very good standard of care to residents" and "Staff are always ready to help."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity.

We saw evidence of the exceptional caring nature of staff. For example, some people who used the service had been invited to attend two staff members' weddings and we saw photographs of the events. The registered manager told us the staff had built up bonds over many years with the people who attended their weddings and were of the view that they wanted the people to enjoy their celebrations should they wish. The people and their families agreed to the arrangements. Another person had been invited to Christmas lunch at a staff member's house. This was because the staff member had identified the person as being "low in mood and withdrawn". The person had commented afterwards, "It was very kind of [staff member] to take me to her house and spend time with her family. [Staff member] is a lovely person and I had a really nice time."

We saw how the service had gone the "extra mile" when the family of a person who used the service had recently moved house in another part of the country and wanted their relative to visit. A member of staff accompanied the person on the return journey to assist with the person's needs. A family member of the person stated, "It was good of you to coordinate a carer who knew [person who used the service] and [staff member] did us and [person who used the service] proud by accompanying us on the return journey." The

provider told us there were plans to facilitate an overnight stay in another care home to allow the same person to attend a family wedding, and they would be providing a 'This is me' information document about the person to the other home to support them with this.

Respect for privacy and dignity was embedded in the service. We saw staff knocking on bedroom doors and asking permission before entering people's rooms. People's care records described how staff were to respect people's privacy. For example, staff should knock on people's doors, await an invitation to enter the bedroom and close the door on leaving. Our observations confirmed staff treated people with dignity and respect, and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Where people were able to make choices and state preferences, these were documented in their care records. For example, one person enjoyed a cigarette before going to bed, and their choices regarding the times they went to bed and got up in the morning were clearly recorded. Another person had stated they preferred female staff to look after them. A person told us staff had respected their wishes about not having the flu jab as they had never previously wanted one.

People's bedrooms had their own toilet and shower facilities which gave them a choice over where they would like to bathe, aiding independence and choice over their daily lives. Care records described how people were supported to maintain their independence. For example, "Staff to prompt [name] to have a shower and give [name] clean towels", "[Name] is able to use the toilet without any assistance or prompts", "[Name] is independent with mobility" and "Staff are to assist with hand washing and prompt [name] wash hands after using the toilet." A person who used the service told us, ""There was a time when I couldn't walk and staff persevered and encouraged me to walk again." Another person told us, "I do a lot for myself but get support with my wheelchair." Another person said, "The staff promote independence but know I need support."

We saw a copy of an email from a family member that stated, "When my [relative] went into Picktree Court she couldn't stand or walk and required a wheelchair due to being in hospital for ten weeks. After lots of encouragement and TLC, she soon managed to walk unaided. I feel Picktree Court was definitely the correct choice for a care home to meet my [relative]'s needs and requirements." A letter from another family member also praised the service for the way they enabled their relative to regain their independence despite their age and fragility. The family member stated, "I have nothing but praise for the way they [Picktree Court] dealt with her rehabilitation after a broken hip at the age of 96. She is back up and walking without assistance!" This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Communication support plans were in place that described the support people required with communication. For example, one person had communication difficulties due to being hard of hearing and having dementia. Their support plan described how they communicated and what method of communication worked best for them. Staff were directed to speak loudly in the person's ear, point to things and use hand gestures. The person was unable to use the nurse alarm call system so a plan was in place specifically for this. This included visual checks every hour, all items the person needed were to be placed within reach (including walking aids), repeat falls were to be reported to the registered manager and it was discussed with the person regarding leaving their bedroom door open so they could be monitored more closely.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it

could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us none of the people using the service at the time of our inspection had independent advocates. However, advocacy information was made available for people should they require it.

Good

Is the service responsive?

Our findings

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. People told us how these had been written in consultation with themselves and their family members. One person told us, "Staff will listen to me when they are not busy and they involve my daughter in my care." Another person told us, "Staff listen to me and involve me in my care, and they are lovely to my family." Family members also told us they were involved in planning their relatives care.

Care records were regularly reviewed and evaluated. Each person's care record included important information about the person, such as life history, important relationships, and likes and dislikes.

Support plans were in place for people and included eating and drinking, sleeping, mental capacity, toilet care, personal hygiene, moving and handling, social contact and activities, end of life, pressure care, and pain relief. These described people's individual needs in a specific area and what action staff were to take to support the person. For example, support required with personal care or accessing the toilet. All the care records we viewed were up to date and staff coming on to duty were provided with a verbal handover.

The registered manager told us none of the people using the service at the time of our inspection visit were receiving end of life care. However, people had end of life care plans in place, which described people's preferences for their end of life care. For example, whether they had made any advance decisions, preferred funeral director, whether they preferred to be buried or cremated, any religious preferences, whether they wanted family to be present and whether they wished to remain at the home or go to hospital. The provider told us staff had received end of life training in the past from palliative care specialists at a local hospice and we saw an email confirming this arrangement. We saw a copy of a letter from a family member that stated, "We are very thankful that for the last two weeks of her life, she was treated with understanding and respect." A letter from another family member stated, "Thanks to [staff member] for the compassion on the day mam passed away, we were very grateful." The provider told us a representative from the home attended the funeral of every person who used the service. We saw a copy of a letter from the family members of one person thanking the management team for attending the funeral.

We found the provider protected people from social isolation. We spoke with the activities coordinator who told us people's preference with regard to social activities were discussed at one to one meetings and added to their individual activities planners. They told us people enjoyed going out into the garden, particularly in the summer months, and they had linked with a local garden centre to get plants and flowers, and people enjoyed planting them. Two people told us they enjoyed the garden and received support in this regard. A family member told us their relative liked to be outside and staff supported them when they went outside to have a cigarette. A local supermarket also provided free out of date flowers to the home on a weekly basis. They told us they had raised funds for the home at another local supermarket and employed external singers and entertainers at least once per month. People had access to satellite television and broadband Internet in their bedrooms.

People's individual monthly planners and daily activity logs recorded activities they had taken part in. For example, bingo, parties, one to ones, listening to visiting entertainers, choirs and organists, and board games. For people with nursing care needs who could not leave their bedrooms, visiting entertainers played in the corridors on each floor so everyone could hear them and visiting school and nursery children were taken into people's bedrooms. During our visit we observed local nursery school children in the ground floor lounge. We also observed people attending a bingo session. It was well attended and people seemed to be enjoying themselves. Care staff were present and helped some of the people to mark their bingo cards.

The activities coordinator told us they used an online social media group to discuss activities and identify best practice. A family member told us, "There are good opportunities for social interaction, with lots of interesting events organised." People had been given the opportunity to take part in a 'Making memories' project led by the local council and historical society. The aim of the project was to help people with dementia by improving concentration, cognition and memory through creative activities and using historical resources. The project took place over 10 weeks with nine people taking part. The activities coordinator stated that the sessions had been beneficial to people and had initiated communication between people about memories from their childhood and their past. The activities coordinator stated that people really enjoyed the sessions and they planned to implement some of the activities and ideas with other people at the home.

Another project involved secondary school pupils attending the home and creating personal biographies about the people who used the service. This involved the pupils spending one to one time with people in order to find out about their histories and interests.

Copies of the provider's complaints policy and procedure were displayed around the home. This described the procedure for making a complaint and how long it would take for a complaint to be responded to. The last recorded formal complaint at the home was in June 2016. People and family members we spoke with were aware of the complaints procedure and who to contact if they had a complaint. A person told us, "[Registered manager] always reminds you how to make a complaint." Another told us, "Staff are receptive and they want to know if something is wrong so they can put it right." Two people we spoke with, who had made a complaint in the past, told us they were happy with how their complaints had been resolved.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since May 2011. We spoke with the provider and registered manager about what was good about their service and any improvements they intended to make in the next 12 months. The provider told us they had recently promoted a nurse to the management team in the role of 'Care delivery manager'. The provider told us the post was a "hands on" management role that included supporting and mentoring the senior care staff. The provider told us investing in a larger management team had led to a higher retention of staff and reduced sickness levels. They showed us a report which showed that employee retention in 2017 had increased on the previous two years.

The provider told us they had secured the 'Investors in people' standard. The Standard defines what it takes to lead, support and manage people well for sustainable results. The service worked well with other organisations. The provider was the chair of the local care home association. The provider told us the association shared best practice, innovation and improvement across the care sector. The service had good links with the local GP practice and multi-disciplinary team. The registered manager told us they had worked with the company supplying the electronic medicine system by helping them to identify and feedback any issues with the product. The provider told us the service had been approved by a local university to bring nursing students to the home. We contacted the university who confirmed this had been in place for two years and they had received positive feedback from the nursing students placed at the home.

The service had good links with the local community. These included local schools, nursery school, church and choir, and pets as therapy who all visited the home. People who used the service visited a local pub for evening entertainment.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

People and family members we spoke with were positive about the management and atmosphere in the home. A person told us, "[Registered manager] is very nice." Another told us, "Staff are happy in their work and I have never heard them calling each other." A family member told us, "I have found the management of the home to be outstanding. The [management] consistently strive for the highest possible standards and are always available for a chat so that any minor issues can be dealt with swiftly and efficiently." Another told us, "The atmosphere is absolutely wonderful."

Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place regularly on each floor of the home. We saw the minutes of the most recent meeting in October 2017 included discussions on the new electronic medicines system, the role of the carer, safeguarding and results of the recent staff survey.

Staff we spoke with felt supported by the management team. A staff member told us, "Honestly, I can't fault [registered manager]." Another told us, "We get plenty of support" and "Work as a team." Another told us, "They [management] are very supportive, you only have to ask if you need anything."

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

We saw the results of the recent staff survey, which asked questions on the quality of the premises, friendliness of staff, training, meals, personal care, laundry, social activities, infection control and security. The majority of the responses were positive, however, where there were any negative comments the provider had provided a response to show they had listened. For example, one member of staff had said, "The day shift expect everybody up in the morning." The provider had responded by saying, "The home operates a raising/retiring schedule that is worked out on the residents' wishes."

The provider carried out staff exit questionnaires, which meant they could obtain feedback from staff leaving the service. This provider told us this practice had led to improvements being implemented within daily practice. For example, better inductions, the new post of care delivery manager, and moving and handling constraints. We saw evidence from the provider's HR department that these had been implemented.

Regular audits were carried out and included medicines, DoLS, care records, staff files, call bells, health and safety, and infection control/cleanliness related audits. Records we saw were up to date and where required, included a list of actions. For example, care plan audits were completed by the registered manager or deputy manager and then given back to the allocated nurse or senior staff to action, with a date for re-submission. Once all actions had been addressed, the completed audit was filed. If further work was required, it was given back to the allocated member of staff again until complete.

The registered manager had an audit matrix, which was used to ensure all audits had been carried out and were up to date.

The provider was based at the premises and conducted regular walkarounds of the home. Formal visits were recorded every six months and included interviews with staff and people who used the service, and inspection of the premises, a review of complaints, and a general report on the conduct of the home. We looked at the records for the previous four visits and found no actions were outstanding.

Meetings took place every six months where people who used the service and their family members met with the registered manager and activities staff to discuss any issues, concerns or suggestions for improvements to the service. People were asked to complete surveys every six months. These included questions on staffing, daily care, comfort and cleanliness, activities, laundry, meals, and privacy and independence. The majority of results were positive and where any issues had been identified, an action plan was in place. Positive comments about the service had also been posted on the NHS choices website feedback page. These included, "I can give nothing but five stars, more if I could to this wonderful care home", "I will always feel and know that I made the right decision in choosing Picktree Court for my mum to be cared for", "If you are looking for a Care Home for a loved one, look no further than Picktree Court. You won't be disappointed" and "Picktree Court Care Home is a fabulous example of what a care home should offer."

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.