Archmore Care Services Ltd

Birchwood Grove

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 5 December 2016 and was unannounced.

Birchwood Grove provides accommodation for up to 24 older people, some of whom are living with dementia and who may need support with their personal care needs. On the day of our inspection there were 24 people living at the home. The home is a large property, spread over two floors, with two communal lounges, a dining room and a garden. It is situated in Haywards Heath, West Sussex. The providers of Birchwood Grove also own another nursing home within West Sussex.

We carried out an unannounced comprehensive inspection on 19 and 20 October 2015. Areas in need of improvement were found, these included minimal activities and stimulation for people living with dementia, lack of detail in moving and positioning risk assessments, lack of risk assessments for people who were unable to use call bells and the lack of records when applying topical creams or assisting people to move and position frequently. A breach of a legal requirement was also found and following the inspection the provider wrote to us to say what they would do in relation to the concerns found. At the inspection on 5 December 2016 we found that significant improvements had been made in relation to these areas. However, despite this we found an area of practice that was in need of improvement.

There were concerns with regard to the management of medicines. Observations showed that some medicines were left unattended on top of the medicines cabinet. There was a risk that these could have been accessed by people for whom the medicines had not been prescribed. Some people required medicines on an 'as and when required' basis. There were insufficient protocols to follow which advised staff of when to administer the medicines, recommended doses and time frames for their use. Records showed that one person had been administered 'as and when required' medicines earlier on in the day. This had been recorded, however the person administering the medicines had not recorded the time the medicine was given and therefore there was a risk that the person might have been given more medicines than they should have had or that they had to wait unnecessarily until they received some more medicines.

People were protected from harm and abuse. There were good levels of appropriately skilled and experienced staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. People's freedom was not unnecessarily restricted and they were able to take risks in accordance with risk assessments that had been devised and implemented. People told us that they felt safe. A healthcare professional told us, "The environment appears to be safe when I visit, they have gates on stairs to prevent falls and the front door is coded and locked and closely monitored, I noted a particularly vulnerable person being monitored one to one by staff during a recent visit".

People were asked their consent before being supported and the registered manager had a good awareness of legislative requirements with regard to making decisions on behalf of people who lacked capacity. Care plans documented people's needs and wishes in relation to their social, emotional and health needs and these were reviewed and updated regularly to ensure that they were current. One relative told us, "The

family have been very involved in the care plan and have had three meetings over the course of time to discuss changes. The nurse keeps us informed about any changes".

Staff worked in accordance with people's wishes and people were treated with respect and dignity. It was apparent that staff knew people's needs and preferences well. Positive relationships had developed amongst people living at the home as well as with staff. One person told us "By nature they are lovely, I think they're excellent". Another person told us, "They're very nice, they're all different".

People's health needs were assessed and met by registered nurses who made referrals to external healthcare professionals when required. People's privacy and dignity was respected and maintained, observations showed staff discreetly supporting people with their personal care needs. People had a positive dining experience and told us that they were happy with the quantity, quality and choice of food. One person told us, "The grubs alright here".

The registered manager welcomed and encouraged feedback and used this to drive improvement and change. There were rigorous quality assurance processes in place to enable the provider and registered manager to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. People, relatives, staff and healthcare professionals were complimentary about the leadership and management of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

People received their medicines on time, these were dispensed by registered nurses and trained staff. There were safe systems in place for the disposal of medicines. However, there were concerns regarding the administration management of medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks and maintain their independence.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Good

The home was effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and had worked in accordance with this.

People were happy with the food provided and were able to choose what they had to eat and drink. However, people's dining experience was poor.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This extended to people when they were at the end of their lives and people were able to plan for good end of life care.

Is the service responsive?

Good

The home was responsive.

Care was personalised and tailored to people's individual needs and preferences.

People had access to a range of activities to meet their individual needs and interests.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals' and their opinions and wishes were taken into consideration in relation to the running of the home.

Birchwood Grove

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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 5 December 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home was last inspected in October 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect of mental capacity assessments and people, who were legally unable to, signing documents on people's behalves. The home received an overall rating of 'Requires Improvement', and after our inspection on 19 and 20 October 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

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Prior to the inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to the inspection included previous inspection reports and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 11 people, three relatives, four members of staff and the two providers, one of which is also the registered manager of the home. After the inspection we liaised with two healthcare professionals to gain their feedback. A majority of people had limited or no verbal communication and were unable to speak to us. Therefore 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. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for seven people, medicine administration records (MAR), five staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care

and support in the communal lounge and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 19 and 20 October 2015, there were concerns regarding the lack of recording to document that people had received care. This related to people, who were at risk of pressure damage, not being regularly assisted to move and position to reduce the risk of developing pressure damage or worsening any pressure damage that they had. Other concerns related to the recording of the application of topical creams, the lack of detail in moving and positioning records to state the type of moving and handling equipment that needed to be used and records to confirm that people, who were unable to use call bells due to their cognitive abilities, had been regularly checked by staff. At this inspection it was evident that improvements had been made. Records showed that there were detailed moving and positioning risk assessments in place that clearly documented the type of hoist, sling and straps that needed to be used by staff to ensure people's safety when being assisted with moving and positioning. Records, to document the application of topical creams, frequent checks to ensure people's safety and the regular repositioning of people who had pressure damage or were at risk of it, had been implemented and embedded in practice. However we found an area of practice that was in need of improvement.

People, who were able, were encouraged to continue to self-administer certain medicines and risk assessments were in place to ensure people's safety in relation to this. People were assisted to take their medicines by registered nurses and trained staff, who had their competency regularly assessed. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person was assisted to take their medicine on a spoon as this was the person's preferred way of having their medicine. Observations showed that people were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Some people were supported to have their medicines covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example, hidden in their food or drink. There were safe and appropriate protocols in place for the safe administration of covert medicines and relevant healthcare professionals had been involved in the decision making process to ensure it was in the person's best interests. Most people were happy with the support they received with their medicines.

Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines, these records should be completed correctly to confirm that medicines are administered appropriately and on time. However, these records showed that there were inconsistencies in the recording of medicines administration. On some occasions staff had used the incorrect code on the MARs, this could have potentially led to confusion as rather than using a code for the medicines not being required they had used a code to indicate that the person was experiencing nausea. Gaps in MARs raised concerns with regard to people's access to medicines. For example, on the day of the inspection one person needed to have their dressing changed and another required their pain relief patch to be replaced. When this was raised with the registered manager and nursing staff they explained that although the MAR indicated that these needed to be changed and replaced at a certain time, that this was not the case and that both the dressing and the pain relief patch would be changed that day. Observations of medicines

administration showed that some medicines were left on top of the medicines trolley, unattended, whilst the registered nurse collected fresh water for people to take their medicines. This raised concerns regarding the security of the medicines and there was a potential risk that people, for whom the medicines were not prescribed, could have access to them.

Records in relation to the administration of certain medicines were not always in place. People had been prescribed medicines that they could take as and when they required them. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in people's care plans. Although the registered manager had a medicines policy that included these guidelines, there were no guidelines that related to individual people for staff to follow in relation to 'as and when required' medicines. Observations showed that one person had been given 'as and when required' pain relief by another member of staff, earlier on in the day. Although the member of staff had recorded the administration of the medicines they had not recorded the time that it had been given. This could have potentially meant that the person could have been given more medicine that the recommended dose within the timeframe or that the person would have to wait unnecessarily for their medicines. The lack of 'as and when required' guidance was raised with the registered manager and registered nurses who explained that there would usually be only one member of nursing staff administering medicines for the duration of the day and that this would not usually occur, but this had changed due to the inspection taking place. One person who was prescribed 'as and when required' medicines was unable to indicate to staff when they might require these medicines. Staff told us that they would be able to notice if there were changes in the person's condition and discuss this as a team and a decision would be made as to whether the person required their 'as and when required' medicines. However, staff were not provided with clear guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way. The management of medicines is an area of practice in need of improvement.

People and relatives told us that the home was a safe place to live, that there were enough staff to meet people's care and support needs and that people received support promptly. Observations demonstrated that people felt at ease and were reassured by staff when being supported. A healthcare professional told us, "The environment appears to be safe when I visit, they have gates on stairs to prevent falls and the front door is coded and locked and closely monitored, I have noted a particularly vulnerable person being monitored one to one by staff during a recent visit".

People were cared for by staff that the registered manager had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed, and their employment history gained. In addition to this their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses all had current registrations with the Nursing and Midwifery Council (NMC).

Sufficient numbers of staff ensured that people were safe and well cared for. The provider used a dependency tool to assess the required staffing levels to meet people's needs. Each month people's individual care and support needs were assessed and this was used to inform the staffing levels, which could be adapted if people's needs changed. Records and staff confirmed that since the previous inspection on 19

and 20 October 2015, the staffing levels had increased during the afternoons. When asked if there was a reason for this the provider explained that this was increased to improve the quality of care provided to people as it enabled there to be more staff to meet people's needs. People, relatives and staff told us that there were sufficient staff and that when people required assistance staff responded in a timely manner, our observations confirmed this. A relative told us, "There is always staff around, I can always find someone".

Some people, due to their cognitive abilities, were unable to use their call bells. The registered manager had ensured that measures had been taken to assess the risk of people being unable to use their call bells and had ensured that regular checks were made to ensure people's safety and well-being.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us, "I would report it to the nurses, managers or CQC". There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to people and staff and they were aware of how to raise concerns regarding people's safety and well-being. Observations showed one person reading a leaflet that had been displayed advising people of how to raise concerns. A whistleblowing policy enables staff to raise concerns about a wrongdoing in their workplace.

People's freedom was not unlawfully restricted and they were able to take risks. Observations showed some people independently walking around the home. People's needs had been assessed and risk assessments were devised and implemented to ensure their safety. For example, care plan records and risk assessments for one person, who smoked, showed that the registered manager had considered the risks to the person as well as other people. An agreement between the registered manager and the person had been made and a risk assessment devised. It was agreed that the person would go into the garden to smoke.

Accidents and incidents that had occurred were recorded and analysed to identify the cause of the accident and determine if any further action was needed to minimise the risk of it occurring again. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan. The provider and registered manager had a maintenance plan to ensure that the home was continually refurbished and safe and pleasant for people to use.

Good

Is the service effective?

Our findings

At the previous inspection on 19 and 20 October 2015, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns regarding mental capacity assessments being generic and not decision specific, the lack of mental capacity assessments when certain restrictive practices, such as the use of lap belts and bed rails were used and people, who were legally unable to make decisions signing documents giving consent on people's behalves. After the inspection, the registered manager informed us of what they would do to meet the legal requirements in relation to this regulation. At this inspection it was evident that improvements had been made and the registered manager was meeting the legal requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered manager was working within the principles of the MCA. People were asked their consent, for day to day decisions such as what they'd like to eat and drink. For more complex decisions, mental capacity assessments had been undertaken to identify if people lacked capacity to make specific decisions, these included the use of bed rails and lap belts. When people had been assessed as not having capacity to make particular decisions, best interest decisions, involving relevant professionals, people's relatives and staff had taken place, to ensure that decisions that were made were in the person's best interest. A healthcare professional told us, "Consent is always obtained from the person, even if they have poor capacity. When I am visiting staff ask the person if they would like a member of staff to stay during my visit".

We checked whether people, who had been assessed as lacking capacity to make certain decisions, were being lawfully deprived of their liberty. The registered manager had a good understanding of DoLS and had worked in accordance with this. Appropriate applications to the local authority to deprive people of their liberty had been made. Four people had DoLS authorisations in place and we checked whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that the registered manager and staff had worked in accordance with the conditions on people's DoLS. For example, conditions for one person, who was unable to leave the building without support from staff, stated that the person should be regularly reassessed, have their social needs met by undertaking activities with the activities coordinator and enjoying conversations with staff and having access to a religious leader to meet their religious needs. The person, staff and records confirmed that this had been implemented in practice.

People, relatives and healthcare professionals told us that they felt that staff had appropriate and relevant

skills to meet people's needs. The registered manager ensured that there was a commitment to learning and development from the start of people's employment. Staff that were new to the home were supported to undertake an induction which consisted of familiarising themselves with the provider's policies and procedures, orientation of the home, as well as an awareness of the expectations of their role and the completion of the care certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers.

Staff had completed training which the registered manager considered essential. In addition they had undertaken training that was specific to the needs of people. For example, dementia awareness. Registered nurses ensured that their practice was current, they completed essential training as well as courses such as wound management and were registered with the Nursing and Midwifery Council (NMC). There were links with external organisations to provide additional learning and development for staff, such as the dementia in-reach and living well with dementia teams. These teams provide advice, training and information for care homes that provide care to people living with dementia. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us, "It's very helpful, we learn new approaches, new techniques, it makes us understand". Some staff had completed diplomas in health and social care. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss their needs and any concerns they had. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions and appraisals helpful and supportive, however, explained that they could also approach the registered manager at any time if they had any questions or concerns. One member of staff told us "We have supervision quite regularly and you can go in and talk about your concerns and they can inform you of any concerns they have about your role. They are always approachable".

People's communication needs were assessed and met. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. For example, when supporting a person who had a cognitive impairment staff gently touched the person's hand to reassure them whilst they communicated with them. Other people used comfort blankets that they could touch to meet their sensory needs. One person wore glasses, a member of staff noticed that these needed cleaning so asked the person if they would mind if they cleaned them for them. Communication between staff was also effective. Regular team meetings, as well as detailed care plans, ensured that staff were provided with up to date information to enable them to carry out their roles.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, opticians, speech and language therapists (SALT) and tissue viability nurses (TVN). There was a weekly doctor's surgery enabling people to see the GP if required. Staff told us that they knew people well and were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. An abbey pain scale was used for people who were unable to express themselves verbally. The Abbey Pain Scale is designed to assist in the assessment of pain for people who are unable to clearly articulate their needs.

People's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had pressure wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended, photographs of wounds had been taken to monitor their improvement or deterioration. There were mechanisms in place to ensure that people at risk of developing

pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses, which were regularly checked to ensure they were at the correct setting.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed each month, to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP and SALT. Advice and guidance provided by the GP and SALT had been followed, for example for one person who was at risk of malnutrition and who had lost a considerable amount of weight it had been advised that the person had food that was fortified with products such as cream, cheese and milk to increase their calorie intake and that their food and fluid intake should be monitored, observations confirmed that this had been implemented in practice.

People had a positive dining experience and told us that they enjoyed the food and had a choice of menu each day. Observations showed one person choosing an alternative to the two main meal choices and this was respected and the person was given a meal of their choice. The person told us, "The grub is alright here". People ate their meals in the dining room, or in their own rooms, dependent on their preferences and care needs. The dining room created a pleasant environment for people, tables were laid with tablecloths, placemats and vases of flowers and menus displaying the variety of drinks people could choose and the available menu choices that day were displayed. People, who required assistance when eating and drinking, were sensitively and discreetly supported by staff, who sat alongside people, explaining to the person what they were about to eat and ensuring that they were ready to be assisted.

Good

Is the service caring?

Our findings

There was a friendly, homely and relaxed atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that people were well cared for. One person told us "By nature they are lovely, I think they're excellent". Another person told us, "They're very nice, they're all different".

Observations of staff's interactions showed them to be kind and caring. One person was walking around the home, showing signs of apparent anxiety. A member of staff asked the person if they were okay and if they would like to sit and look at a newspaper, the person did and this appeared to calm them. Other observations showed staff taking time to explain their actions, offer reassurance and ensure people were comfortable and content. People were treated with respect and were able to independently choose how they spent their time. They were cared for by staff that knew them and their needs well. People were encouraged to maintain relationships with their family and friends and received visits throughout the day. People appeared to enjoy interacting with staff and it was apparent that caring relationships had been developed. One member of staff, who was assisting a person in their room, was overheard saying, "Would you like me to comb your hair", "How would you like it"? "Tell me if it hurts", "What cardigan would you like to wear"?

People's privacy was respected. Information held about people was kept confidential as records were stored in offices to ensure confidentiality was maintained. Staff showed a good understanding of the importance of privacy and dignity and how this should be maintained. People confirmed that they felt that staff respected their privacy and dignity. Observations further confirmed this, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

People were involved in their care. Records showed that people and their relatives had been asked people's preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt fully involved in the delivery of care and could approach staff if they had any questions or queries relating to it. Observations showed that relatives were involved in their loved ones care. They were observed talking with staff about the care their relative had received. Residents' and relatives' meetings provided people with an opportunity to be kept informed and to raise any concerns or suggestions that they had. Staff told us that people used these meetings to make their thoughts known and records confirmed this. Records of a recent resident's meeting showed that people had been consulted about the planned extension of the home and had made suggestions about activities they would like to take part in. Observations further confirmed that people were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff took time to talk, explain information and listen to their needs. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives or independent mental

capacity advocates (IMCA) when appropriate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People received good end of life care. A healthcare professional told us, "I am contacted very early on if they are beginning to note any deterioration towards end of life with people and if staff require end of life care advice for a person not known to me they contact the GP quickly and request referral to our services". They went on to say, "They have supported many people at end of life, often with input and advice from myself. They are keen for people to remain with them for end of life care as it is their home now and the staff know them and their families well. This is what I promote and advise on, this is a refreshing approach". Registered nurses had received end of life care training from a local hospice and shared their knowledge with other members of staff. People were able to remain at the home and were supported until the end of their lives. According to the Social Care Institute for Excellence (SCIE) people with dementia should be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advise that providers of homes also need to ensure that they are prepared for situations and do their best to ensure that they know, document and meet the person's wishes at the end of their life. Records showed that people's end of life care had been discussed and advance care plans devised. These contained details of people's preferences with regard to their spirituality, preferred place of care and who they wanted with them at the end of their lives. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. Feedback from a relative regarding their loved one's care stated, "I would like to thank you for the care and attention you gave to my relative in the final two years and four months of their life. The medical attention was exemplary and for that I am truly grateful".

Good

Is the service responsive?

Our findings

At the previous inspection on 19 and 20 October 2015, there were concerns regarding the lack of activities, stimulation and opportunities for social engagement for people. Improvements had been made in relation to the provision of activities.

The provider had employed an activities coordinator who had worked at the home for many years as a member of care staff. It was evident that they knew people well and positive interactions were observed. The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people and taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Observations showed one person assisting staff to deliver the mail to certain members of staff and set the tables with napkins ready for the lunchtime meal. The person clearly enjoyed these activities. Records showed that people had taken part in activities such as chair aerobics, craft activities, quizzes, bingo and film afternoons. Observations showed several people enjoyed making Christmas paper chains which enabled staff and people to reminisce about their Christmases when they were younger. Photographs showing people taking part in activities such as baking were shown to people and people were clearly entertained by this, smiling and laughing at themselves in the photographs.

A daily reminiscence newspaper had been introduced. This was called 'The Daily Sparkle' and was provided by an external organisation. These newspapers were provided each day and provided articles that would have been in the news on the same day in years past. There were also quizzes, puzzles, sing-alongs and entertainment to provide opportunities for reminiscence. Staff told us that these were sometimes used to engage in conversations with people. Records further confirmed their use. For people who spent time in their rooms or who preferred more one to one time with staff, innovative activities had been introduced such as using I-pads and laptop computers to take to people to watch their favourite sport or programmes. Other sedentary activities such as looking at books and listening to music were also used to enable people, who were less able to engage in more active activities to be stimulated and entertained.

People's social, physical, emotional, and health needs were assessed when they first moved into the home and care plans had been devised. These were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. A healthcare professional told us, "Overall, I feel Birchwood Grove provides good person centred care and they are willing to call for professional advice in any areas that are beyond their expertise". Life histories had been completed detailing information about where people had lived, their families and hobbies. Staff told us that they found the information useful as it provided them with an insight into the person's life before they moved into the home. Records showed, and people and relatives confirmed, that they had been involved in the development and review of the care plans. Reviews had identified changes in people's needs and practice was adapted accordingly. For example, a review for one person showed that the person had lost a considerable amount of weight during the month. Action to ensure the person's well-being was taken such as contacting their GP for advice and guidance. A relative told us, "The family have been very involved in the care plan and have had three meetings over the course of time to discuss changes. The nurse keeps us informed about any changes".

People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what time they wanted to get up, what clothes they wanted to wear, what they had to eat and drink and what they needed support with. One member of staff told us, "If they want an extra hour in bed, that's fine, it's their choice". People were happy with their rooms and were able to furnish them according to their tastes and display their own ornaments and photographs. One person told us, "I'm quite content here, my bedroom is lovely, I have my radio beside my bed and I can listen to my favourite classical music".

There was a complaints policy in place, this was clearly displayed in resident's handbooks and on notice boards for people to see. There had been no formal complaints made since the previous inspection. The registered manager encouraged feedback from people and their relatives. There were suggestion boxes for people and relatives to use and leaflets provided information as to how they could make comments about the home on external websites and with external parties. People and relatives told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager, who was always approachable and listened to their concerns or suggestions. A relative told us, "My relative is better here than in the previous home, the carers are nice and we've never felt the need to complain".

Good

Is the service well-led?

Our findings

People, relatives, staff and healthcare professionals were complimentary about the leadership and management of the home. They told us that they were encouraged to make their feelings known, that the management team was friendly, approachable and listened to and acted upon their comments and suggestions.

Two providers owned Birchwood Grove, as well as another nursing home in West Sussex. The management team consisted of the two providers, one of which was the registered manager and a deputy manager. The provider had a mission statement, which stated, 'It is the objective of the home that all residents shall live in comfortable, happy and safe surroundings, to be treated with respect and sensitivity to their individual needs and abilities. We want our residents care to have a person-centred approach. It was evident that this was embedded in the culture and implemented in practice. The home had a homely, friendly and warm feeling. People appeared happy and looked well cared for. One person told us that they had looked at other care homes and they felt that the home was, "small and homely".

Feedback from people, relatives, staff and healthcare professionals as well as our observations, showed that there was good leadership and that the home was well-managed. A healthcare professional told us, "The management team are very engaged and keen to improve where required and welcome new initiatives. There appears to be a continual drive to improve the service". There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting people's needs. There were mechanisms in place to obtain feedback from people and relatives. Part of the provider's and registered manager's quality monitoring included a monthly management record, which audited and analysed the systems and processes used within the home to provide them with oversight. This ensured that people were receiving the quality of service they had a right to expect. The registered manager had used learning from other homes within the local area to improve the systems that were in place within the home. For example, following an incident in relation to the application of paraffin based creams they had devised risk assessments for their use.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, the dementia in-reach team, living well with dementia team, local hospices and other healthcare professionals. The management team attended manager forums to ensure that people's needs were met and that the staff team were following best practice guidance. The providers had accreditation with 'Making it Real', this is a national initiative and includes a set of statements from people who use care and support stating what they would expect, see and experience. They act as indicators to inform organisations of how they are performing in relation to the delivery of good quality care. The providers had also signed up for the 'Social Care Commitment'. This is the adult social cares promise to provide people who need care and support with high quality services. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.