The Orders Of St. John Care Trust

Windsor Street Care Centre

Inspection report

35-37 Windsor Street
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 and 12 March 2018 and it was unannounced. At our previous inspection on 1 and 2 December 2016 we rated the service 'Requires Improvement' overall.
Following the last inspection we asked the provider to complete an action plan to show what they would do to ensure people's care records were maintained accurately. The provider told us the improvements would be made by 30 September 2017. During this inspection we found people's care records had been maintained and they contained accurate information about people's care.

Improvements had also been made to staff recruitment, staffing numbers, and staff skills, which had improved how people were kept safe and supported. Changes in the management of the home had improved the overall governance of the service and resulted in positive results for people who lived in the home and the staff who worked there. This action and the improvements completed support the service's overall rating of 'Good' awarded at this inspection.

Windsor Street Care Centre is a purpose built '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.

People, relatives and staff referred to the home as 'Windsor Street' so this has been done in this report. Windsor Street specialises in the care of those who live with dementia, but also provides nursing care to some people. There were four beds commissioned by the NHS, these were called 'safe haven' beds. These were used for people who required a short admission; either after a stay in hospital or to avoid a hospital admission. Referrals for these beds were made by people's GPs. People's medical care was temporarily handed over to the GP who attended Windsor Street. Once discharged, people's medical care was transferred back to their own GP. In total 81 people can be accommodated in one adapted building. At the time of this inspection 63 people were receiving care.

People lived on 5 units referred to as 'households'. Four households provided care to people who lived with dementia; one of these provided nursing dementia care. A fifth household also provided nursing care. Single bedrooms with private toilet and washing facilities were provided. Each household had a lounge, dining/kitchen area and additional adapted toilets and bathrooms. A passenger lift helped with access to upper floors. There was a secure, large garden and balconies for outside use. Car parking was available. The home had wheelchair access.

The home had a registered manager in post who had managed the home since May 2017. Previous to this they had been the home's deputy manager and dementia care lead. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Arrangements were in place to keep people safe and to protect them from abuse and discrimination. Improvements had been made to how the home was staffed. Staff had been recruited safely, providing the home with enough staff with the right skills, knowledge, experience and commitment. People lived in a clean home where good infection control measures reduced the risk of infection. The staff had support from the home's visiting GP, which meant people's health needs and medicines were reviewed and managed well.

Staff were trained and well supported. Robust assessment of people needs meant these were well identified and understood by the staff. Frequent reviews of people's needs and their abilities meant staff were quick at identifying changes and deterioration in people. People and where appropriate their representatives, were involved in reviewing the care delivered.

People were supported to have a voice. People who lacked mental capacity had decisions made on their behalf but, in their best interests and lawfully. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies, systems in the home and staff training supported this practice. Staff ensured people had enough food and drink. All risks relating to people's ability to maintain their nutritional wellbeing were identified and addressed.

Staff were caring and compassionate. People were treated with respect, dignity and their rights were upheld. Staff treated people equally, as individuals and differences were respected and celebrated. Care was planned around people's diverse needs, their likes, preferences and wishes.
The home did particularly well at meeting many different and diverse needs in a personalised way.

People were supported to take part in social activities which meant something to them and which they enjoyed. Activities which promoted a healthier life were also provided, for example, singing for the brain, yoga and physical exercises. People at the end of their life were supported to have a dignified and comfortable death. Relatives were able to visit freely and to remain with a relative who was dying. Relatives were encouraged and provided with support to be part of the Windsor Street 'family'. They were valued and positive input was seen as integral to people's ability to live well with dementia.

The home benefited from strong leadership. The registered manager was supported by their deputy and senior staff team. Since the registered manager had been managing the home there had been a focus on changing the staff culture. The registered manager had made their expectations clear, as well as their vision for the home and the values they wanted to see followed. All the staff we therefore spoke with put people at the centre of what they did. They were committed to improving people's wellbeing and quality of life.

The registered manager was approachable and transparent in how they managed situations, incidents and complaints. They expected their staff to work likewise. They met on a regular basis with people, relatives and all grades of staff. Both managers welcomed feedback and used this to help them improve the service.

Managers used the provider's quality monitoring processes to ensure the home remained compliant with necessary regulations and legislation. Actions necessary to make improvements were carried out and followed up by the provider to ensure these were fully completed. There was a strong desire to further improve the services provided to people and to become a centre of excellence.

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.

There were enough staff, in number, to support people's individual needs. Recruitment practices were robust which helped to protect people.

Risks were assessed and managed in order to reduce harm to people, visitors and staff. People were protected from the risk of abuse and discrimination.

People's medicines were managed safely and they had access to medicines which had been prescribed for them.

People lived in a clean home where control measures helped to reduce the risk of infection.

Is the service effective?

Good

The service was effective.

People's needs were assessed. Support and access to other professionals helped to maintain people's health and nutritional wellbeing.

Consent was sought from those who could provide this and people were supported to make independent decisions. The principles of the Mental Capacity Act were followed in order to protect those who could not make independent decisions or give consent.

Staff received training and support which enabled them to care for people safely and appropriately.

Adaptations had been made to the environment, both internally and externally, to accommodate people's needs and make it easier for people to use.

Is the service caring?

Good

The service was caring.

People were cared for in an understanding, caring and compassionate way.

Staff helped people feel included by adapting how they communicated with people. Relatives were welcomed and also supported to be involved.

People and staffs' diverse needs and differences were accepted, respected and celebrated.

Information was made available for people in formats which met their needs. Personal and confidential information about people and staff was kept secure.

Is the service responsive?

Good

The service was responsive.

People's support was planned and delivered to meet their care and social needs. Some further improvements were being made to some care records to ensure they fully captured a record of people's care and treatment.

There were arrangements in place so that people could make a complaint or raise dissatisfaction. When raised these were fully investigated and addressed.

People at the end of their life received care which supported a dignified and comfortable death.

Is the service well-led?

Good

The service was well led.

There was strong leadership in place. This had resulted in improvements to how people were cared for and how staff performed and worked together.

There was evidence of an open, transparent, inclusive and empowering culture. The provider's policies and procedures promoted and supported this.

The home was managed in such a way which, ensured staff were clear of their responsibilities, performance expectations and regulatory requirements.

The provider's quality monitoring systems ensured necessary regulations were met and that actions for improvement, were carried out and completed. There was a strong desire to improve

the service further for those who used it.

Windsor Street Care Centre

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 10 and 12 March 2018 and was unannounced. One inspector visited the home on 10 March 2018 and two inspectors and an expert by experience visited the home on 12 March 2018. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person who has experience of caring for older relatives who lived the dementia.

Before the inspection visit we reviewed all the information we held about the home since the last inspection in December 2016. This included all statutory notifications and the Provider Information Return (PIR). Statutory notifications must, by law, be sent to us by the provider. These inform us of important and significant events which have happened in the home. We used information the provider sent us in the PIR to help plan the inspection. This is information we require providers to send us at least once annually, to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who used the service and four relatives about their experience. We spoke with 10 staff about their roles and responsibilities and people's care and treatment. This included day and night nurses, team leaders, care staff, an activities co-ordinator, the chef and the maintenance person. We also spoke with the registered manager, deputy manager and one of the provider's operational managers. We sought the views of one visiting health care professional.

We reviewed records relating to the Mental Capacity Act 2005 for nine people. We case tracked six people's care, which included a review of all care plans, risk assessments and other care records for these people. We inspected four staff recruitment files, the home's training record and planner for all one to one staff support conversations. We read the minutes of some staff meetings. We reviewed audits, which included those for accidents and incidents, infection control, medicines, health and safety, care planning and catering services.

We reviewed all records completed and held by the maintenance person and those relating to complaints received. We visited all five households and attended one staff hand-over meeting.

Good

Is the service safe?

Our findings

At the last inspection on 1 and 2 December 2016 we recommended the provider review the staffing needs of the home to ensure people's nursing needs were fully met. Following our inspection, managers had reviewed how the 'safe haven' beds in the home were used. These were used for people who required a short admission; either after a stay in hospital or to avoid a hospital admission. The level of people's needs admitted to these beds had been reviewed with commissioners and altered. For example, people who had nursing needs were no longer admitted to these beds which reduced the demands placed on nursing staff. The registered manager had also successfully recruited more staff, including nurses and a deputy manager.

The deputy manager had been appointed in November 2017 and was a registered nurse. They had overall responsibility for all nursing care in the home. Since their appointment, nurses had been better supported to lead their staff on the nursing units. The work of the care staff, on the nursing units and other units, had been better organised in order to meet the needs of the home. Overall staffing numbers had increased. New and additional staff had been employed to replace staff who had left and to enable better cover for when staff took annual leave, sick leave and attended training. The registered manager told us, the home did not work with minimum staffing numbers. For example, some people required one to one support, which was organised, in addition to the normal staffing numbers. At the time of the inspection one agency member of staff was providing this. They were used on a regular basis so knew the needs of this person well. This showed the managers adjusted the staffing numbers according to people's needs. Equally so, bed vacancies were also accounted for when adjusting staffing numbers.

People told us there were enough staff available when they needed them. One person told us, "….. they're pretty good at getting here quickly." The registered manager monitored staff response times to people's call bells in order to ensure people remained safe. They followed up the reasons why a call bell may not have been responded to within a reasonable length of time. They told us response times had improved across the last year and they had been satisfied with their findings so far.

Staff on all five households confirmed there were enough staff on duty to meet people's needs. One member of staff said, "Staffing levels have improved" and another said, "There have been huge improvements; we have enough staff and better support." Another member of staff told us they specifically thought that the new system, at weekends, of making one senior member of staff overall in-charge, had worked. The member of staff in-charge was the contact point for all concerns and staffing issues during their shift. A consistently reliable weekend on-call rota for managers provided additional support to making sure the home remained staffed adequately at all times.

Staff recruitment files showed that robust recruitment procedures had been followed. This ensured people were protected from those who may not be suitable. The additional recruitment of staff had resulted in less dependency on agency staff. One person spoke about the staffing on their household. They said, "Well we don't see agency staff anymore, it was nearly all agency staff here a year ago." Another person also commented that agency staff were no longer used on their household.

Risks to people's health and wellbeing were identified, managed and reduced. Risk assessments recorded levels of risk and an associated care plans gave staff guidance on how these would be managed. Risks included, falls, development of pressure ulcers and nutrition. One person had experienced several falls, which had proved difficult for staff to prevent. The home's falls lead had analysed this person's falls history, looked for trends and patterns and provided advice. Adjustments had also been made to the support provided to this person. A falls audit showed that this person's falls had significantly reduced.

Risks associated with the safe moving and handling of people were assessed and arrangements put in place to address these. Staff were trained to adhere to safe ways of working, for example, when moving people with a hoist. Risks associated with falling out of bed were assessed and specialised equipment was used to prevent injury to people. For example, beds which almost lowered to the floor were used with padded floor mats [crash mats].

People lived in a clean environment where effective infection control measures helped reduce risks associated with cross contamination and the spread of infection. Risks associated with the environment were also assessed, managed and reduced. For example, fire and legionella risk assessments had been completed. Regular monitoring, maintenance and servicing of related equipment and systems helped reduce potential risks. We reviewed all maintenance records which showed safe ways of working were adhered to.

People's medicines were managed safely and in a way which reduced potential medicine errors. Medicines were stored safely and securely. We observed staff checking stocks of medicines to ensure these tallied with the stock recorded. Medicines were stored according to the manufactures' guidance. This ensured optimum effectiveness of the medicine. We reviewed monitoring records which showed these temperatures were checked on a daily basis.

People were protected from potential abuse and discrimination. Staff had received training on how to recognise abuse and potential discrimination. They knew how to report any concerns they may have. Senior staff shared relevant information with other agencies and professionals in order to safeguard people. The provider's policies and procedures worked in conjunction with the local authority's multi-disciplinary policies and procedures for protecting people. Staff were aware of the provider's whistle blowing procedures and had used these to report concerns about, for example, the behaviour, or attitude of a colleague or visiting professional. The provider's HR policies and procedures had been followed and disciplinary action had been taken where necessary. This helped managers to protect people from poor practice.

Good

Is the service effective?

Our findings

People told us they felt well cared for. They told us, by having been admitted for a short period of time or by living permanently at the home, this had improved their health and quality of life. One person told us how they had made a "proactive decision" to move into the home. They told us their health had been very poor beforehand and they were now "so much more well." In particular they told us how the chef had helped them "get their diet right." They said, "I couldn't have picked anywhere better." Another person said, "Yes, if I've got to be anywhere it's here, the staff are very nice, and they look after me very well." A third person said, "It has been really marvellous here. I've been in three or four places and this is the best."

People's needs were assessed prior to their admission. We reviewed pre-admission assessments which contained information about the person. Information had been sought from the person requiring care, where this had been possible, and from relatives and health and social care professionals. This helped managers decide if the person's needs could be met at Windsor Street.

We checked whether the service was working within the principles of the MCA and Deprivation of Liberty Safeguards (DoLS) when delivering people's care. 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. People can only be deprived of their liberty, so they can receive care and treatment, when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. Prior to admission, people's consent to live at the home had been obtained; this had been recorded. Where it had not been possible to obtain people's consent, the principles of the MCA had been applied.

The home had a member of staff who acted as the home's DoLS champion. They supported staff to appropriately submit DoLS applications to the supervisory body (the local authority). We saw evidence of this having been done, although in some cases, the supervisory body had yet to process these. We reviewed records relating to DoLS which had been authorised. We checked to see if any conditions were added and if they were met. One condition had been added for one person and this had been met. The DoLS champion also supported staff to appropriately record best interests decisions. They were aware of people's right to advocacy (support which enabled a person's voice to be heard, when the person lacked mental capacity and, when decisions were being made on their behalf).

The MCA 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 make particular decisions, any made on their behalf, must be in their best interests and be as least restrictive as possible. We found best interests decisions had been recorded. We also found people were supported to make independent decisions and care was delivered in the least restrictive way possible. In one person's case a best interests decision had been made to administer their medicines covertly (hidden in food or drink). Staff told us they supported this person to make an independent decision about taking their medicines before they resorted to covert administration. They confirmed this person was often able to do this.

People had access to healthcare professionals to ensure their health needs were reviewed and addressed. People's care records had recorded when health assessments and reviews had taken place. Healthcare professionals involved in these included, the home's GP, community nurses, mental health practitioners, physiotherapists, occupational therapists, speech and language therapists and dieticians where needed. People also had access to regular chiropody (foot-care), NHS eye and dental care. One person said, "Yes, my hearing aids broke, but within two weeks I had new ones fitted and yes, I see the GP, and that's once a week and more if I need it. I have seen the chiropodist, and the optician comes in. They [the staff] make my appointments at the hospital and they have never missed an appointment."

The home's GP visited for a day each week and as often as people needed them. Staff reported an exceptional level of support from this professional. The registered manager told us they were able to contact the GP at any time. They told us the GP often visited or reviewed people several times a week, when they were particularly poorly, to ensure they received the medical care they required. In one person's care notes there were entries which showed the GP had visited and reviewed the person's end of life needs numerous times to ensure they were kept comfortable.

People received support to maintain their nutritional wellbeing. Risks to people's ability to maintain their weight were identified, monitored and reduced where possible. Any concerns about people's weight or appetite were discussed with their GP. Some people were at risk of inhaling or choking on food or drink. Action had been taken to reduce the risk of this happening. For example, one person had been assessed as being at high risk of "aspirating" (accidentally inhaling food or fluid). A detailed care plan gave staff guidance on what type of food, fluid and support they required. Another document showed that the kitchen had been advised of this person's dietary needs on admission. We observed staff supporting this person to eat and drink. They were provided with pureed food and thickened fluids so they could swallow more easily. A weight chart and nutritional assessment tool showed the person had maintained a stable weight.

We visited three different units at mealtimes and on each unit a relaxed and enjoyable dining experience was promoted and observed. We observed people chatting with each other and staff helping them to make meal choices. Some people were able to refer to a pictorial table menu to help them remember what they had already chosen. Others were supported by staff who showed them two pre-plated meal options.

Comments about the food provided included, "It's as well as can be expected, and we get a good choice. I don't get hungry at night and if I did I could always have a sandwich and I always have a drink in my room". One person had specific dietary needs. They said, "I have [name of condition] and they cater for me here and they're very good. They do come to me and tell me what I can and can't have; there is always a good choice. I can honestly say I never get hungry at night, but if I did, I would always ask for something." One relative said, "Food is good six out of seven days." This relative told us their relative got a "good choice".

People's needs were met by staff who held the right qualifications, skills, knowledge and experience. All staff completed induction training and had to successfully complete a probationary period. During this time they were provided with training and mentorship which supported safe practice. We observed one new member of staff working alongside more experienced staff. They were learning about people's needs and the home's procedures and safe ways of working. Training in several mandatory subjects was also provided. Subjects included for example, first aid and emergency life support, fire safety awareness, safe moving and handling and various health and safety related areas of study. Staff also attended training on the MCA and DoLS, as well as dementia and end of life care. The Provider Information Return (PIR) stated that all staff new to care completed the care certificate. The certificate aimed to provide staff new to care with knowledge and skills, which enabled them to provide basic care to a recognised standard. All care staff were encouraged and supported to complete a nationally recognised qualification in care.

On-going staff support was provided through planned one to one support meetings, held between the staff member and a senior member of staff. This was protected time to discuss learning needs, goals and any concerns staff may have about their work. One member of staff told us how they had been supported to start further training. Nurses were supported to maintain their registration with the Nursing and Midwifery Council (NMC). End of year appraisals were held with each member of staff to reflect on progress over the year. Staff performance, career achievements, goals and aspirations were discussed at this point. Staff who held lead roles, for example, in dementia care, DoLS and falls management, promoted best practice and provided additional support to staff.

The building had been purpose built to accommodate the needs of those who required care. All areas therefore were spacious and able to accommodate care equipment. Bathrooms contained specialised equipment to help people use the facilities, for example, bath hoist and grab rails. Additional adaptations had been made to meet the needs of people who lived with dementia. For example, one person's toilet door frame had been painted a different colour, to help them find the bathroom independently. Signage in the home was both written and pictorial to help people understand.

Good

Is the service caring?

Our findings

We observed kind and caring actions by staff and overheard some genuinely warm conversations between staff and people. Care staff were cheerful, polite and respectful. Staff supporting people with social activities spoke with people in an inclusive and adult way. People told us staff were kind and caring towards them. One person described the staff as "wonderful" and "so kind". Another person said, "They [staff] do take time to get to know me." A third person said, "The staff are so good and so kind." When speaking with a member of staff they said, "I can talk to the residents…. and we can do a lot of activities in the afternoon. They're [the people they cared for] like my family and I am getting to know them all by name." A relative told us the staff were "really caring".

There were examples of staff going above and beyond to help improve people's quality of life and wellbeing. A relative, in their feedback, acknowledged one example. This said, "I am grateful to the pro-active carers in my [relative's] household who have gone the extra mile to provide materials and personalised handmade bags for each resident." One member of staff had made these in their own time, to hold personal items and to help maintain dignity. Another member of staff, in their own time, made finger fiddle quilts. These were purchased for people by the home and usually depicted something which was familiar to the person. They had different textures and items sewn onto them, which people who lived with dementia could feel and 'fiddle' with to help them relax.

Caring relationships were formed between staff and people. Staff helped people to feel included. People were supported to communicate by staff sometimes adapting the way they communicated and approached people. The Provider Information Return (PIR) explained how staff had stopped using certain communication aids in one person's case because they had become frustrated by them. Staff had adapted how they communicated with this person and the person was able to respond more easily and freely.

We observed staff communicating with people who lived with dementia. This was done in a kind and non-threatening way. Staff listened to what people had to say and responded skilfully to their memories, perceptions or worries. Staff took opportunities to sit with people and provide interaction or just company. Meaningful conversations were held with people, which supported their wellbeing. In one person's case a particular soft toy was important to them. We observed them talking to this and getting great comfort from it. A member of staff sat alongside them and supported their wellbeing by relating to the soft toy and recognising its importance to the person. We could see this made this person happy and they subsequently engaged with the member of staff.

In some people's records we saw the Alzheimer's Society's document 'This Is Me'. This contained information which further helped staff to know what was important to the person and how best to communicate with them. We spoke with one relative who, over time had provided comprehensive information about their relative. They told us this had definitely had a positive impact on their relative. This information had helped staff to personalise the care they provided to this person.

We observed moments of distress being managed kindly, but skilfully, to avoid further behaviour which

could challenge. On one unit we heard two people, shouting loudly in a distressed way. Two members of staff immediately but calmly respond to this. We observed how one member of staff managed one of the situations. They called one of the people's name clearly and cheerfully and in a genuine and kind manner, they asked what they could do to help. The person subsequently stopped shouting. When people were known to be distressed staff provided support, which kept people safe and helped reduce the distress. The use of an activity or company was used to help distract people from their distressing thoughts. One member of staff explained these were chosen options, before staff resorted to using medicines which had been prescribed to help alleviate distress.

People were treated equally, as an individual and their different needs, abilities and beliefs accepted. The provider's policy and procedures, and the training provided to staff, supported this approach. Differences could relate to race, ethnicity, gender, sexual orientation, status in life, age, physical abilities, religious beliefs, political beliefs, or other ideologies, all were accepted. Questions to staff on interview were based on these values and staff support meetings included discussions around these.

The PIR explained that one person was supported to be part of a regular religious service by using computer software which allowed interactive discussion and involvement from any distance. It also explained that people's preferences were met with regard to staff gender when providing intimate personal care. One person told us they had been asked if they preferred a male or female member of staff to help them but they said, "I have a shower nearly every day and the staff help me, and I am happy with male or female." The provider and managers of Windsor Street were also supportive of staffs' diverse needs and differences. They told us they promoted and supported a zero tolerance of any form of discrimination. For example, ensuring staff's sexual orientation were respected as well as supporting different cultural and religious beliefs.

People were supported to have access to independent advocacy, support and advice. For example, to POhWER (a charity that provides information, advocacy and advice services across England) and SOLLA (a not for profit organisation which can provide financial services and advice for later in life). The registered manager was also aware of the Accessible Information Standards. This meant the home made information available in different formats, to meet different needs. For example, information could be provided in different languages, different size font, on different coloured paper and in audio form if needed. The registered manager was soon to make an area available for new information and guidance on subjects they described as potential "sensitive and difficult for some". This was to include information relating to, for example, LGBT (lesbian, gay, bisexual and transgender) community, different cultural and religious beliefs and death and dying. This showed proactive thinking in how to raise awareness of these subjects.

A new initiative had started to support people, their relatives and staff. An emotional and wellbeing clinic was now in place. A mental health nurse with many years of experience, specialising in dementia care and mental health in the NHS, ran this. They ran sessions and discussions on for example, 'What Dementia is?' 'What it is about?' 'How we treat it?' and mental wellbeing. Sessions discussed the management of behaviours associated with dementia and how these could be positively supported. People, relatives and staff could discuss concerns at these sessions on a group or one to one basis. The home's dementia lead had invited families to drop in sessions at the clinic. The registered manager was able to report to us that this had started to have a positive impact in the home.

People's dignity and privacy was maintained. We observed staff to close doors when providing personal care and discussions about people's care took place in private. Do not disturb signs were available for use on people's bedroom doors. One person told us, "They [staff] always respect my dignity and they always knock on my door and they close the curtains and the door if they are doing anything personal for me."

Information about people's care and health was only accessed by appropriate staff and was kept confidential. Staff only shared information with appropriate representatives of people. People's specific wishes, with regard to what information, about them, was shared with whom, were respected.

Good

Is the service responsive?

Our findings

At the last inspection on 1 and 2 December 2016 an accurate record of people's care and treatment had not always been maintained. Records, on the nursing units, designed to give staff guidance and record the care and treatment given to people, were not always in place. This put people at risk of inappropriate or unsafe care due to a lack of updated information about their care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked the provider to take action to ensure these records gave staff and visiting professionals the information they required and that a proper record be kept of people's care and treatment. The provider told us this would be done by 30 September 2017. During this inspection we found this regulation had been met for people receiving nursing care and for others who lived in the home on a permanent basis. Further improvements were needed to records, which had not been chosen for use by the provider, but which were used for people on short-term admissions.

Care records for people admitted into 'safe haven' beds were less detailed and not overly personalised. People admitted to these beds could stay at the home for as little as three or four days or up to two or three weeks. Due to the faster turnover of these beds, commissioners of this service had designed more concise care records for use. A single document acted as an initial assessment of needs and a care plan. It gave staff pre-populated care options with little room to personalise care planning. The records we reviewed had not always fully captured details about the care and treatment provided to people. Although there was detail in the records, we also needed to speak with staff to fully understand what care and treatment had been provided. Managers were aware of the single document's limitations. They had arranged for some of their own care records to also be used to help staff record the necessary detail. Following this inspection the registered manager informed us that another additional record, a daily care record, had been added to further help with this.

The completion of the provider's own care records, for people who lived at the home permanently, had improved since the last inspection. They were detailed, highly personalised and had been reviewed regularly. When reading these we gained a clear picture of what people's needs were and what care and treatment was needed and what had been provided. We could also see that people's wishes, preferences, likes and dislikes had been included when planning their care. For example, one person had a recent diagnosis of dementia which had been recorded. The impact of this condition had also necessitated an alteration in their prescribed medicines. The relevant care plan reviews clearly recorded the fact this had taken place and recorded the impact of this on the person; more settled nights. The accurate maintenance of these records gave staff and visiting professionals an updated account of people's needs, care and treatment and the impact of this on the person.

People received personalised care which was responsive to their individual needs. We spoke with one person who needed care staff to be aware of their particular communication needs in order to support them. A member of staff showed us how best to communicate with this person; they obviously understood these needs and knew how to support them. The person was subsequently able to tell us their care was

"marvellous" and that "it could not be better." People, or an appropriate representative, were provided with opportunities to be involved in planning and reviewing their care. A relative, who acted as a legal representative for their relative, told us they were fully involved in the planning and reviewing of their relative's care. They told us they were able to speak on behalf of their relative. They said, "I have real peace of mind" and they told us their relative was in a "good place". Another relative told us they had been able to review relevant care records with staff. They said, "I have seen it [their relative's care file] when I've asked to see it, so I could see what [relative's name] was eating."

People were able to raise a complaint and records showed investigations had taken place and where possible, people's issues had been addressed. Information about how to make a complaint was seen in reception and on the different units. People told us they felt confident that, if they had to make a complaint, it would be sorted out. Where complaints had been made or dissatisfaction expressed, this had been the case.

The registered manager kept a record of all complaints received and followed the provider's complaints procedures when investigating these. They particularly told us, that complaints or areas of dissatisfaction, expressed by a person who lived with dementia, would not be given any less attention. We reviewed the records kept of situations and circumstances, which the registered manager had managed under the provider's complaints procedures since March 2017. In total there had been eight and all had been formally investigated. Six had been addressed within the time frame stated in the provider's complaints policy. There were good reasons why two had not been. One relative had been dissatisfied with the length of time it had taken staff to respond to their relative's call bell and had complained about this. This had been upheld and action taken to resolve this. A report of missing property had been investigated and appropriately reported to the police.

People were supported to take part in activities, which they enjoyed and which helped them to feel included. They were also supported to take part in sessions, which supported a healthier life and which had a recognised therapeutic value. One person said, "I do certain things, I like sing songs and they [activity staff] come and see me to do exercises one on one." Another person said, "I like mind song and the emotional wellbeing clinic, and I like the sing along and the exercises."

We spoke with an activities co-ordinator. They were part of a team which promoted choice in relation to the activities provided. Where people required more support to make choices and to be included, information provided by relatives and friends, helped staff to provide activities which had meaning to people. We observed one exercise to music session, which was held on one unit, but was also attended by people from other units. People were actively engaged in this. We spoke with one person who had been supported to attend from another unit. They said, "If you don't try you don't know what you can still do." Some activities were held on specific units to address specific needs. For example, a unit which had several people who were not overly active or mobile would be targeted by the activities team. They would hold a short, daily exercise session, for example, just before lunch. We were told this would help people engage with the thought of needing to move; first to the toilet and then the dining room for lunch.

An activities planner showed the different activities which were provided across the home. These included, visits by pets used for therapy, various group and individual games, socialisation groups such as 'Knit and Natter' and other themed discussions. A mother and baby club used the home to meet on a regular basis. This arrangement had provided them with a location in the community to meet, but had also proved to be popular and therapeutic for those who attended from within the home. Units also had their own activity plans and these were sometimes decided on, on the day, depending on what people preferred to do. A team of volunteers helped to provide people with activities and opportunities to chat. In particular they supported

more specific smaller groups, such as a group of men to come together or opportunities for one to one chats. The home had its own transport and plans were being made for outings out in the spring and summer. People were also supported to visit shops and parks in the local community.

People were supported to have a dignified and comfortable death. Staff had received relevant training and more senior staff were being supported to have 'difficult conversations' with people and relatives. Staff and visiting professionals, followed an end of life path way of care, which helped provide a consistent approach and standard of care. We visited one person who was in the last hours of their life. We observed them to be peaceful and well cared for. A previous decision had been made by their GP, in consultation with family members and staff, to stop all routine medicines. They had prescribed medicines, to be used, at an appropriate time, to keep the person comfortable and pain free. These had been ordered and had been ready for use when they were required. We observed best practice being followed in the on-going monitoring of the administration of these medicines.

The care this person required and received to achieve a dignified and comfortable death, was now recorded in a single booklet specifically designed for use in the last few days of life. This one document recorded all professionals' involvement, decisions made on behalf of the person and the person's own end of life wishes. This document kept this information in one place. It gave guidance to staff on what personal care, health support, emotional and spiritual support was to be provided. We saw staff visiting this person when their relatives were absent. Relatives were free to visit when they wanted to and arrangements could be made to support those who chose to stay overnight.

Good

Is the service well-led?

Our findings

Since the last inspection on 1 and 2 December 2016, the then deputy manager, had registered with the Care Quality Commission (CQC) and become the registered manager of the home. People, relatives and staff told us the home was managed well and that improvements had been made. One person could not remember meeting the registered manager but knew of her and said, "I think she's doing a good job." Another person talked highly of the senior staff they knew. They said, "I have met the manager [registered manager], yes, I think they are all doing a good job, they are brilliant here." One relative said, "The manager [registered manager] is smashing, she always has time to spend with you and yes she is quite transparent."

The registered manager told us there had been a need to make changes to the staff culture. They said, "We [the staff] are privileged to be in their [the people] home and for them to want us to look after them." Managers had wanted to address the balance in the home again and to have a staff group who were as equally committed to the people as they were. They had been aware that with change, came periods of upset and of staff needing support to settle into new ways of working and thinking. Both managers including a provider representative, felt the changes so far had resulted in a better staff culture and improved outcomes for people.

During this period of change managers had made their expectations clear, both in general staff meetings and on an individual basis. They included 'an expectation to hear and see staff being sensitive to their colleagues and towards people's thoughts and feelings, asking for and listening to opinions, to share ideas, valuing and appreciating honesty. Giving people and other staff space to express their ideas and views without interruption. Being open to different approaches and trying new ways of doing things.'

The provider's HR policies and procedures had been followed when addressing staff performance. All staff had been supported to be aware of their responsibilities and to be more accountable. Senior staff had been supported to lead their unit teams and to feel more confident to use their initiative. A stronger senior staff structure was in place. There had been a focus on team building and effective team working and more bespoke support was planned.

The deputy manager had worked alongside staff to see where support was needed and where changes in ways of working were needed. A daily meeting was introduced so that staff leaders and managers could come together and address any issues presenting on the day. This increased communication between team members and enabled managers and team leaders to be aware of what was going on, throughout the home, on each day. These daily meetings were still in place at the time of the inspection.

Two senior staff described the impact of these changes and of the better management.
One member of staff said, "There have been positive changes and we now have a stable nurse team. There is more of a sense of purpose and direction now and everyone appears to be happy in their roles." A second member of staff said, "The team is coming together." Other staff told us they felt more supported by this registered manager and that she was approachable. One member of staff explained they had lacked confidence and they said, "[registered manager] has made it better for me and told me I can achieve more."

This member of staff was being supported both personally and with their work. Another member of staff said, "[registered manager], I get on with her very well. She is lovely; she is open and easy going and she will have a laugh and a joke with you."

The PIR recorded many improvements to the service, which we were able to confirm during the inspection. For example, the improved care records and an acknowledgement that some further improvement was needed with the short-term admission records. The positive impact of improved staff recruitment and staff support was clear to see. The embedding of lead roles and staff champion roles had an impact on how best practice was making a difference to people's standard of care. Staff were knowledgeable and were using their skills to improve people's quality of life and to ensure people's rights were upheld. There were many more plans for further improvement over the next 12 months. Both managers demonstrated a real desire for on-going improvement and at the centre of all of this were the people who were being cared for.

Managers used the provider's quality monitoring systems to ensure the home remained compliant with necessary regulations and legislation. The last full audit, completed by the provider, had been in September 2017. Some areas of improvement were needed and had been met since this. Audits had been completed by staff, actions taken to address shortfalls and improvements made to the service. For example, cleaning of the tops of wardrobes and actions to address some reported medicine errors. Medicines were audited on each unit monthly; in-between other checks applied. The managers had sight of these audits, had identified errors made, followed these up and taken necessary action. The supplying pharmacist had completed a full audit of the home's medicine system in January 2018. The results of this had been "excellent". We reviewed similar audits and actions completed in relation to health and safety and care planning.

On-going and planned refurbishments had included new corridor carpets and a new phone system was soon to be installed.

Managers were keen to obtain feedback from people, relatives and staff. Feedback from people was obtained mainly through informal chats, for example, during an activity. Relatives confirmed they were able to speak with the registered manager at any time. Managers of the home monitored feedback submitted through a website designed for this purpose and on comment cards completed by visitors. The provider completed a satisfaction survey each year. This had been done last in September 2017 but the home had not yet received the collated results of this. Staff meetings had been held regularly. The registered manager said, "I always seek advice and ideas from them [staff]. We work on ideas together and action them together."

Both managers kept their knowledge and skills updated. They attended forums and groups which kept them informed of best practice and new ideas and initiatives in care.

Care records were stored securely, including archived records and all computer based information was password protected. Staff were completing training to ensure the safe use of and storage of computer based information.

Managers ensured appropriate notifications were forwarded to the Care Quality Commission (CQC) and that the rating awarded to the home, by CQC, was displayed. The provider also ensured that the home's rating was displayed on their website. This demonstrated that both the provider and registered manager met their responsibilities in relation to the home's registration with the CQC.