Porthaven Care Homes LLP

Astbury Mere Care Home

Inspection report

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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 the 27 and 28 September 2018 and was unannounced.

Astbury Mere Care Home was previously inspected in June 2017. During the inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of staffing. The registered person had failed to ensure that staff received appropriate support and training necessary to enable them to carry out the duties they were required to perform.

At this inspection we found that the registered provider had taken action to address the breach identified at the last inspection.

Astbury Mere is a 'care home' run by Porthaven Care Homes LLP. 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.

The care home provides accommodation, personal and nursing care for up to 62 older people on two levels, each of which have separate adapted facilities. The ground floor accommodates up to 31 people with residential and nursing care needs. The upstairs floor accommodates up to 31 people living with dementia. At the time of our inspection, the care home was accommodating 57 people.

The care home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was present throughout the two days of our inspection and was supported by their regional manager and deputy manager. The management team engaged positively in the inspection process and were helpful, transparent and keen to share and receive information regarding the operation of the care home. They also demonstrated passion and enthusiasm to ensure the continuous improvement of the service.

Astbury Mere Care Home presented as a warm and comfortable environment in which to live. We observed that staff were attentive to the needs of people living in the care home and that they engaged with people in a positive, respectful and dignified manner.

Since our last inspection, the registered provider had introduced a new electronic system to manage, store and record information on people's assessed needs and the support they required and received from staff. This included care plans, observation records and progress notes. This was work in progress at the time of our inspection.

People were offered a choice of nutritious and wholesome meals that were provided in dining areas that offered a pleasant environment for people to socialise and eat their meals.

A comprehensive programme of group and individualised activities was in place which included both on and off-site activities. People using the service were seen to participate in meaningful activities and had access to a range of resources which enhanced their experience and wellbeing.

People were supported to attend healthcare appointments and staff liaised with people's GPs and other healthcare professionals as necessary to maintain people's health or support them at the end of life. Policies and procedures had also been developed to ensure staff were aware of their roles and responsibilities for ordering, storing and administering medication.

Systems had been established to ensure that staff working in the care home had been appropriately recruited and to safeguard people from abuse or harm. A complaints policy and procedure was also in place and people's views, concerns and complaints were listened to and acted upon.

Staff had completed induction, mandatory and service specific training to help them understand their roles and responsibilities. Since our last inspection, systems and processes for staff training and development had been modified. This included sourcing new training, ensuring staff completed training over a longer period of time and verifying their knowledge and understanding of training completed.

Staff understood the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

The registered provider had developed a range of management information and quality assurance systems to enable oversight and scrutiny of the service. This involved seeking the views of people who used the service and their representatives.

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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.

The premises were safe and provided a well maintained, comfortable and pleasant environment.

Safeguarding systems and processes were in place to help protect people from abuse and improper treatment.

Staffing levels were adequate to ensure people received appropriate levels of care and support.

Recruitment procedures provided appropriate safeguards for people using the service. This helped to reduce the risk of unsuitable people being employed to work with vulnerable people.

Systems had been established to protect people from the risks associated with unsafe medicines management.

Is the service effective?

Good

The service was effective.

Staff learning and development, systems and processes had been developed to ensure staff were appropriately trained and supported for their roles and responsibilities.

Managers and staff acted in accordance with the Mental Capacity Act 2005 to ensure that people received the right level of support with their decision making.

People had access to a choice of nutritious meals and systems were in place to liaise with GPs and other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

Staff engaged with people in a warm, friendly and caring manner

and understood the principles of good care practice. People were treated with dignity and respect and their privacy and human rights were safeguarded.

People's personal information was stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

Care plans and supporting documentation were in place that were subject to ongoing development and review to ensure people's needs were identified and acted upon.

People were encouraged to engage in a range of group and person-centred activities and were supported to follow their preferred routines.

There was a complaints procedure in place and any complaints were responded to appropriately.

Is the service well-led?

Good

The service was well led.

The care home had a registered manager in place to provide leadership and direction.

Governance and quality assurance systems had been developed to ensure oversight and scrutiny of the service. This included processes to enable people who lived in the care home and their relatives to be consulted about their opinions of the service.

The service worked in partnership with other agencies and health and social professionals.

Astbury Mere Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The inspection took place on the 27 and 28 September 2018 and was unannounced.

The inspection was undertaken by one adult social care inspector.

Prior to our inspection, we requested the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at all the information which the Care Quality Commission already held on Astbury Mere Care Home such as intelligence, statutory notifications and / or any information received from third parties. We also contacted the local authority to provide us with any information they held about the care home. We took any information provided to us into account.

During the inspection we used a number of different methods to help us understand the experiences of people living in the care home and to gather information.

During the inspection we talked with nine people who used the service and six relatives. We also spoke with the regional manager; registered manager; deputy manager; client services manager; administrator; receptionist; one nurse; two team leaders; one care assistant; the home trainer; two leisure and wellness coordinators; the head chef; a maintenance technician and a visiting health care professional.

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 looked at a range of records including three care records belonging to people who lived in the care

home. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and well-being.

Examples of other records viewed included; three staff files, complaint and safeguarding records; rotas; staff training information; minutes of meetings; menus; medication; maintenance checks and audit documentation.

Good

Is the service safe?

Our findings

People spoken with told us that they felt safe living at Astbury Mere Care Home.

We reviewed the care records for four people living in the care home. Since our last inspection the registered provider had transferred to an electronic recording system. We found that the system included information on people's assessed needs and a range of risk assessments relevant to each person. This information helped staff to be aware of people's diverse needs and how to keep people safe.

A fire risk assessment, fire evacuation policy, personal emergency evacuation plans and a business continuity plan were in place to ensure an appropriate response in the event of a fire or major incident. This information helped staff to be aware of current risks for people using the service and the action they should take to minimise and control potential risks.

The registered provider had developed an accident management policy. Systems were in place to log and record any incidents, accidents and falls. We noted that the electronic system was able to provide a detailed annual and monthly analysis of incidents such as the number of events; times; type; location and people affected (including those a most risk). Other summary information reports could be extracted from the system such as clinical information relating to wounds and infections. These management information systems helped the manager and the senior management team to identify trends, maintain an overview of significant events and monitor the care delivered to people using the service.

At the time of our inspection there were 57 people being accommodated in the care home who required different levels of care and support. The service employed a registered manager on a full-time basis who worked flexibly subject to the needs of the service. Additionally, a deputy manager was in post that worked alongside nursing and staff responsible for the delivery of care. Ancillary staff were also employed in client service; administration; reception; leisure and wellness (activities); hostess; domestic; laundry; catering and maintenance roles.

Dependency profiles had been completed for each person using the service. A system had been developed by the provider to review the dependency of people using the service and to calculate approximate staffing hours. The registered manager confirmed that she had the authority to vary the staffing levels in the home subject to changes in occupancy and the needs of people using the service.

We looked at the staffing rotas with the registered manager and noted that the home was staffed with a minimum of one registered nurse, two team leaders and nine care assistants on duty from 8.00am to 2.00pm. This changed from nine to eight care assistants from 2:00pm to 8:00pm. During the night one registered nurse, two team leaders and four care assistants were on duty.

The provider had developed a recruitment and selection policy to provide guidance to people responsible for recruiting new staff. We looked at the personnel files for three staff members who had recently commenced employment at the home. The records confirmed prospective employees had undergone an

interview process and checks such as Disclosure and Barring Service (DBS), references, proof of identification and medical information had been completed. A valid DBS check aims to help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. In the case of nursing staff, NMC (Nursing and Midwifery Council) personal identification numbers had also been checked to ensure valid and current nursing registration.

The registered provider had developed a policy on 'safeguarding adults and prevention of abuse' and 'whistleblowing' to provide guidance to staff. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. A copy of the local authority's adult protection procedure was also available for staff to reference.

Discussion with the registered manager, home trainer and staff together with a review of training records confirmed the majority of staff had completed safeguarding training. Staff spoken with demonstrated a satisfactory awareness of the different types of abuse and the action they should take in response to suspicion or evidence of abuse. Staff were also able to explain how they would whistleblow should the need arise.

We asked the registered manager for information on any safeguarding incidents that had occurred in the service or that were known to the service since our last inspection. We noted that tracking systems had been developed by the registered manager so that they could maintain oversight of safeguarding incidents, action taken and outcomes. Records viewed confirmed that where safeguarding incidents had been identified, the registered provider had managed them correctly and reported them to the local authority's safeguarding team in accordance with policies and procedures.

No whistleblower concerns had been received by the Care Quality Commission (CQC) in the past twelve months.

The provider had policies and procedures in place for the administration of medicines. A copy of the policy was in the medication storage room for staff to reference together with other relevant guidance and information such as patient information leaflets.

Medication was dispensed by a local pharmacist and stored securely within trolleys that were sited in a temperature controlled room. Separate storage was also available for medication requiring cold storage and for controlled drugs. Medication was administered by nursing staff and team leaders who had completed medication management training. Competency assessments were also undertaken periodically by the registered manager or deputy manager to check staff knowledge and understanding.

We checked the arrangements for the management of medicines on one unit with a team leader. Since our last inspection, the registered provider had transferred from a paper based recording system to an electronic system. The electronic system enabled medications to be recorded, administered, tracked and audited – all within a single system.

We observed the team leader operate the system during a medication round and noted that the system was fully integrated with the dispensing pharmacist. Key profile information regarding people and PRN (as required medication) had been recorded and electronic medicine administration charts (eMAR) were completed to record the administration of medicines. The system was able to monitor stock and generate automated alerts and warnings. This helped staff to ensure that medications were administered within a safe tolerance or not too close together.

We looked at sample of eMAR and requested a copy of a medication exceptions report so that we could identify any issues with the system and check whether people had received their medication when required.

The registered provider's medication exception report identified some occasions when medication was recorded as 'out of stock' or 'awaiting pharmacy delivery'. The registered manager informed CQC that the service had agreed to share the details of any weekly changes, made by the GP, with the GP's practice in addition to the dispensing pharmacist. This practice will help to flag any issues, improve efficiency with medication ordering and improve safety systems and processes regarding the management of medication, when changes to medication occur.

Examination of team meeting minutes confirmed medication was regularly discussed with staff during meetings to ensure any issues were highlighted and discussed with staff. Medication audits were also routinely undertaken by the registered manager. At the time of our inspection one of the people using the service had chosen to self-administer their medication. A risk assessment had been completed to ensure the person was safe to manage their medication independently.

We checked a number of test and service maintenance records with the care home's maintenance technician relating to: the electrical wiring; portable appliances; fire alarm system; fire extinguishers; gas installation; passenger lifts and hoists and slings and found all to be in order. We found that equipment and utility supplies had been routinely maintained and serviced and a suite of health and safety checks were undertaken at different intervals throughout the year.

Health and safety committee meetings were coordinated at quarterly intervals throughout the year during which any issues related to: accidents and trends; fire safety training issues; risk assessments; health and safety issues; enforcement and registration inspections; training; audits; emergency continuity plans and checks and records were reviewed and discussed. This helped to raise the importance of health and safety matter within the care home and ensure safe working practices.

We conducted a tour of the home and observed that in general the home was generally clean with no malodours. We noted that one wooden toilet seat needed replacement and this was addressed immediately by the maintenance technician.

Staff had access to personal protective equipment and policies and procedures for infection control were in place. We noted that verification of control process and infection control audits were routinely undertaken as part of the registered provider's quality assurance system and that the most recent overall score was 92%. This confirmed the service operated good infection control procedures.

Good

Is the service effective?

Our findings

We asked people who used the service or their representatives if they felt the service provided at Astbury Mere Care Home was effective. People spoken with confirmed the service was effective.

For example, comments received from people living in the care home included: "They [the staff] look after me very well"; "We have lovely food"; "I have been in three other places for respite care and this is the best" and "The standard of care and food is good."

Likewise, a relative reported: "It's a wonderful place."

At our last inspection in June 2017, we found a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'staffing'. This was because the registered person had failed to ensure that staff received appropriate support and training necessary to enable them to carry out the duties they were employed to perform.

Following our inspection, the registered provider produced an action plan which described the action they planned to take to meet the regulation. A 'what you said, what we've done' document had also been prepared. This information provided evidence that the registered person had acted upon the breach and made improvements to training and development systems and processes.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach.

For example, we spoke with the home trainer and noted that the registered provider had decided to purchase e-learning training products from a new training provider (Skills for Health). This training was in the process of being rolled out to staff and was work in progress. Skills for Health, is a not-for-profit organisation committed to the development of an improved and sustainable healthcare workforce across the UK. Established in 2002 as the Sector Skills Council for Health for the UK health sector, Skills for Health helps to inform policy and standards focusing on health, education and improving the wider wellbeing of public health.

Staff had recompleted mandatory and service specific training. Records indicated that staff would only complete a maximum of 4 e-learning courses in one day and that training was now spread over at least one week or longer to help staff retain learning and development information.

Eleven staff had completed a two-day course in dementia leadership which covered strategies to manage behaviour that challenges a service. A further twenty-two staff had also completed an in-house accredited course in 'behaviour that challenges' to help staff understand how to respond appropriately and disseminate the learning into practice.

A review of all training assessment records had also been undertaken by the home trainer to ensure staff

had scored at least 80% or above before they were signed off as competent. Where necessary staff had completed the training again.

Discussion with staff and examination of training records confirmed that staff had completed a range of induction, mandatory, service specific and qualification level training that was relevant to their roles and responsibilities. Training data evidenced good completion rates overall.

We noted that nursing staff had access to a range of clinical training relevant to their roles and responsibilities. The home trainer informed us that they had sourced training for staff to complete where any gaps had been identified.

Staff spoken with confirmed they had attended various team meetings relevant to their roles and responsibilities. For example, clinical governance, nurse, team leader, night staff, floor level, daily stand-up and handover sheets were coordinated and utilised to share and receive information. Additionally, staff had access to formal supervision and annual appraisals throughout the year.

Astbury Mere is a modern two storey purpose built care home that was decorated and furnished to a high standard. The home has 62 single rooms each of which is fitted with an en-suite shower and washbasin.

People were encouraged to personalise their rooms with their individual belongings such as pictures, ornaments and personal possessions to make them homely and comfortable. We also noted that people had access to aids and equipment to help people mobilise and maintain their independence.

The home has two passenger lifts in place and communal facilities for cooking, dining, personal care, relaxing and leisure. There were also four lounges, two dining areas, laundry and a hairdressing salon. A private dining room is also located on the ground floor which residents and their relatives are encouraged to book for special occasions.

We saw that various measures had been taken to create a safer and more dementia friendly environment. For example, on the first floor in the dementia unit we noted that small illuminated cabinets had been fitted outside people's bedrooms which contained photographs and personal items that were familiar and unique to each person to help people locate their bedrooms and reduce confusion. Orientation boards were also in place to remind people using the service of the day, date, season and weather. The service continued to promote 'Doll therapy' as a means to help comfort people and to reduce anxiety, together with a range of other activities that were geared towards people's individual needs.

Since our last inspection, signage had improved on the unit and staff were in the process of developing a memory station in the hallway. This consisted of a seaside theme and old-time memorabilia. A fish tank had also been installed for people to observe and to stimulate conversation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.

When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that 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 (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

The registered provider had developed policies on the MCA and DoLS. Staff spoken with told us that they had completed training in this this protective legislation to help them understand their duty of care.

We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Applications were submitted to the local social services department who were responsible for arranging any best interest's meetings or agreeing to any DoLS imposed and for ensuring they were kept under review.

The registered manager maintained a record of people with authorised DoLS in place and the expiry dates. Information on applications awaiting authorisation had also been recorded.

The registered provider continued to operate a four-week rolling menu plan for the care home that was reviewed periodically in consultation with the people using the service. A copy of the menu plan was displayed outside each dining area on a menu stand for people to view and on each table. People using the service were supported to make their individual meal choices on a daily basis and alternative options were also available upon request.

We spoke with the head chef on duty during our inspection. The head chef told us that they had recently won the 'seasonal challenge' competition from the provider. We viewed a copy of the certificate of achievement, which had been presented to them by a Michelin star chef.

We looked at the most recent food standard agency rating for the home following an inspection in January 2018. We noted that the care home had been awarded a rating of 5 stars again. This is the highest award that can be given.

Since the last inspection, two white boards had been purchased to record and display key information on people's dietary needs such as required consistencies; allergies; special requirements (including religious or cultural preferences); likes and dislikes and malnutrition universal screen tool (MUST) scores. Separate records were also in place to identify different meals and their allergen content. This helps to protect the health and wellbeing of people and ensures their equality, diversity and human rights are safeguarded.

The care home had a combined dining room and serving area located on the ground and first floor. Dining areas viewed offered a clean, pleasant and comfortable environment for people to socialise and eat their meals. Tables were appropriately laid with good quality tablecloths, napkins, table mats, condiments and cutlery.

We undertook a short observational framework for inspection (SOFI) on the unit accommodating people living with dementia during a lunch time meal.

We saw that people had a choice of refreshments and meals. Food was attractively presented in the dining room and looked and smelt appetising. People were also supported to eat their meals in their rooms if they wished.

Meals were prepared appropriately for people who required a soft or pureed diet and staff were observed to offer people two different types of meal. This practice helped people to understand the choices on offer and

select their preference. Additional refreshments and snacks were provided throughout the day.

We observed that staff were helpful and attentive to the needs of people during the meal time. However, we noted that many people required intensive support from staff to eat their meals and other people required regular prompt or general assistance. We discussed our findings with the regional manager and the deputy manager as more people needed support than the number of staff available to assist during the mealtime. The registered manager agreed to review the arrangements for supporting people at lunch time and has since confirmed that two mealtime sittings have been introduced. This will help to improve people's dining experience.

Staff spoken with demonstrated a good understanding of each person's dietary needs and food preferences. Staff confirmed they completed relevant monitoring charts for food and fluid intake for people at increased risk of malnutrition or dehydration. They also made referrals to speech and language therapists and dieticians subject to people's individual needs.

We noted that systems were in place to ensure the needs of people were assessed and kept under review following admission to the home. This helped to ensure the changing needs of people were responded to in a timely way and that potential and actual risks were appropriately managed.

The registered manager told us that they endeavoured to work in partnership with other teams and services to ensure the delivery of effective care and support for people using the service. This included a range of health and social care practitioners such as GPs; the continuing health care team; dieticians; speech and language therapists; chiropodists; opticians; community psychiatric nurses and social workers. During the inspection we observed a visiting GP undertaking a weekly visit to the home.

People using the service told us that they were supported to access a range of health care professionals subject to their individual needs.

Good

Is the service caring?

Our findings

We asked people who used the service or their representatives if they felt the service provided at Astbury Mere Care Home was caring. People spoken with confirmed the service was caring and that they were treated with dignity and respect.

For example, comments received from people living in the care home included: "On the whole the care is very good"; "I am being looked after too well. I get preferential treatment in my view" and "I have no problems here. The standard of care is great."

Likewise, we received feedback from relatives such as: "All the staff are lovely"; "The standard of care is wonderful. They [staff] can't do enough for my mum" and "The quality of care here is superb."

During our inspection of Astbury Mere Care Home we spent time talking with people and undertaking observations within the care home. We noted that the environment offered people a homely and comfortable place in which to live and that people were encouraged to follow their preferred routines and to maintain their independence subject to their individual needs.

Staff were seen to be attentive and responsive to the needs of the people they cared for. People living in the care home appeared comfortable and relaxed in the presence of the staff team. People were also seen to be appropriately dressed and well-groomed in their appearance.

During the inspection we observed staff maintain people's dignity and privacy by knocking on people's bedroom doors before entering and providing personal care in private areas with doors closed. We also saw that staff took time to communicate and engage with people in a warm manner and in a way that people could understand and respond to.

For example, we spoke with a member of staff responsible for administering medication to people. We noted that the staff member had a good understanding of people's needs and their support requirements in relation to the administration of medication. We also observed that the staff member took time to administer medication in a discreet, unhurried and sensitive manner.

We saw other positive examples of staff interacting and laughing with people on an individual and group level. For example, through activities, spending time with people in communal areas and when assisting people with activities of daily living such as mobilising around the care home.

It was clear through discussions with staff that they had developed a good awareness of the individual needs and preferences of the people they cared for and how best to support them. Staff also told us that they had recently completed training in equality, diversity and human rights which had helped raise their awareness of diversity issues, people's rights and their duty of care.

Throughout the inspection we observed that friends and relatives were encouraged to visit their loved ones

and to participate in the activities on offer and scheduled events within the home.

The registered provider had developed a policy on the general data protection regulations and information on the organisation's privacy notice was published on the Porthaven Care Home's website for reference.

Electronic and paper records were kept securely within the care home to help ensure confidentiality. Information on Astbury Mere Care Home been produced in various forms including a 'Statement of Purpose' and a 'Residents Handbook'. Both documents were displayed in the reception area of the care home for people to view. The documentation provided current and prospective service users with key information on the service such as: philosophy of care; operational structure; aims and objectives; registered provider and manager details; admission criteria; services available; facilities provided and the complaints procedure etc.

The manager was aware of how to access advocacy services in the event a person required support to make decisions and did not have family and friends to assist them. An advocate is a person that helps an individual to express their wishes and views and help them stand up for their rights.

Good

Is the service responsive?

Our findings

We asked people who used the service or their representatives if they felt the service provided at Astbury Mere Care Home was responsive. People spoken with confirmed the service was responsive to their needs.

Comments received from people living in the care home included: "We had a very good entertainer today"; "I'm invited to get involved in activities" and "I have no complaints about this place."

Likewise, we received feedback from relatives such as: "They [the staff] look after and pick up on things"; "It's a personalised service. They [the staff] are responsive and on the nail with everything" and "They look after my wife very well."

A health care professional told us: "I have a good relationship with the staff and if there are any problems they alert me. They are very good at recognising if people's health is deteriorating."

We reviewed the care records for four people living in the care home. Since our last inspection, the registered provider had transferred to an electronic recording system. This enabled records to be stored safely, improved accessibility for staff and reduced the need for excessive paperwork.

The electronic recording system had been adopted by the registered provider as its preferred care management solution. The system was used to generate and store documentation and records relating to the needs of people using the service and the care undertaken by staff. It included a dashboard for key messages to be conveyed to staff and was able to generate and produce live interactive reports for management and staff to view. For example, the system could highlight if any actions had not been completed on time.

We looked at the system with the registered manager and deputy manager. We noted that a range of records were stored within the system such as assessment records, care plans, personal profiles, risk assessments, observational charts and progress notes.

We saw that a summary statement of care and extended care plans had been produced for each person that were based upon the activities of daily living model.

Overall, important information such as people's identified care needs, aims and the support required and provided from staff had been recorded. However, we identified areas were further information would be beneficial to ensure the information recorded was more personalised to people using the service. We discussed this feedback with the management team during the inspection and received assurance that additional information would be added where necessary.

It was clear from discussions with management and staff that transferring from a paper based system to an electronic model had created a lot of intensive work for all involved and this project remained work in progress. Systems were in place to ensure records were kept under monthly review and the organisation's

group clinical auditor continued to undertake audits on the system to drive ongoing improvement.

At the time of our inspection, none of the people using the service were receiving end of life care.

We discussed the home's arrangements for end of life care planning with the registered manager and noted that records were in place to record people's wellbeing and wishes. For example, the care home utilised a booklet produced by the East Cheshire Hospice end of life partnership and a dedicated care plan entitled 'wishes for the future'. This took into consideration important factors such as where a person would prefer to be cared for when nearing the end of life and what their wishes were after death such as their preferred funeral director.

The registered manager told us that the care home had established links with GP's, Macmillan specialist nurses and other healthcare professionals. This helped to ensure that people received appropriate support towards the end of their life if they expressed a wish to stay at Astbury Mere Care Home.

The registered provider had developed a complaints procedure in a standard text format to provide guidance to staff and people using the service or their representatives on how to raise a concern or complaint. The procedure included timescales for investigation and providing a response.

Information on how to raise a complaint or concern was displayed in the entrance area of the care home and had also been included in the statement of purpose and in the resident's handbook.

At the time of our inspection the care home was supporting people with a diverse range of needs. We noted that the complaint policy had not been produced in alternative formats.

The registered manager told us that the registered provider had produced an accessible information statement which was displayed in the reception area. This detailed that where practicable, the registered provider would ensure that processes were in place to help people understand information that was given to them.

The Accessible Information Standard (AIS) requires that all publicly funded adult social care and care provided by social care services must identify and meet the information and communication needs of those who use their services.

The registered manager assured us that the service would continue to explore options for the development of accessible information. We saw examples of how the registered provider had used pictures, signs and symbols to convey information to people in different formats. For example, when producing activity programmes.

We looked at the complaint records for the care home which highlighted that there had been 10 complaints in the last 12 months. Records confirmed that appropriate action had been taken to investigate and respond to any concerns raised.

No formal complaints were received from people using the service or their representatives during the inspection. People spoken with told us that they were confident that if they raised a complaint their concerns would be listened to and acted upon.

Two people spoken with told us that they sometimes had to "wait a while" to receive a response from staff. We discussed this feedback with the registered manager and noted that the event logs for the nurse call

system were routinely monitored and discussed with staff during daily meetings. This ensured that any excessive response times were discussed with staff and action taken if necessary.

The provider continued to employ one full time and two part-time leisure and wellness coordinators who were responsible for the planning and development of activities within the care home.

The care home was a member of NAPA (National Activities Provider Association). NAPA is a charity and membership organisation dedicated to understanding the unique needs of people in care settings. It aims to equip staff with the necessary skills to enable people to enjoy spending time purposefully and enjoyably doing things that bring them pleasure and meaning.

Two staff had previously completed the National Activities Provider Association level 2 training. One of the leisure and wellness coordinators told us that they had been nominated and shortlisted for the North-West Care Awards 2018 and was waiting to find out the results.

Leisure and wellness staff spoken with were passionate about their role. They demonstrated a strong commitment to developing and facilitating a range of person centred activities which were appreciated by people using the service. For example, one person spoken with during a baking session told us that "This lady [a leisure and wellness staff member] has changed my life" and "I don't get fed up. They always ask me if I'd like to get involved in things."

A monthly programme of activities and notices was produced for people using the service to view, which had been produced in large print and signs and symbols. This helped people to read and understand the information recorded which was prominently displayed around the home on notice boards. Copies of the weekly activities were also delivered to each resident's room.

Activity engagement records viewed provided evidence that people had participated in a comprehensive range of meaningful activities and that the level of people's participation and outcomes were evaluated.

We observed that a range of individual and group activities took place during the two days of our inspection which people using the service were seen to participate in and enjoy. The activities included a quiz; ball games; art and craft work (creating poppies); scrabble and board games; baking; a visit from the pets as therapy dog; a coffee morning for relatives and a coffee and cakes afternoon with an entertainer to raise money for the Macmillan cancer charity. This event was attended by 18 people who live in the care home and 10 relatives.

It was also evident that staff worked to involve members of the community such as school children, volunteers and family members in social events. For example, the Porthaven annual garden challenge, Great Britain in bloom competition, theme days such as armed forces day, summer fayres and a show performed by children from a local primary school.

Conversely, we heard and saw evidence that people were supported to access their local and wider community and places of interest. For example, one person had been supported to visit Cosford air museum and another person to visit West Kirby to meet the lifeguard. A day trip out on a narrow boat had also been organised for a group of people during the summer.

People using the service had access to an activities room that displayed art and craft products made by residents and staff. The room was well-equipped with various resources including a fully integrated kitchenette, tables and chairs, television, personal computer, digital versatile disc and iPad facilities. The

care home also had a minibus which was used to transport people on trips and to various destinations.

Since our last inspection the registered provider had purchased an OMI vista mobii machine. This device creates an interactive surface and is pre-loaded with a sensory suite of different applications with audio-visual effects designed to stimulate, engage and relax. The care home also subscribed to 'Our Yesterday'. This is a new service that offers a twice weekly newspaper, activity suggestions, quizzes, menus, music and other initiatives to help engage with older people.

The care home utilised a range of assistive technology to help keep people safe and to maintain their independence. For example, call bells, mobile pendants, chair and floor sensor mats and a range of audio visual equipment were available for use, subject to individual needs.

Good

Is the service well-led?

Our findings

Astbury Mere Care Home had a manager in place that was registered with the Care Quality Commission. The registered manager was present throughout the two days of our inspection and was supported by their regional manager and deputy manager.

The management team engaged positively in the inspection process and were helpful, transparent and keen to share and receive information regarding the operation of the care home. They also demonstrated passion and enthusiasm to ensure the continuous improvement of the service.

We observed the registered manager to operate an open-door policy and it was clear that they remained passionate about their role and responsibilities. Throughout the inspection the registered manager took time to communicate and engage with people living in the care home, staff and family members. It was evident that the registered manager had good interpersonal skills and was warm, welcoming and friendly in her approach.

Astbury Mere Care Home is operated by Porthaven Care Homes LLP (the registered provider) and is governed by a board of directors that have overall responsibility for the management and operation of the service.

The registered provider had developed a vision statement and strategy. This detailed that "Porthaven aims to create and manage care homes that emphasise quality of life and enable residents and staff to achieve optimal level of wellbeing". The registered provider had also published a range of information on its website for people to view.

The registered provider had developed a quality assurance system which was based upon seeking the views of people who use the service or their representatives and included a number of routine checks and audits. This helped to ensure continued oversight and scrutiny of the operation of the service. The registered provider's quality assurance policy detailed that the key elements of quality assurance with the organisation were: evidence based practice, policies and procedures; risk management; clinical supervision / appraisal; continuing professional development and revalidation; complaints and compliments management and audits.

We noted that the regional manager had monitored quantitative, qualitative and key performance data regarding the performance of the home via monthly reports prepared by the registered manager. Furthermore, the regional manager had undertaken monthly visits to the care home and produced a report on their findings in addition to periodic visits from other members of the senior management team i.e. the hotel services manager, estates manager and leisure and wellness manager.

We were informed that the operations director also scrutinised quantitative data via weekly reports from the registered manager. Additionally, the operations director had visited and monitored the performance of the service for a short period, during the absence of the regional manager in addition to their usual visits.

The organisation's group clinical auditor had also undertaken site visit and remote audit checks on information stored in the electronic care records management system. This identified areas where further work was required and action taken in response to previous audits.

A 'whole home audit' was completed by the registered manager on a quarterly basis following which an action plan was produced. This was a comprehensive 21-point audit tool that focussed on areas such as: home presentation; enquiry management; medication; care plan documentation; accidents and incidents; infection control; complaints; general and human resource records; finance; training and staff supervision; leisure and wellness; catering and dining experience; housekeeping and laundry and maintenance. The results for the most recent audit in August 2018 indicated that the overall score was 95.7%.

The regional manager told us that the purpose of the audit was to ensure key operational areas were assessed, to evaluate findings, formulate an action plan and then review progress against specific timescales during a recurring three-month cycle. We could see that actions were being monitored and that an overall action plan for the home had been produced. Other audits such as property and maintenance; clinical audits and unannounced home visits were also routinely completed.

Resident questionnaires were also sent out to people living in the care home or their relatives at quarterly intervals. We viewed the summary report for the period October 2017 to September 2018 which indicated that 32 feedback forms had been completed.

The questions focussed on the quality of care, food, leisure and wellness (activities), customer care, home environment and the likelihood of recommendation. Overall, 100% of respondents indicated they would recommend the care home to others. 100% scored positively when asked to rate the quality of care received. Likewise, 99% of the respondents gave positive feedback on the food, activities provided and standard of the environment. 98% selected positive for customer care.

We spoke with the regional manager, registered manager and the care home's administrator to ascertain whether it was possible to separate the feedback received from people using the service and their relatives. Likewise, we queried whether it was possible that the annual summary report had captured feedback from individual respondents on more than one occasion over the year through the quarterly cycles. We queried these points to determine whether the feedback was proportionate and reflected the overall views of people living in the home.

The registered manager reported that they would take this feedback forward in order to explore ways to refine the way in which people's experience was obtained and recorded to ensure continuous improvement.

People were also encouraged to share their feedback via the carehome.co.uk website and information on how to use this facility was displayed in the reception area of the home. We asked for a copy of the reviews submitted to the website and noted that there had been 34 reviews (21 in the last 12 months) had been completed between the period January 2016 to September 2018. The results were overall positive and resulted in an overall score of 9.7 out of 10.

Relative and resident meetings were coordinated throughout the year during which people were encouraged to share and receive information. Likewise, seasonal newsletters were distributed to people using the service and their representatives to share information regarding the home.

Staff had access to policies and procedures that had been developed by the registered provider that they could view via manual records or the care home's electronic records management system.

The registered manager continued to maintain a 'best practice' file which contained a range of awards that the home had achieved for example: the 'Gold Medal Award 2017' for the residential accommodation category and 'Community Housing Award 2017' from Britain in Bloom (North West) and a 'Certificate of Participation' for a food journey around the commonwealth awarded by the National Activities Provider Association (NAPA). Information on person centred trips and experiences, celebrations and meetings and other signification information such as staff appreciation awards was also recorded.

Periodic monitoring of the standard of care provided to residents funded via the local authority was also undertaken by Cheshire East Council's quality assurance team. This is an external monitoring process to ensure the service meets its contractual obligations. We contacted a representative from Cheshire East Council prior to our inspection and were informed that there were no outstanding issues with the care home and that they were due to undertake a full annual Quality assurance visit.

The registered manager is required to notify the CQC of certain significant events that may occur in the care home. The registered manager had kept a record of these notifications and had notified the Commission of reportable incidents as required under the Health and Social Care Act 2008.

Ratings from the last inspection were displayed in the entrance area of the care home as required. The provider's website also reflected the current rating of the service. Since April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services and the public with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.