New Century Care (Caterham) Limited

Buxton Lodge Care Home

Inspection report

53 Buxton Lane
Caterham
Surrey
CR3 5HL

Tel: 01883340788
Website: www.newcenturycare.co.uk

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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 4 December 2018 and was unannounced. Buxton Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection there were 32 people living at the home.

Buxton Lodge Care Home is registered to provide accommodation, care support and nursing care for up to 44 older people some of whom may have specific needs and/ or are living with dementia. At the time of our inspection there was an experienced registered manager in post. 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.

At our last inspection of the service on 28 June 2016 we rated the service overall as 'Good' and 'Requires Improvement' in Responsive. This was because guidance from healthcare professionals was not always being followed, daily notes and charts were not always being completed accurately and people's care records did not contain information of their medical conditions. Records were stored in multiple places and some staff did not have access to them. Following the inspection, the provider submitted a plan in which they told us that they would audit all files and change the way files are stored making them accessible to all staff. At this inspection we found improvements had been made and the service was meeting the regulations.

Risks to people were assessed and managed safely by staff. Medicines were managed, administered and stored safely. People were protected from the risk of abuse and staff knew what action to take to ensure people's safety and well-being. There were systems in place to ensure people were protected from the risk of infection and the home environment was clean and well maintained. The home environment was suitably adapted to meet people's needs. Accidents and incidents were recorded, monitored and acted on appropriately. There were safe staff recruitment practices in place and appropriate numbers of staff to meet people's needs in a timely manner.

There were systems in place to ensure staff were inducted into the service appropriately. Staff received training, supervision and appraisals. There were systems in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's nutritional needs and preferences were met. People had access to health and social care professionals when required and staff worked well with health and social care professionals to meet their needs.

People were treated with kindness and staff respected their privacy and dignity. People's diverse needs were

met and staff were committed to supporting people to meet their needs with regards to their disability, race, religion, sexual orientation and gender. People were involved in making decisions about their care. There was a range of activities available to meet people's interests and needs. The service provided care and support to people at the end of their lives. People's needs were reviewed and monitored on a regular basis.

There were systems in place to monitor the quality of the service provided. People's views about the service were sought and considered. The provider worked in partnership with other professionals and agencies and in line with best practice to ensure people received appropriate levels of care and support to meet their needs.

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

Risks to people's health and well-being were assessed, managed and reviewed on a regular basis to ensure people's safety.

There were systems in place to safeguard people from possible harm or abuse and staff were aware of the action to take if they had any concerns.

There were systems in place for the monitoring, investigating and learning from incidents and accidents.

There were safe staff recruitment practices in place and appropriate numbers of staff to meet people's needs in a timely manner.

Medicines were stored, managed and administered safely.

There were systems in place to manage emergencies and to reduce the risk of infection.

Is the service effective?

Good

The service was effective

There were processes in place to ensure staff new to the service were provided with an induction.

Staff were supported to do their job and received training, supervision and appraisals of their work performance.

There were systems in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005).

People's physical, mental and social needs were assessed before they moved into the home.

The home environment was suitably maintained and adapted to meet people's needs.

People were supported to eat a well-balanced diet and cultural

and nutritional preferences were met.

People were supported to maintain their health and well-being.

Is the service caring?

Good

The service was caring

People were supported to maintain relationships that were important to them.

There were established and affectionate relationships between staff, people and their relatives.

People were able to express their views and were provided with information about the service.

People's diverse needs were met and staff were committed to supporting people to meet their needs.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Good

The service was responsive

People's diverse needs were assessed and met.

People were involved in making decisions about their care.

There was a range of activities available to meet people's interests and needs.

The service provided care and support to people at the end of their lives.

People's needs were reviewed and monitored on a regular basis.

People were provided with information on how to make a complaint.

Is the service well-led?

Good

The service was well-led

There were systems in place to monitor the quality of the service provided.

The leadership at the home was positive and there was a caring

culture. Staff spoke positively about the registered manager.

Staff worked well as a team, communicated clearly and supported each other where needed.

People's views about the service were sought and considered.

The provider worked in partnership with professionals, agencies and in line with best practice to ensure people received appropriate levels of care and support to meet their needs.

Care Quality Commission

Buxton Lodge 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 checked 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.

This inspection took place on the 4 December 2018 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to our inspection we reviewed the information we held about the provider. This included notifications received from the provider about deaths, accidents and incidents and safeguarding. A notification is information about important events that the provider is required to send us by law.

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

We spoke with 10 people using the service and seven visiting relatives. We also spoke with 13 members of staff including the provider's clinical and governance director, registered manager, clinical lead, nursing and care staff, the chef and domestic staff. We looked at 11 people's care plans and care records, six staff recruitment, training and supervision records and records relating to the management of the service such as audits and policies and procedures. Following our inspection, the provider and registered manager also sent us information we requested.

People living at the home had varying levels of communication so we therefore used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing the support provided to people in communal areas, at meal times and the interactions between people and staff.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe within the home environment and with staff that supported them. Comments included, "Yes I am safe. I am happy here, they [staff] look after me and are very good", "[Relative] is very happy here", "Been here three years, I'm really well looked after", "It's a good place and the staff make sure I'm safe", and, "They [staff] have got me a button instead of a pull cord, they come straight away in minutes."

People were protected from the risk of abuse. There were up to date policies and procedures in place for safeguarding adults from abuse and staff we spoke with had a comprehensive awareness and understanding of what they needed to do to ensure people were safe from harm and potential abuse. They told us the signs they would look for and what they would do if they thought someone was at risk of abuse. They said they would report any concerns they had to the registered manager or the nurse in charge. Staff told us and records confirmed that they received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. and they were aware of the procedures and contact details of the local authority safeguarding team. This information was displayed around the home for staff and people's reference. One member of staff said, "I have done my safeguarding training and I have no problems reporting anything that's wrong. I know what to do." Another member of staff told us, "The registered manager would let the local authority know of any safeguarding concerns. I would tell the local authority or the CQC if I thought nothing had been done." Safeguarding records we looked at included local and regional safeguarding policies and procedures, reporting forms, a safeguarding monitoring tool to learn from any on-going enquiries and to assist in managing any concerns if required.

Accidents and incidents were recorded, monitored and acted on appropriately. There were systems in place to record and review accidents and incidents and to look for any patterns and trends to minimise the risk or reoccurrence. Monthly analysis was conducted and looked at factors that contributed to the accident or incident and records showed that health and social care professionals such as GPs and emergency services were referred to when required. Staff we spoke with knew what action they should take in the event of a medical emergency and described the training they had received which prepared them to be able to respond to emergencies appropriately. Staff were also aware of who was for resuscitation and care plan records showed evidence of this.

There were arrangements in place to deal with foreseeable emergencies. Records confirmed that staff received regular training on fire safety. The home had a fire risk assessment in place and we saw records confirming that the fire alarm was tested on a weekly basis and regular fire drills had been carried out. People had individual emergency evacuation plans in place which highlighted the level of support they would need to evacuate the building safely in the event of an emergency. There were systems in place to manage gas, electrical, and water safety. We saw certificates of maintenance and servicing from external contractors that confirmed that these were safe. Equipment such as hoists, call bells, mobility aids and lifts were serviced regularly to ensure they were functioning correctly and safe for use. Staff told us there was adequate equipment to meet the needs of people. One member of staff said, "We always have enough equipment to use here, and we can get more if we need." Pressure mattress settings were checked and

recorded on a daily basis by staff to make sure they were at the correct pressure for individuals and in proper working order.

We observed that call bells were responded to quickly when activated by people. The registered manager told us that most calls were responded to within three minutes of activation. If a call bell was ringing for more than three minutes the system automatically went into emergency mode and staff on hand attended immediately. They said that this did not happen frequently. The registered manager told us they did not formally record how they monitored the call bell system. We suggested to the registered manager that they formally record the occasions that the call bell system automatically went into emergency mode in order to assess if people were being responded to in a timely manner. We will check on this at our next inspection of the service.

We found that the home was warm, clean and tidy and free from any unpleasant odour. The home employed housekeeping/domestic staff. We observed them cleaning the home during our inspection. Staff we spoke with told us they had completed training on infection control, health and they had access to personal protective equipment such as gloves and aprons when they required them. There were hand wash facilities in bathrooms and toilets throughout the home which were used by staff. The registered manager showed us a report from an infection control audit carried out at the home in August 2018 and told us another audit was due to be carried out. They told us that all of the issues identified in the audit had been addressed for example, bin liners had been provided, there was a named infection prevention control champion at the home and taps and sinks had been descaled.

During the course of our inspection we observed there were enough staff on duty and deployed throughout the home to meet people's care and support needs promptly. A member of staff told us, "I would say staffing levels are adequate. We are busy, but there is enough staff. If staff are sick we get agency staff to cover." Another member of staff said, "We always have enough staff to meet people's needs." The registered manager showed us a staffing rota and told us that they used a dependency tool to arrange staffing levels according to people's needs. We noted that staffing level ratios and rotas corresponded with staff that were on duty. A nurse showed us a daily staff allocation record. This was used to plan how staff allocation at the home would be deployed. This was done according to people's assessed needs. For example, in the mornings extra staff were deployed to support people that needed two staff to support them with personal care and fewer staff were allocated to support people that could do most things independently. The clinical lead told us they worked three days during the week 'supernumerary' during which they carried out tasks such as updating people's care plans, arranging and following up on people's health care appointments, liaising with health care professionals, supporting the GP on their weekly visit and auditing pressure sores, falls, complaints and any incidents and accidents. The home also employed a care practitioner that worked 'supernumerary' two days each week that carried out similar tasks in relation to supporting health care staff.

The registered manager told us there were six health care assistant vacancies and two nursing staff vacancies. They said they were currently using more agency staff than they would want to and this was because the number of residents had recently increased. They told us the home was currently recruiting staff to fill these posts and in the mean time they used regular health care agency staff and occasional nursing agency to cover these vacancies. The homes administrator showed us records confirming that the agencies they used had carried out robust recruitment checks, that agency staff had completed training that reflected the needs of people living at the home and that agency nurses were registered with the NMC (Nursing and Midwifery Council). Appropriate recruitment checks took place before staff started work. We looked at the recruitment records of six members of staff and found completed application forms that included their full employment history and explanations for any gaps in employment, employment

references, health declarations, proof of identification and evidence that criminal record checks had been carried out.

Risks to people were identified, assessed and reviewed to help keep them safe. There were a variety of care plans and risk assessments in place to recognise people who may need further support and help to keep them safe. There were a wide range of risk assessment tools used to mitigate such risks. These included nutrition and hydration, falls and mobility, bedrail use, mental capacity, skin integrity, medicines management, communication, behaviour and for specialised medical areas such as diabetes, asthma and chronic obstructive pulmonary disease management. Risk assessments included guidance for staff and the actions they should take to support people safely whilst ensuring their well-being. For example, one care plan and risk assessment documented that the person may display behaviour that may challenge and a behavioural program was in place to support them. The plan detailed an evaluation of distressed reaction, how the individual communicates, signs of anxiety, how social relationship affected them, triggers and evaluation of any physical distress and triggers and interventions staff should take. There was also a monitoring chart in place for staff to record any behaviour. These enabled staff to provide care and support to people in a consistent and safe manner.

There were processes in place to ensure people's medicines were recorded, stored and administered safely. We observed staff administering medicines to people in a patient and kind manner. People received their medicines safely and care records detailed the support each person required to take their medicines. Medicines were managed and administered by staff who had received the relevant training and who underwent annual assessments of their competency. One member of staff told us, "We take medication very seriously, it is a big responsibility and I am very careful. We have support to make sure things are done right." Appropriate management systems were in place to ensure medicines were managed safely. Medicines were kept securely in locked trolleys and rooms, and administered by trained staff. Medicine Administration Records (MARs) contained information such as photographs and allergies of each person to ensure safe administration of their medicines. There were checks of medicines and audits to identify any concerns and address any shortfalls. Staff followed guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines. The provider had an up to date medicines policy in place which provided guidance for staff to ensure continued safe medicines practice.

Good

Is the service effective?

Our findings

Staff we spoke with told us they felt supported in their roles. One member of staff said that they received regular formal one to one supervision with their line manager. Another member of staff told us they were well supported by the registered manager and they attended staff meetings every two months, they said they even liked to attend staff meetings when it wasn't their day to work. A third staff member told us that team work at the home was very good and they felt supported by the registered manager, nursing staff and their colleagues.

The provider's current policy stated that, "Staff should receive personal supervision six times a year. Personal supervision can also be discussed in the form of staff meetings, group discussions as well as one to ones in a consultative form between three people." Staff records we looked at showed that staff had received supervision at various frequencies. For example, two members of staff had received supervision four times in 2018, another member of staff had received supervision two times, a third member of staff had received supervision once and a fourth member of staff had no record of having had supervision. We drew these omissions to the registered managers attention who told us they were aware of the issue regarding staff supervision and said that staff received group supervisions during staff meetings that had not always been recorded in staff files or on the supervision matrix. The registered manager told us they also held staff learning sets at the staff meetings for example, at the last meeting staff discussed safeguarding and nutrition and fluids. All staff we spoke with confirmed they had attended regular team meetings and they were aware that the meetings were group supervisions and a forum for learning. One member of staff told us, "The team meetings are very good, we discussed how we should support people with eating and drinking which was very helpful." Records showed that some staff had received an annual appraisal of their work performance. The regional manager told us they had recently carried out clinical supervision and an appraisal with the homes clinical lead nurse. The registered manager and clinical lead nurse told us that they were due to cascade clinical supervision and appraisal with the home's nursing team. The registered manager told us they planned to ensure that all staff working at the home had an annual appraisal of their work performance at the beginning of 2019. We will check on this when we next inspect the service.

Staff told us they had completed an induction which included a training programme when they started work. They also told us they shadowed experienced staff as part of their induction. The registered manager told us that new staff were required to complete an induction programme that included topics that were in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. We looked at staff training records and found they had completed training the provider considered to be mandatory. This training included dementia awareness, safeguarding adults, infection control, dignity, choice and equality and diversity, food safety, fire safety, health and safety, moving and handling, basic life support, fluid and nutrition, data protection and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff commented, "I enjoyed the dementia awareness training. It helped me to understand that people living with dementia will be affected in different ways and we need to support them as individuals." Where appropriate nursing and senior care staff had received training in the safe administration of medicines. Nursing staff had also completed training on topics such as medicines, wound care, catheterisation and syringe drivers amongst others.

People were supported by staff that had knowledge and understanding of gaining consent and the Mental Capacity Act 2005. People confirmed that staff sought their consent before supporting them. Comments included, "Oh yes they [staff] always ask me", "They [staff] are very good. They are always polite", and, "I can make my own decisions and staff respect that."

Staff we spoke with demonstrated good knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) including people's right to make informed decisions independently, but, where necessary to act in someone's best interests. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Care plans showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements of the MCA. We saw that applications had been made to local authorities to deprive people of their liberty for their safety, where this was assessed as required. Where these applications had been authorised, we saw that the appropriate documentation was in place and kept under review and any conditions of authorisations were appropriately followed by staff.

People's dietary needs and preferences were met and respected and people received their meals and support where required promptly. People and their relatives told us they were happy with the menus and food served at the home and they were given choice. Comments included, "Good food and just enough", "The chef is very good. She knows what they like", "I brought in Diwali food for the holiday which was encouraged", and, "I enjoy the food. It's always hot and there's lots of choice."

We visited the kitchen and observed it was clean and well organised. The chef was extremely knowledgeable about each person's dietary needs and requirements and they were able to explain to us in great detail how each person liked their food cooked, presented and how they wished to be supported with eating and drinking if appropriate. They showed us residents meal time information sheets that included a photograph of the person, their food preferences, the consistency of food and drinks for example normal, fork mashable, soft or pureed food and thickened or normal drinks. People's needs and risks relating to eating and drinking had been risk assessed. People that were at risk of choking had been assessed by speech and language therapist [SALT] and there were support guidelines in place so that they could eat and drink safely. The chef told us that three people at the home were fed using percutaneous endoscopic gastrostomy (feeding tube). Two of these people's information sheets recorded that they could have small amounts of soft pureed foods each day. The SALT guidance confirmed this was safe for these individuals. The chef told us they had regular meeting with nursing staff who advised them when people's dietary needs changed or following the nurses meeting with a SALT and the person's risk assessment had changed.

The chef told us they went around the home each evening asking people what they would like for supper that day and what they would like for lunch the following day. They told us they used a four-week rolling menu for meal planning, but these could be changed according to what people wanted. For example, on the day of the inspection some people said they didn't want to have either of the two meals on offer (lasagne or chicken) so they were offered a different option. We noted that there were no picture menus or sample

plates of food for people to choose from at meal times, however we saw a menu in large print that was displayed in the dining area indicating what was on offer during the week. The registered manager told us they were in the process of developing picture menus so that people could see what was on offer each day. We will check on this at our next inspection of the service.

We observed the lunchtime meal in the dining and lounge areas where some people preferred to eat their meals. The atmosphere in dining areas were relaxed and there were enough staff to support people promptly when required. Staff communicated effectively with people about the choices on offer and people had a choice of drink to accompany their meal for example, a selection of juices or wine. Food was served promptly and where required we observed staff supported people with their meals on a one to one basis and people received their specialised diets where appropriate, for example soft or reduced sugar diets.

People's individual care needs and preferences were assessed before they moved into the home to ensure staff and the home environment could meet their needs safely and appropriately. Assessments incorporated details about peoples' personal histories to help develop individualised care plans. Care plans included information about people's health and wellbeing, life story, physical and mental health needs, communication and medicines amongst others. Care plans documented the involvement from people and their relatives where appropriate and any health and social care professionals involved to ensure all individual needs were addressed and respected.

People were supported to maintain their health and well-being and when required were referred to health and social care professionals for intervention. Records, information and guidance from visiting health and social care professionals were retained in people's care plans to ensure staff were aware of people's presenting health and social care needs.

People living with dementia were cared for in an adapted environment to meet their needs. This had been achieved by displaying easy read and pictorial signage and memory boxes outside people's rooms filled with photographs and objects that were important to them to aid orientation. This made it easier for people living with dementia to identify different rooms in the home and to orientate themselves within the home environment.

Good

Is the service caring?

Our findings

Throughout our inspection we observed people were supported with kindness and compassion. People and their relatives told us they had developed caring relationships with staff who supported them. Comments included, "They [staff] are very good and very kind", "They [staff] are very considerate. When I came they put my pictures and a clock up on the wall for me", "Staff are very good, they always have time for a chat", "When I visit [relative] always appears well looked after. Staff are very good at letting me know if there are any problems", and, "They [staff] know [relative] very well. [Relative] always appears happy and enjoys the company of the staff."

Throughout the course of our inspection we observed people had positive, respectful relationships with staff and staff demonstrated a strong commitment to providing compassionate care. Staff knew the people they supported and had good knowledge of their personalities, behaviour and communication needs. They were aware of individual's daily routines, preferences, life histories, family and the things that were important to them. One member of staff told us, "In order for us to ensure that people have the best care we must know what's important to them and how best to support them." Another member of staff commented, "This is their home and everything I do, I do to my best ability to make sure people are happy and cared for well."

People were involved in decisions about their day to day care; were supported to express their views and were provided with information about the service that met their needs. One person told us, "Oh yes, I'm always asked what I want or how I want things to be done. They [staff] always involve me." A relative told us, "I am very happy with [relative's] care. They [staff] are very thoughtful and always make sure I'm involved." Another relative commented, "We have relative's meetings every three months and our concerns or suggestions are listened to. I suggested that the lounge chairs seating plan be reorganised which they did and it's better." The registered manager told us that people received a copy of the provider's residents guide on admission to the home. This provided people with information about the home including the home environment and facilities, the provider's promise and values, activities, admission process, cultural needs and the providers complaints process amongst others.

People's diverse needs were assessed and respected. Care plans included information about people's cultural requirements and spiritual beliefs and staff told us and we observed that they were committed to supporting people to meet their needs. Care plans considered and documented the support people may require in regard to any protected characteristics under the Equality Act 2010. For example, in relation to age, race, religion, disability, sexual orientation and gender. One member of staff told us, "I have had training on equality and diversity and I understand what it all means. I respect people who are different. I am happy to support people as best as I can no matter what their background or beliefs." One person told us, "I'm seen every week for communion. A priest visits me which I like." A relative commented, "[Relative] has a close relationship with another resident and staff respect this. They hold hands."

Staff we spoke with told us they supported and encouraged people to maintain their independence as much as possible. One member of staff commented, "I always tell people what I am doing for them and I encourage them to do as much as they can for themselves." Another member of staff said, "It's important we

support people to meet their care needs and to maintain their privacy and dignity. I make sure I close people's doors and draw the curtains when I am helping them with personal care." Throughout our inspection we observed staff spoke to people and their relatives in a respectful manner, addressed them by their preferred name and knocked on people's doors before entering. People were able to personalise their rooms with items and pieces of furniture that were important to them. One person told us, "They [staff] decorated my room for me but all the furniture is mine."

People were supported to maintain relationships with their friends and families and to make new friends with people living in the home. One person told us, "I have made lots of friends here and my old friends still visit." Another person commented, "My family visit all the time. I love seeing them." A third person commented, "I've settled down here. The staff here are helpful, and I am friends with other residents." Visitors to the home told us they were made to feel welcomed when they visited. One relative told us, "Staff are very friendly and I know I can visit whenever I wish." The home had systems in place which promoted and supported people to remain in contact with people that mattered to them. For example, people had access to the internet so people could send and receive e mails or make video calls to relatives and friends who were unable to visit. One person told us, "They provide Wi-Fi. I have a tablet."

Good

Is the service responsive?

Our findings

At our last inspection of the service on 28 June 2016 we found that people's care plans and records did not always contain detailed information on people's physical and mental health needs and were not always person-centred documenting individual's life history's and preferences. Following our last inspection all care plans and records were updated.

At this inspection we saw that people received care which met their individual needs and preferences. Personalised care plans were in place and developed based on assessments of people's needs and risks. Care plans contained personal information, which recorded details about people and their lives. Information was gathered from individuals, their relatives and professionals and staff involved in the person's care. One person told us, "They [staff] asked me all about my life and what I liked. They always ask if I am happy or if I want anything changed." A relative told us, "Staff spoke with us about [relative] and wanted to know all about them. I am aware of [relative's] care plans and staff always involve [relative] and us." Another relative commented, "Staff are very on the ball, we are always kept informed and they [staff] always call if there are any changes or problems."

Care plans documented the support people required and contained guidance for staff to support people appropriately in areas such as personal care, nutrition and hydration, mobility, skin integrity, communication, behaviour, life history and medicines amongst others. For example, one care plan documented the equipment needed to maintain the person's safety and promote good hygiene. This also included pictures of equipment for staff direction. The person's dietary profile also included good guidance and details for staff on safe positioning whilst the person ate and how staff were required to support them at meal times. Another person's care plan had clear guidance for staff on how to support the person in times of anxiety or agitation including the use of clear communication methods and de-escalation techniques. Care plans were reviewed on a regular basis through a 'resident of the day' process to help ensure they remained up to date and reflective of people's current needs. One relative told us, "Staff are very good at taking action quickly if needed. If ever there's a problem or change they act appropriately." Daily records were kept by staff about people's day to day well-being to ensure that people's planned care met their needs.

People's diverse needs, human rights and independence were supported and respected. Care plans and assessments considered the support people may require in regard to any protected characteristics under the Equality Act 2010. For example, in relation to age, race, religion, disability, sexual orientation and gender. Care plans reflected individual's preferences, social and cultural diversity and equality and impact assessments were completed to respect and consider any needs individuals may have. The registered manager told us that the home supported events that have meaning to individuals, for example they supported the celebration of Memorial Day, St Patricks day, Diwali, Hindu New Year, Ramadan, communion service, Easter and Christmas. Staff demonstrated an understanding of individual's needs and listened to people, their relatives where appropriate and supported people to observe their faith and any religious or cultural needs and wishes.

The home environment assisted in the promotion of people's independence, in meeting their needs safely

and equipment was readily available for people when needed. For example, with the use of pictorial signage and memory boxes that were in place to aid orientation and the use of wheelchairs and walking aids to support safer mobility around the home. The home was proactive in ensuring good communication and information was displayed around the home for people in accessible formats in line with the Accessible Information Standard. The Accessible Information Standard ensures that services must identify, record, flag, share and meet people's information and communication needs. The registered manager told us they had access to different communication formats to ensure everyone's needs were met.

People were supported to take part in a range of activities that were meaningful to them and that met their need for social interaction and stimulation. People and their relatives told us they enjoyed the activities on offer. Comments included, "I enjoy most of the activities. We've been on outings to the poppy factory, the seaside and visited a farm in the mini-bus", "We play games and I enjoy the arts and crafts", and, "I like to join in the quizzes." A relative told us, "[Relative] wasn't walking before they came here, now [relatives'] walking. [Relative] was withdrawn at home, but now [relative] joins in and comes across to people." During our inspection we observed group activities in the lounge which included quiz time and making music which the activities co-ordinator engaged directly with people and their relatives and handed out tambourines and maracas for people to play. People appeared happy and engaged in the activities and with the staff facilitating.

Staff worked in partnership with health and social care professionals to ensure people's needs and preferences were met. For example, care plans and records showed that staff worked with visiting GP's, speech and language therapists, social workers, community mental health teams and with palliative care teams to ensure people's end of life care needs were respected and met. Staff provided appropriate support to people at the end of their lives and care plans included information about individuals' end of life preferences where they had chosen to discuss this. We saw that some people had 'Do Not Attempt Resuscitation' orders in place where they, or their relatives where appropriate had agreed with a GP that this was in their best interests.

People and their relatives knew how to make a complaint and told us that they would be comfortable to do so if necessary. Comments included, "I'd go straight to the manager if I needed to make a complaint", "I have complained before about staff, I was listened to and action was taken", and, "The manager is very good, she is who I would complain to if needed." There was a complaints policy and procedure in place and this was displayed within the home for people and visitors to refer to. The policy included information on what people could expect if they raised any concerns, details of the timescale for responses and actions to take if they remained unhappy with the outcome. Complaints records we looked at showed that when complaints were received these were responded to timely and appropriately in line with the provider's policy.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the care they received and were complimentary about the staff and management of the home. Comments included, "Staff are like family they are awfully good", "All the family are involved and it's a good rapport", "The manager is very kind and approachable. I can talk to her", and, "I love living here, all the staff are marvellous." A relative commented, "Staff are very kind and helpful. I am happy that [relative] is here and gets good care."

We discussed the culture and ethos of the home with people, relatives and staff. One person told us, "There's a friendly atmosphere here and everyone seems to get along with each other." A member of staff commented, "I like working here, team work is good. The staff get on really well with each other." The provider had values in place which included, people were to be treated with dignity and respect at all times, to receive appropriate prompt professional and person-centred care to suit individual needs and to provide a supportive and friendly atmosphere, where individuals can live the life they choose. Staff we spoke with told us the registered manager was supportive and promoted the provider's values in their everyday role which was understood and respected by the staffing team. One member of staff commented, "The manager is very supportive and will always help if needed. They are always on hand and ensure that we have everything we need to make sure people are happy and get good care and support."

There were systems in place to recognise and acknowledge excellence in the work place. Where staff had demonstrated a positive influence on the quality of people's lives and provided good standards of care their efforts were recognised and celebrated through an employee reward scheme. The registered manager told us that they had a 'caring hearts' annual award and monthly staff awards whereby good staff practice was recognised and staff were awarded with a badge. The registered manager also told us that they showed staff their appreciation every few months by providing staff with treats such as pizzas for lunch.

At the time of our inspection there was an experienced registered manager in post. They knew the service well and were aware of their registration requirements with CQC. They knew the different forms of statutory notifications they were required to send the CQC by law and had completed their CQC Provider Information Return, as required. They were aware of the legal requirement to display their CQC rating. They demonstrated an in-depth knowledge of people's needs and the needs of the staffing team. During our inspection we observed that the registered manager was visible and available within the home to people, their relatives, visitors and staff.

Throughout our inspection we saw that staff were motivated in their roles, were smartly presented and displayed a sense of a caring culture within the home. One member of staff commented, "I find working here gives me job satisfaction and it's very rewarding." Staff worked well as a team communicating clearly and offered each other support when needed. There were good lines of communication within the home providing staff with opportunities to meet and communicate on a regular basis. Staff told us they regularly attended staff handover and team meetings and found them vital to ensure they carried out their jobs well. One member of staff said, "We meet every day to ensure all staff know what's happening and how people are. Staff meetings are also held and we have learning sets where we focus on specific areas like

safeguarding. The manager always keeps us updated." Another member of staff told us there was an out of hours on call system in operation that ensured that management support and advice was always available to them when they needed it.

The home worked in partnership and developed partnerships with other professionals and agencies and worked innovatively to ensure people received high standards of care. The home had implemented a 'Dementia Support Group' which aimed to meet exceptional standards of dementia care and worked in line with NICE guidelines (National Institute for Health and Care Excellence). We looked at the group's action plan and noted some actions that had been taken. These included, changes to the home environment and communal toilets which now have bright blue toilet seats to enable better visual orientation. Staff had also created and implemented positive behaviour support plans and staff were aware of the effects of dementia and sundowning and closing all curtains by 4pm in the winter months to manage these effects. Sundowning is a symptom of Alzheimer's disease and other forms of dementia. It's also known as "late-day confusion." The registered manager told us they worked closely with the local community and other groups and benefited from visits by local school children every Friday to spend time with people. They said, "Our residents enjoy spending time with the younger people, the younger people relate to the residents because of their grandparents and vice versa because of their grandchildren. There aren't any barriers in the interaction between the two groups which makes it such a positive experience."

There were governance arrangements in place to monitor, assess and improve the quality of the service. Records we looked at demonstrated that regular checks and audits were conducted in a range of areas to ensure the service was managed well and people received good standards of care. Audits undertaken focused on areas such as health and safety, medicines, nursing and clinical audits, catering, housekeeping and care records amongst others. As well as monthly or weekly internal home audits we saw that the providers regional manager visited the home and conducted audits every two months following the CQC Key Lines of Enquiries. Following the regional manager's audit conducted in October 2018 an action plan was implemented and completed for areas that were considered to require some improvement. For example, where recommendations were made for staff to have a better understanding of safeguarding policies and procedures and the MCA and best interest, training had been provided, learning had been discussed at team meetings and new behaviour tools had been implemented.

There were systems in place to ensure the provider sought the views of people and their relatives through regular residents and relative's meetings, 'you said we did' survey and through the use of comments and suggestion feedback cards. We looked at the results of the 'you said we did' survey conducted in May 2018. Responses showed that people were satisfied with the services provided and no responses came back as dissatisfied. Actions were taken to address comments made, for example, some people said they wanted a handbook with a copy of the complaints procedure and actions were taken including emails sent to all relatives outlining the complaints procedure, a copy of the complaints procedure displayed on the relatives notice board and a copy of the resident guide displayed at the reception desk. People were also encouraged and provided with the opportunity to leave comments on the provider's website and a care home website. Comments we noted included, "Residents always have lots of entertainment going on. Staff greet us with a smile every day", and, "On the whole, care is very well managed. Staff are pleasant and most helpful. This can also be said for the maintenance man, and the office staff upstairs."