WCS Care Group Limited

Dewar Close

Inspection report

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Date of inspection visit:
12 April 2016
13 April 2016

Date of publication:
23 June 2016

Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 April 2016 and was unannounced. The service was last inspected on 7 January 2014, when we found they were meeting the regulations.

The registered manager had been in post since April 2013. 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 service provides accommodation and personal care for up to 43 older people, who may have dementia. Thirty-six people were living at the home at the time of our inspection.

People were at the heart of the service. The provider's philosophy, vision and values were understood and shared across the staff team. Staff received training in the provider's values and philosophy, which included, 'play, make their day, be there and choose your attitude'. People were supported to maintain their purpose and pleasure in life. People's right to lead a fulfilling life was enshrined in a charter of rights, which all staff understood and respected.

The provider was innovative and creative and constantly strived to improve the quality of people's lives, by working in partnership with experts in the field of dementia care. The provider had researched and reflected on how an internationally recognised provider of excellence in dementia care provided care. They had re-modelled the home in accordance with current best practice principles, which included artefacts and different rooms designed to stimulate memories, provoke curiosity and to rest and relax.

The registered manager and staff participated in research projects aimed at improving the quality of care. Actions taken by the provider and planned improvements were focused on improving people's quality of life, based on the research and experience of experts. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences. The provider ensured people had the opportunity to share their views face-to-face, by telephone and by using the most up- to-date 'on-line' computer based methods.

People and relatives behaved as if the home were their own home. They maintained their preferred and familiar routines and habits, which made them content and relaxed. Staff took time to understand people's life stories and supported and encouraged people to celebrate important personal and national events. People were supported take an active interest in the local community and to maintain their personal interests and hobbies.

The provider employed a team of exercise and activity co-ordinators who were dedicated to supporting people to make the most of each day. The group activity sessions were effective and the positive impact on people's moods was visible. People and staff shared the moment of fun together, which developed trust and

positive relationships. Healthcare professionals and external agencies commented on the rapport between people and staff and the 'lovely' feeling that their rapport created across the home.

People planned their own care, with the support of their relatives and staff, to ensure their care plans matched their individual needs, abilities and preferences, from their personal perspective. Care staff showed insight and understanding in caring for people, because they understood people's individual motivations and responses.

Staff were attentive to people's appetites, moods and behaviours and were proactive in implementing individual strategies to minimise people's anxiety. Staff ensured people obtained advice and support from healthcare professionals to minimise the risks of poor health.

All the staff were involved in monitoring the quality of the service, which included regular checks of people's care plans, medicines administration and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence. The provider shared their learning with all the homes in the group.

There were enough staff on duty to meet people's physical and social needs. The registered manager checked staff's suitability to deliver personal care during the recruitment process. The premises and equipment were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored in their own rooms and administered safely.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. Staff understood the risks to people's individual health and wellbeing and risks were clearly recorded in their care plans.

Staff received training that matched people's needs effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care. Care co-ordinators were part of the duty management system, which meant there was a named manager available to respond to issues and to support staff, seven days a week.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people who were assessed as not having the capacity to make all of their own decisions, records showed that their advocates, families and healthcare professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because people were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs, staff supported people to maintain a balanced diet.

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. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who had the relevant training and skills for their roles. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Care staff were kind and compassionate towards people and encouraged them to take pride in their lifetime's achievements. People were encouraged and supported to live with meaning and purpose every day. Care staff respected people's individuality and encouraged them to maintain their independence in accordance with their abilities.

Is the service responsive?

Outstanding

The service was very responsive. People and their relatives were involved in planning their care and support. People's preferences, likes and dislikes were understood by the staff from the person's point of view. People were supported to maintain relationships that were important to them and to engage with the local community. People's views were regularly sought, listened to and used to drive improvement in the quality of service. Complaints and concerns were listened to, taken seriously and responded to promptly.

Is the service well-led?

Outstanding

The service was very well led. The provider's philosophy, vision and values were shared by all the staff, which resulted in a culture that valued people's individual experiences and abilities. The provider worked with other specialist services and organisations to ensure people were at the heart of the service. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences.

Dewar Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 and 13 April 2016 and was unannounced. The inspection was undertaken by one inspector.

The provider completed 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 reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with seven people who lived at the home and three relatives. We spoke with the registered manager, the care manager, a lead care staff member, six care staff and the cook. We also spoke with the Head of Care Services and Quality from the provider's senior management team.

Many of the people who lived at the home were happy to talk to us about their daily lives, but they were not able to tell us in detail, about their care plans, because of their complex needs. However, we observed how care and support were delivered in the communal areas and reviewed people's records.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and observed how care and support were delivered in the communal areas. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs.

We reviewed the results of the provider's quality monitoring system to see what actions were taken and

planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People and relatives told us the home felt like a safe place to be because they trusted the care staff. One person told us they felt safe because they could lock their door when they wanted to. A relative told us, "There's not a huge turnover of staff and that makes us feel safe." Another relative said, "I think [Name] is safe here. I would notice if they felt unsafe, I would see signs." We saw people trusted the staff. For example, we heard one person ask, 'Can I come with you?' to staff and they kissed the staff's hand.

People were protected from the risks of abuse. Care staff told us they had training in keeping people safe from the risks of harm and they knew the actions to take if they had any concerns about people's safety. A member of care staff told us, "I could report any safeguarding concerns to the manager." Care staff were confident they could challenge any poor practice and report it to the manager, because they had read and understood the provider's whistleblowing policy. Records showed the registered manager notified us when they referred concerns to the local safeguarding authority. The local safeguarding authority had not needed to take any further action to the concerns raised, because people were not at risk.

The registered manager assessed risks to people's individual health and wellbeing. For example, they assessed risks to people's mobility, nutrition and communication. Where risks were identified, people's care plans described the equipment needed and the actions care staff should take to minimise the risks. For example, one care plan we looked at identified that the person was at risk of falling. They were able to walk for short distances, but needed to use a wheelchair for longer distances. One member of care staff told us, "Two staff walk alongside [Name] to the bathroom, but we need to use a wheelchair with one staff to support them to the dining room." We saw staff supported the person as described in their care plan.

Care staff told us the measures and actions they took to minimise risks to people's safety were relevant, proportionate and individual to each person. They told us they were confident the registered manager or care co-ordinator assessed people's needs, abilities and their individual risks accurately. A member of care staff told us, "The care co-ordinator or manager learn all about people at the initial assessment. All the information is written in the care plan and updated when needed."
We saw care staff made sure people had call bells close to hand and ensured the environment remained safe, such as removing items that people might trip over. Care staff were vigilant about supporting people to avoid unnecessary risks. For example, when one person tried to sit on their walking frame, because they wanted to sit in a particular spot, a member of care staff moved a chair into their chosen spot so they could sit safely.

Care staff reported accidents and incidents to the registered manager and recorded them in people's personal daily records and the 'handover' book, to ensure all staff were aware and took action to minimise the risks of a reoccurrence. Detailed records of accidents and incidents included the location and time and identified the probable cause and the actions taken. Actions included referring people to the local falls clinic and other healthcare professionals, to check for changes in people's health, eyesight or hearing. Care co-ordinators reviewed people's risk assessments at monthly care plan review meetings to ensure any changes in their care and support were included in the person's updated care plans.

The registered manager analysed the accident and incident reports to identify whether there were any patterns or trends. The analysis showed the most recent accidents had all been due to people's individual mobility or health conditions. Records showed the registered manager shared the results of their analysis at monthly meetings and reminded staff of the actions they should take. For example, care staff were reminded to, "Check people more frequently at night," if they showed signs of ill health.

People and relatives told us there were enough staff on duty to support people safely. People told us they had the help and support they needed, when they needed it. The registered manager told us the provider trusted their judgement about how many staff were needed, because they used an agreed scoring system that took account of people's needs and abilities. Care staff were allocated to each floor, according to their skills and experience. Their responsibilities for each shift were clearly explained and documented in the management handover book. The care manager showed us how they reviewed each care plan monthly to assess whether people's needs had changed and whether more staff were required.

Care staff told us, although the mornings were 'the busiest', they felt there were enough staff to support people when they needed it, because people liked to get up at different times. Care staff told us there were two care staff on each floor and one additional member of care staff, who worked across the three floors, to support them. Care staff told us, "and the duty manager is always hands-on when needed." There were additional support staff, such as housekeeping assistants, cooks, activities co-ordinators and laundry assistants, which meant care staff were not distracted by household tasks, but could focus on each individual's personal needs. Care staff told us there were enough staff to support people's physical and emotional needs. Care staff had time to talk and socialise with people, which improved their well-being.

The provider's recruitment process ensured risks to people's safety were minimised. Records showed new staff underwent an application and interview process so the registered manager could check their skills and experience, and that their behaviours would fit well with the team and ethos of the service. Staff told us the provider checked their identity and right to work, obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. A member of care staff told us, "I had to wait four weeks for my DBS check. I did training while I waited."

The provider assessed risks to the premises and equipment and took action to minimise the identified risks. Records showed the provider had implemented a system of regular checks of the premises, the fire alarm and essential supplies such as the water, gas and electricity. Equipment, such as hoists, profiling beds and wheelchairs, was serviced by the supplier and staff regularly checked that items such as slings and walking frames were safe and fit for use. Care staff told us the equipment they needed was always available and safe to use. A member of care staff told us, "The equipment has a 'service date due' sticker and the battery pack (for the hoist) has a 'recharge' sign. We always put it back to recharge."

Care staff knew about the provider's emergency policy and procedures. Staff had training in fire safety and practised the routine. We saw signs in the hallway advising that the 'fire plan' and people's personal evacuation plans (PEEPs) were in the administration office in the reception area. A member of care staff told us, "I have seen the PEEPs and understand them." The care manager told us they regularly had a fire drill and care staff practiced using the specialised evacuation equipment. They told us, "Staff took the manager down the stairs in the ski pad as a practice." A ski pad is a piece of equipment used to assist people who are not independently mobile to evacuate a building in an emergency.

The registered manager took advice and guidance from the provider's health and safety officer and made changes to the home on their recommendations. For example, the bookcases that gave each landing on the

stairway a homely feel, had been identified as a fire risk as they could prevent people from exiting the building in a hurry. The registered manager had removed the bookcases because people's safety was their first priority.

Medicines were managed and administered safely and the risk of errors was minimised by effective procedures. Only trained staff administered medicines. The provider had recently implemented a new system for managing medicines. Instead of using the traditional trolley, everyone had a lockable cabinet in their own room to store their own medicines, which offered a more personalised service. The registered manager told us this supported people to have ownership of their medicines and enabled care staff to focus on the individuals' needs. People told us they liked the new system, because it was an opportunity to have a conversation while staff were in their room with them.

Medicines were delivered from the pharmacy with a medicines administration record (MAR), which listed the name of each medicine and the frequency and time of day it should be taken. Staff signed to say when people's medicines were administered, or recorded the reason why not, for example, if a person declined their medicines. The care manager told us the new supplier's MAR sheets used a slightly different style for recording pain relief tablets. They did not put any specific times for staff to offer pain relief, but stated the maximum amount a person could take safely in 24 hours. We saw staff had been directed to sign on the reverse of the MAR and write down the time pain relief medicines were administered with an end of day total, to ensure they were given in accordance with the manufacturers' guidance.

A care co-ordinator showed us one person's administration record and the boxes of tablets in their cabinet. Care staff showed us a manufacturers' leaflet was included in each box, so they could understand and explain to people about the importance and benefit of each medicine. They told us when the system was first introduced there were additional safeguards in place to ensure medicines were administered and recorded in accordance with people's prescriptions. For example, they had counted how many of each medicine were in the cabinet before and after they administered them. Once the care manager was confident the new system was working effectively, they had reverted to counting all the medicines once a week.

Good

Is the service effective?

Our findings

People told us the care staff were effective, because they were supported in the way they needed. One person told us, "The staff are very nice, very helpful. There are lots of them." Relatives told us they were pleased with the way care staff supported their relations. They told us, "The staff are experienced, they get it" and "Staff's training is useful. It teaches them the right attitude. They know what to do and how to behave."

People received care from staff who had the skills and knowledge to meet their needs effectively. Care staff told us they felt prepared for their role because their induction programme included observing experienced staff, training, reading people's care plans and getting to know people. Care staff told us, "I learnt the person's unique signs and was given guidance" and "I felt prepared because I trained on site. I got to know people in those four weeks. It was useful to have the opportunity to get to know them."

Staff attended training in subjects that were relevant to people's needs, such as moving and handling, food hygiene and how to care for people living with dementia. Care staff told us their training gave them confidence in their role. One member of care staff told us, "I have had training in Parkinson's and other older people's illnesses. I understand now what they are going through. I found that really helpful." Another member of care staff told us, "I had the training about people living with dementia. I enjoyed it. You've got to put yourself where there are." The provider's recently issued annual training plan, showed training was available for a wide range of needs and conditions that staff could access either on the computer or at trainer led sessions.

All new staff were required to complete the Care Certificate during their probationary period, unless they had already obtained a nationally recognised qualification in health and social care. The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

Care staff told us they had regular opportunities to discuss their practice, training needs and any concerns at one-to-one meetings with their manager. A member of care staff told us, "You can talk to the managers at any time. We have six monthly supervision and appraisal. I am quite happy. I enjoy what I do." Care staff told us they had annual meetings with their manager, to discuss their personal development plan. One member of staff told us they had been encouraged by the manager to apply for a senior role, which meant taking on new responsibilities. They told us they felt well supported in their new role because they had specific tasks, other senior staff coached them and they attended management meetings.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager understood their responsibilities under the Act. The registered manager completed risk assessments for people's understanding and memory, to check whether people could weigh information sufficiently to make their own decisions or whether decisions would need to be made in their best interests. Records showed, for example, people, or their legal representatives, signed to say they consented to how they were cared for, but the decision for most people to live at the home had been made in their best interests by a team of healthcare professionals.

Care staff understood their responsibilities under the MCA. They told us they attended training and understood people's rights to make their own decisions. One member of care staff told us, "Some people are able to express themselves. They might verbalise or make a face, or I can ask experienced staff." We saw care staff followed the code of conduct of the Act and asked people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff maintained eye contact and watched the person's facial expression and body language, to understand whether they consented to support.

One care plan we looked at was signed by the person because they had the capacity to decide how they were cared for and supported when they moved into the home, but their capacity had since declined. The registered manager told us the person would not be safe to go out alone because they did not recognise risks to their safety and therefore their care plan now included actions that restricted their freedom. The registered manager had applied to the local supervisory body for the authority to deprive the person of their liberty.

The registered manager had applied to the supervisory body, for the authority to deprive 12 people, of their liberty, because their care plans included restrictions. At the time of our inspection, the registered manager was waiting for the local authority's authorisation. The registered manager told us they were working on an additional 15 applications. People's liberty, rights and choices were not restricted unnecessarily. For example, two people, who had the capacity to understand the risks of going out alone, told us they could go out whenever they felt well enough and wanted to.

People were supported to maintain a balanced diet that met their needs and preferences. The cook told us menus were agreed by the provider, in consultation with nutritional specialists, and offered a balanced diet to help people, for example, with small appetites, to maintain their weight. Records showed there was a wide and varied choice of dishes at every meal. People's preferences, likes and dislikes were recorded in their care plans and care staff shared this information with the cook. The cook told us, apart from four people who followed a diabetic diet, no-one had any allergies, or had expressed any cultural or religious preferences currently, but they would be able to cook for any dietary requirement. The cook told us, "If anyone has specific religious or cultural dietary requirements, the manager will let me know and print out some guidance about what that means for meal planning and preparation."

People were supported to eat and drink enough and to enjoy mealtimes. People told us, "The food is spot on", "There is soup every day" and "There is always a choice of meals and they are very nice." People told us care staff asked them every day, "What would you like to eat?" and they could ask for a different meal from the menu. They told us if they changed their mind about what they wanted, staff would bring them a meal of

their choice. One person told us, "The menu changes every six weeks or so. I can have a salad or omelette or tuna if I don't want the cooked meal." A relative told us, "They know [Name]. They always give them their preferred breakfast cereal in the morning."

People told us they could eat where and when they wanted. For example, one person told us they liked to have their breakfast in their room, when they were ready and did not have to go to the dining room at a given time. At lunchtime we saw people were encouraged to eat in the dining room, which gave them an opportunity to socialise. Care staff respected people's right to choose and people ate in their rooms if that was their preference. Care staff were able to sit and eat with people to make each mealtime more of an occasion and encouraged them to eat.

Care staff supported people to eat independently by making sure they had appropriate plates, cutlery and adapted cups they could use without assistance. People were offered meals in a form that matched to their abilities to manage independently and swallow and could be changed with their changing needs. For example, one person who needed soft meals when they first returned from hospital had been re-assessed and was now able to eat textures as long as the food was presented in small enough pieces.

Care staff had a good understanding of people's appetites and behaviours to know whether they had eaten well, within their normal range. One person declined to eat any of their lunch, so staff put it aside for 'later'. Care staff told us, "[Name] isn't hungry. They were up early and had two breakfasts, that's probably why." Another person ate the whole of their meal and pudding, then moved away from the table. Care staff told us, "[Name] got up and left the table, which told me they didn't want any more." Relatives were confident that care staff understood their relation's preferences and appetites. A relative told us, "[Name] always says, 'I'm not hungry.' They are not a big eater and staff weigh them regularly to check. If I was worried, I would say."

Care staff monitored people's weight and their appetites and sought advice from healthcare professionals, such as a dietician if, they were at risk of poor nutrition. Records showed people were weighed monthly, or weekly if their appetite or weight was a concern. A member of care staff told us, "We keep food and fluid charts for people who might be low weight or losing weight. We can refer them to the GP if we are worried." They told us one person's food and fluid intake was monitored because, "Their appetite is unpredictable." The management handover book showed that care co-ordinators checked that staff kept the charts up to date, so they could monitor whether the health professionals' advice was effective.

People and relatives told us care staff obtained advice from healthcare professionals when needed. People told us care staff had called a doctor and an ambulance for them in the past. Relatives told us, "They will call the doctor for [Name] if needed" and "They keep us well informed, any issues and we are always informed immediately."

People were supported to maintain their health and were referred to healthcare professionals, such as GPs, opticians and chiropodists, when needed. Records showed staff noted the healthcare professionals' advice and whether their advice had the intended impact. Staff handover meetings were led by a care co-ordinator with care staff from each household. Staff shared verbal information about people's appetites, behaviours, appointments with healthcare professionals and the advice the professionals gave, to make sure all staff were aware of any concerns and the actions they should take.

Good

Is the service caring?

Our findings

People and relatives told us care staff were kind and caring. People told us, "I like it here. All the carers are good", "It's lovely here" and "I do think of it as home now." Relatives told us, "When they said the words, 'person centred care' I knew this would be the right place" and "The staff are wonderful. They love [Name] and that's what counts. There's a lot of love here."

Care plans were written from the person's perspective, so staff understood their needs and abilities from the individual's point of view. Care plans included a personal profile, entitled, 'This is me', as promoted by the Alzheimer's Society. The profile included a brief history for each person and details about their preferences, likes, dislikes and people who were important to them. People's relatives were encouraged to share their memories of their relation, so staff could get to know them better. A relative told us, "They asked us to put a book of photographs together to help [Name] remember. They look at it with [Name]."

Relatives told us care staff understood their relations well and were especially observant of people who could not express their wishes verbally. They told us, "They play it by ear with [Name], it depends on [Name's] mood" and "The reality is that care is determined by the individual person." We saw care staff understood people well. When people showed signs of being upset, staff demonstrated well-learnt techniques of distracting them with conversation, a walk around and a cup of tea, which reduced this. A relative told us, "I know when I am not here it still goes on. Their understanding of [Name] is great."

People and relatives told us the staff treated them with dignity and respected their choices. Care staff told us, "Dignity and respect means following their preferred routine - and using coverings when delivering personal care." People told us they made their own decisions about how they lived their lives and were encouraged to maintain their preferred routines. People told us they got up, went out and went to bed when they chose and care staff supported them with their decisions.

One person told us, "I can stay in bed as long as I like. I like a lie in. I get up when I am ready and I get a nice cup of tea first thing in the morning." A relative told us it was an 'easy place' to be because, they had observed, "People just get on with their lives." Relatives told us were encouraged to share in caring for their relation as they would have done in their own home. One relative told us, "I can come in and support [Name] with personal care as often as I like." Care staff were reminded of the person's and their relatives' preferences about laundry in a note in the person's room.

The registered manager and staff had decorated the hallways and communal rooms to help people find their way around and to promote memories and conversations. For example, there were posters of vintage vehicles' and black and white pictures of the local town, and the main employers in the town, from the 1960s. One person remembered the days when they worked for one of the employers and explained what their job entailed to us. For one person who was particularly interested in the royal family, staff had put up photos of the queen through the years in the corridor where the person could easily see them.

The registered manager's drive to make the home more like a person's own home, included keeping

chickens in the back garden and a cat, whose favourite place to sleep was in the conservatory. The care manager told us the cat had moved in with one person, but people had voted to keep the cat at the home when its original owner had passed away, because they loved it. The cat feeding bowls on the floor and a half-finished jigsaw puzzle on the conservatory table were encouraging signals for people to treat the home as their home. Relatives told us, "This home just felt right. It's not too new, not intimidating" and "It's not the poshest, but the love is fantastic.

We saw people had brought their treasured personal possessions and small items of furniture with them to the home. One person told us their relative dusted and cleaned their photos and ornaments and they liked reminiscing with them while they dusted. Staff and relatives had supported people to make 'memory boxes' with photos and memorabilia, which were put up outside their bedroom doors. This helped people remember which room was theirs and enabled staff and visitors to start conversations with people about topics that interested them. Care staff had created a mural of a tree on one wall and attached people's photos to the ends of the branches, to illustrate they all belonged to the Dewar Close family.

Relatives told us they could visit at any time and always felt welcome. One relative told us, "When I first phoned up to ask if I could visit, the manager said 'this is [Name's] home, you don't have to ask us if you can visit, we just work here'." Relatives told us they visited as often as they liked and stayed as long as they liked. They told us, "They've let me be a part of it. Sometimes I spend all day here. I feel at home here" and "It's not about the building, it's about the staff, the relationships."

Outstanding ☆

Is the service responsive?

Our findings

People told us the registered manager and staff were very responsive to their needs. One person told us they had a care plan and a life diary and an annual review, which made them feel in control of how they were supported. Relatives told us, "I was pleased I didn't need to make an appointment to look round, I just came in" and "We were shown around and were able to speak with the other residents before [Name] moved in. We got a good feeling. This felt right." One relative told us, "When we tell healthcare professionals at appointments where [Name] lives, they say the staff are very good and there's a lovely feel to the place."

The registered manager and staff were flexible and responsive to people's individual preferences and ensured people were supported to live the lives they wanted, in accordance with their needs and abilities. For example, in one person's room, we saw a reminder to the morning staff to, "Ask [Name] if they want to go out with [Name of relative]. If they say yes, make sure they are ready by 10:30" because that was the time their relative had agreed with them. The person told us their family members visited whenever they wanted them to and they often went out with their family.

One relative told us their relation took a particular delight in flowers earlier in their life and still enjoyed seeing them. The relative showed us a huge plant box that staff had filled with flowers, which was placed right outside the person's window and filled the room with colour. The relative told us, "It's real here. They try everything. They are never impatient. They keep trying."

The registered manager and staff took particular care to respond to the needs of people who were not able to express themselves verbally, but responded to sights, sounds and smells. One relative told us they understood how people's needs and abilities were assessed because the registered manager had shown them and explained how they used the assessment tools. For example, the assessment tool used to understand people's ability to engage with others noted whether they were able to 'plan, explore, respond to or sense' activity, which determined the level of support needed from care staff.

Care staff showed us the words and picture book they had created for one person who had difficulties in communicating verbally. The book included yes, no, the names of television and radio programmes, a series of 'I would like to' options and a range of facial expressions to illustrate different emotions. A member of care staff told us, "We don't need to use them so much now we have got to know [Name]."

People told us they were supported to maintain their interests and preferred pastimes. People's care plans included a social history record, which outlined people's previous lives, family, work and experiences. This gave valuable information for staff to know and understand how people might choose to live their lives. People told us they 'pleased themselves' about how they spent their time. One person told us they continued to go out to a local gym with a friend and continued with their membership of a local charitable organisation. For another person, being able to feed the birds from their window was important and gave them a continuing sense of satisfaction. Several people said they enjoyed playing dominoes and cards with other people, attending the activity and exercise sessions available at the home and spending time in their own room watching television.

The registered manager had recruited two activity and exercise coordinators, who had attended accredited training to deliver a programme of personalised activities and exercise for five hours a day, seven days a week. We saw everybody had a copy of the 'daily activities plan' to remind them of the opportunities for 'purposeful' activity and socialising every day. People told us they were able to pick and choose which events to attend. Two people told us they went to the exercise class because, "It is fun."

During our visit we saw people who had not mentioned the exercise classes to us had also turned up and joined in or enjoyed watching. The activity co-ordinator stood in the middle of the room and demonstrated the arm and leg movements people could try out in time to music. They called out instructions, such as, "Wave, shimmy, disco arms, spin arms, splish, splash, stamp in puddles, reach far, far away, grab dreams." People were given coloured pompoms to wave, which created a party atmosphere. Several staff supported the activity co-ordinator and encouraged people to join in with smiles and their own enthusiasm. When one person appeared confused by the instructions, staff took hold of their hands and danced with them, which caused them to smile.

One relative told us, "[Name] likes the activities and it's good for them to keep mobile." We saw the person had a certificate in their room, awarded by the activities co-ordinator, for [Name's], "Amazing dance moves." The relative told us, "The staff like [Name] and she responds to them." Staff kept a daily diary (blue book) with photos for each person in their own room, which was available for people and their relatives to look at and remind them of events and activities they had attended and enjoyed. One person invited us to look at their blue book, behind the door in their room. The person was proud to show us the photos of them enjoying themselves.

Before people moved to the home, the registered manager visited them at their own home or hospital, to assess their needs and to understand how they wanted to be cared for and supported. A relative told us, "Two managers took a whole day to assess [Name's] needs. [Name] only said one word, and they understood from that word that [Name] was passionate about [pastime]. Then they found out all about them." Another relative told us, "We had an initial assessment and I come to all of [Name's] reviews." People's needs and abilities were reviewed every month and their care plans were updated when their needs changed.

People and relatives told us they were involved in planning their care and support. One person told us the registered manager had encouraged them to make current and future plans to make sure their wishes were known, if they ever became too poorly to express them. They told us the manager had referred them to an 'advocacy service', to make sure they had independent advice for their financial plans, which they really appreciated.

People were supported to express their religious beliefs and to maintain their cultural or religious needs during their initial needs assessment. There was a dedicated page in the care plans to record these. A member of care staff told us, "The 'clipper' assessments tell us about people's preferences, hobbies and spiritual needs and people tell us." During our visit, some people attended a religious service that was held at the home and we spoke with the representative of a local church group, who was visiting the home. They told us they planned to 'bring the local community into the home', for those people who could not easily access the community independently. The plans included young people from the church visiting the home to join people in celebrating the Queen's 90th birthday. They showed us a copy of a souvenir book they planned to give to everyone at the home.

People were encouraged to maintain links with people who were important to them and to celebrate important events. We saw photos of one person celebrating their birthday in the lounge with their family,

who wanted to arrange it. We read about a new member of the provider's management team helping people to celebrate reaching 100. The new staff member had interviewed two people about their life stories and written a report as part of their anniversary celebrations.

The registered manager told us the report would be used in a publication about the home and served a dual purpose of, "Giving people a voice and improving new staff's understanding of the care home environment and its purpose." We learnt that one centenarian was one of two generations of their family to live at the home, and the second centenarian had laid the foundation stone when the provider built a new home in the town. The stone is affectionately known as '[Name's] stone'. We saw both people had put their telegrams from the Queen in their memory boxes.

The Head of Care Services and Quality told us about the provider's plans to offer pastoral care, through volunteers. The volunteers would be asked which activities they would be able to support people with, such as gardening, and to become a listener and friend to individual people they supported with that activity.

All the staff were dedicated to supporting people to celebrate special occasions. The cooks told us they frequently stayed on to cater for special events and barbecues. They provided meals for the 'Evening Club', which offered meals from other cultures, prepared cheese boards for the 'Cheese afternoons' and made cakes and scones for special functions and birthdays. Plans for future events included celebrating the Queen's 90th birthday and organising a garden party for the National Care Home Open Day.

People and relatives told us they were confident any concerns would be dealt with appropriately. The provider's complaints policy was shared with people and their relatives and was displayed in the reception area. People told us they had not made any complaints. A relative told us, "I would know how to complain. There is a leaflet in the hallway. It's good that it would go straight to head office. You might not want the staff to know you had made a complaint." Another relative told us, "The complaint forms are on display, but they always resolve problems early."

The registered manager logged all issues raised, not just formal written complaints. They told us, "Treating comments, concerns and issues with the same respect as written complaints gives people a voice. Nothing is insignificant to the person. We act and build trust by taking their concerns seriously, because someone has listened to them." The local authority commissioners told us, during their recent visit, that people had said they were, "Very happy with their care."

Records showed no formal written complaints had been received, but the registered manager responded to concerns promptly and took action to resolve them. We saw actions taken to resolve issues included the provider paying for a repair to some electronic equipment that was accidentally damaged and the implementation of the specific responsibility for staff to check, and record their check, that, "All bells and alarm mats are plugged in at the start and end of each shift." A relative told us, "They respond to complaints. The chief executive came and did a shift in the laundry to get to the bottom of the problems raised last year."

Outstanding ☆

Is the service well-led?

Our findings

People told us they were very happy with the quality of the service they received, because it felt like their home and they continued to live the lives they wanted to. Relatives told us they were happy with the quality of the service. One relative told us, "They have fulfilled the trust we have in them" and another relative told us, "I've told them (the registered manager), I would move in here."

The registered manager and provider proactively sought people's views and took action to improve their experience of the service. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The questionnaires asked people what they thought of the food, their care, the staff, the premises, the management and their daily living experience. The provider had a history of taking action to improve the quality of the service based on the results of their surveys. During the previous 12 months, the provider had introduced a seven-day laundry service and a seven-day duty manager system. This meant people, relatives and staff had a senior member of staff with the appropriate authority, to refer to between 7:00am until 9:00pm, seven days a week.

Following analysis of the most recent quality survey in 2015, and a service manager's observations of people's experience, the provider's action plan included the introduction of 'mealtime experience standards' across the group of homes. Registered managers were tasked with observing mealtimes from the point of view of a person who lived at the home, discussion with staff about how to improve people's experience and agreeing the criteria for how to ensure the best possible mealtime experience. The standards encompass the atmosphere, staff's knowledge of people's needs and abilities with eating and how people are supported to engage in the process of preparing for and consuming meals. This initiative supported the provider's philosophy of putting people at the heart of the service.

People were encouraged to share their opinions informally through freepost comment cards in reception and via a hotline number to the Chief Executive. The provider made sure people knew they listened to people's views. They explained the results of the surveys and the actions they had taken in response to the questionnaires and comment cards through a regular newsletter that was posted in reception. We saw the duty manager's name was displayed in the reception area, so visitors knew who to ask for if they had any concerns, whenever they visited.

The provider had recently restructured the management team and identified new roles of Director of Innovation and Delivery and Head of Care Services and Quality to support their commitment to continuous innovation and improvement. The Head of Care Services and Quality told us the provider planned to introduce two new methods for people to feedback about the service. They planned to include a survey facility on their website and to leave 'business cards' in reception showing their email address, to ensure continuous availability for feedback. This will enable people and relatives to share their views whenever they wish, not just when requested by the provider.

The provider sought feedback about the quality of the service from other agencies, for example, from Age UK. Records showed an 'expert by experience' from Age UK had spent time at the home observing and

listening to people's experience of the service. The provider had a history of taking action in response to feedback from Age UK. They had already changed how people's medicines were stored and administered, in response to the finding that medication trolleys 'rattling' along the corridors was not a good experience for people. The provider already planned to introduce 'acoustic call bell monitoring at all of their homes. When a call bell is pressed, a message is sent directly, but silently, to care staff's work mobile phone so they know who needs attention. The monitoring system includes voice recognition, which can be programmed to a person's voice if they are unable to use the call bell, and can be monitored remotely.

Age UK's most recent visit to the home, in November 2015, had highlighted the 'rapport and bond' and level of 'openness and trust' between people and staff, which reflected that, 'people felt safe and secure'. A recent service manager's visit had identified that improvements could be made in ensuring people and relatives were encouraged to maintain their relationships with the support of a named member of staff. The registered manager planned to create 'family profiles' for each person, to include each family member's date of birth, so people were assisted to remember and contact their families on important dates. Key worker photos were planned to be given to each person and their families, so they could easily identify the member of care staff that that best understood and advocated for them.

The registered manager told us they had been working in partnership with Age UK to provide emotional support for carers when their relation moved into the home. Relatives could meet with a member of staff, or an Age UK volunteer, at the care home, or their own home, to have the time and space to talk about the carer's own emotional concerns related to the move. We saw this free and confidential psychological support service was explained in a poster in the hallway.

The registered manager told us relatives did not always want to attend annual 'reviews of the home' when they were arranged. However, relatives told us they did not need to because they felt well informed and the manager responded to their individual feedback. One person told us they had chosen for their relation to change bedrooms, because the room was 'better' than the original room, but they wanted to make some changes to the décor in the new room. Although the relative was prepared to pay for the changes, they told us the registered manager had agreed the provider would pay for all the changes they had suggested.

The registered manager had held drop-in sessions for people and relatives to support them to understand the impact of the recently implemented living wage on their costs. People and relatives were 'signposted' to other agencies, such as Age UK clinics, for financial advice. The meetings were not minuted as the advice was confidential. One person told us they really appreciated being signposted to an independent advocacy service. A relative told us, "They are very open and happy to talk. At the last relatives' meeting we had coffee and a talk in the conservatory. We were shown people's craftwork and they explained the vision of the company."

The provider's vision and values were imaginative and person-centred and put people at the heart of the service. The Chief Executive had personally delivered training sessions to managers, followed by further sessions delivered to the rest of the Dewar Close team, about their vision, values and philosophy, 'To make a difference'. The training included all staff signing up to, "Play, make their day, be there and choose your attitude" (by parking the personal). The vision and values included a charter of what people should be able to expect of the organisation. Almost all the staff had attended the training, and the ethos was demonstrated through the management team's leadership and behaviour.

Relatives told us the registered manager was approachable and a good leader, because they led by example. Relatives told us, "The manager is brilliant", "The manager's very nice. We missed them when they were away" and "The managers frequently do shifts so they know what they are asking of the staff. They

understand."

The registered manager understood their legal responsibilities. They sent us notifications about important events at the service and their provider information return (PIR) explained how they checked they delivered a quality service and the improvements they planned.

The provider's policies and procedures relating to safety were implemented consistently and effectively. The information we held about the service showed a continuous history of meeting the regulations since the initial registration. The registered manager's approach to risk management and their response to issues was effective. This was reflected in a complete absence of people, relatives, staff or other agencies sharing any negative comments with us in the previous 12 months.

The provider's improvement plans included a clearly described staff retention and development programme. They had appointed care co-ordinators, to improve management level skills and support at the home and to support staff's career development. Care co-ordinators were attending a leadership training programme to ensure they were equipped with the skills and knowledge they needed to be successful in their role. The programme included care co-ordinators across the provider's group of homes meeting together to share information and ideas. A newly appointed care co-ordinator told us, "I have line management meetings about developing my practice and attend care co-ordinators meetings and learn from that."

Care staff told us they felt well supported. They said they attended regular meetings and received the training and development they needed to be confident in their role. They told us they felt well informed about the home, their responsibilities and areas for improvement. One member of care staff told us, "There is always a senior manager available for advice and support. I never feel alone or unsupported." Another told us, "I have specific tasks and get guidance and feedback from the care co-ordinators and the manager. They explain the parameters." Staff told us they enjoyed being able to 'make a difference' to people's lives. They told us, "This isn't a job, this is their home" and "I have been here a couple of years and I absolutely love it."

The provider promoted an open culture by encouraging staff and people to raise any issues of concern with them, which they always acted on. All the staff team were involved in monitoring the quality of the service through regular audit checks of, for example, people's care plans, the premises, equipment, food and medicines. Where gaps or omissions were identified in recording, staff were reminded of the importance of keeping good records at group or one-to-one supervision meetings.

The provider had created cleaning and safety audit schedules for daily, weekly and monthly checks with designated responsible staff. The registered manager's role included checking that staff monitored and reported their findings to make sure appropriate action was taken when necessary and to minimise the risk of a re-occurrence. Records showed, for example, medicines errors, accidents and incidents were analysed by the individual affected, the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring individuals to healthcare professionals, refresher training for staff and sharing information with relatives, the local safeguarding team and CQC.

The Head of Care and Quality told us the recently implemented, "Provider's 'compliance audit dashboard' tracks how well we know the person and the efforts we have made to get to know them. We track whether memory boxes and life histories are in place at assessment, after six weeks and after 12 weeks." This initiative will enable the provider to analyse where there are barriers to getting to know people and take action to overcome them.

The registered manager delivered monthly reports to the provider so the provider could be assured that care was delivered and monitored consistently across the group of homes. The provider produced monthly statistics for a range of indicators, which enabled managers to compare their performance and learn from others. For example, the provider monitored how many people were at risk of poor nutrition, the number and causes of accidents, incidents and falls and how complaints were handled. The registered manager attended regular meetings with other registered managers to discuss the monthly reports, to reflect on their practice and share ideas for improvements.

The provider learnt from their experience and took action to improve. When issues arose at any of the homes in their group, they investigated the issue and applied their learning across all the homes. For example, the provider had recently reviewed and updated their policy for assessing people's mental capacity and for how they recorded when they made decisions in people's best interests. The updated policy and procedures were shared immediately by email and then through workshops for all staff who were responsible for implementing the policy. The registered manager had enacted the policy and completed mental capacity assessments for everyone at the home. They had subsequently applied to the supervisory body for the proper authority to restrict the liberty of those people who were assessed as not having the capacity to recognise risks to their wellbeing.

The provider followed guidance from specialists in the field of residential care, such as the Social Care Institute of Excellence. The provider had adopted recognised tools and methods to ensure people received care in accordance with the latest best practice. For example, they used recognised assessment tools to understand people's lifestyles and activity levels, in order to develop an individual profile of a person's interests, likes and dislikes and to diagnose their level of ability and interest to plan how to present activities at the 'right' level. The registered manager had explained to a relative how they assessed people's abilities, which gave the relative confidence in the manager and in how best to support their relation themselves.

The provider's emphasis was on continually striving to improve by implementing innovative systems and practices. As part of their research into dementia care, a management team had visited an internationally recognised provider of excellence in dementia care, to learn about their methods, and planned to introduce their methods into the home. The Head of Care Services and Quality told us how the provider's experience was used to promote and influence best practice in dementia care. An organisation that offered training in care-staff-led activities and exercise programmes had recently used one of the other homes in the group to film a teaching video, to demonstrate how the programme could be used.

After consultation with the staff, the registered manager had signed up to an NHS funded programme aimed at enabling research in care homes (ENRICH). The purpose of the programme is to develop best practice guidance and information about training and resources for health care staff.

The registered manager and care staff had participated in studies with three universities at the time of our inspection. Care staff had attended one-to-one interviews with researchers and completed questionnaires about their experience in three different areas of care. They had explained their feelings at the time of death and loss, their experience of supporting people who exhibit challenging behaviour and their experience of delivering palliative care for older people and end of life care. The study results and clinical implications will be shared with the participants and will inform the development of best practice guidance.