Follett Care Limited

# Tripletrees

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

The inspection took place on 27 April 2016 and was unannounced.

Tripletrees provides accommodation for twenty-eight older people, some of whom were living with dementia and who may need support with their personal care needs. On the day of our inspection there were twenty-two people living in the home. The home is a large detached property situated in Burgess Hill, it has a communal lounge and dining room and well maintained gardens.

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

Staff told us that they found their induction training helpful and that it enabled them to develop an awareness of people's needs and an understanding of their role. Staff were sufficient in number to ensure people's needs were met and their safety maintained. People were safeguarded from harm. Staff had received training in safeguarding adults at risk, they were aware of the policies and procedures in place in relation to safeguarding and knew how to raise concerns. People felt safe. One person, when asked what made them feel safe told us "Everything, they look after me".

Risks to people's safety had been assessed and identified and measures put in place to ensure people's safety. For example, for people who had been assessed as being at risk of developing pressure sores, appropriate measure had been taken to ensure they had access to relevant professionals and equipment to minimise the risk of skin breakdown.

People received their medicines on time and told us that if they were unwell and needed medicines that staff provided these. Observations confirmed this. Medicines were administered by trained staff who had been provided with relevant guidance to inform their practice. There were safe systems in place for the storage, administration and disposal of medicines.

People were asked their consent before being supported with care. Mental capacity assessments and deprivation of liberty applications had been undertaken to ensure that, for people who lacked capacity, appropriate measures had been taken to ensure that were not deprived of their freedom unlawfully.

People had access to relevant healthcare professionals to maintain good health. Records confirmed that external health professionals had been consulted to ensure that people were being provided with safe and effective care. Healthcare professionals confirmed that people received appropriate support to maintain their health. One healthcare professional told us "There is good communication, they ring us or speak to us when we are here for other people if they are ever worried about anyone".

People could choose what they had to eat and drink and felt that the food was good. For people at risk of malnutrition, appropriate measures had been implemented to ensure they received drink supplements and foods were fortified to increase their calorie intake.

People were involved in their care and decisions that related to this. Regular reviews and meetings provided an opportunity for people to share their concerns and make comments about the care they received. Relatives confirmed that they were involved in people's care, felt welcomed when they visited the home and knew who to go to if they had any concerns.

People were treated with dignity, their rights and choices respected. Observations showed people being treated in a respectful and kind manner. People's privacy was maintained, when staff offered assistance to people they did this in a discreet and sensitive way. People confirmed that they were treated with dignity and their privacy maintained.

Staff knew people's preferences and support was provided to meet people's needs, preferences and interests. There was a variety of activities that people appeared to enjoy. People were able to make suggestions as to how they wanted to spend their time and these were listened to and acted upon.

There was a homely, friendly and relaxed atmosphere within the home. People were complimentary about the leadership and management. Staff felt supported by the registered manager and were able to develop in their roles. Healthcare professionals were positive about the leadership and management of the home. One healthcare professional told us "There have been clear improvements in the service provided to residents in the last few years. The registered manager has made a huge difference to the managerial side of the home".

There were quality assurance processes in place that were carried out by the registered manager and the provider to ensure that the quality of care provided, as well as the environment itself, was meeting the needs of people.

## 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 home was safe.

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

People were able to take risks. Risk assessments recognised potential risks and provided guidance as to how these be minimised, whilst ensuring that people's freedom was not unnecessarily restricted.

People received their medicines on time, these were dispensed by trained staff and there were safe systems in place for the storing and disposal of medicines.

### Is the service effective?

Good

The home was effective.

People were cared for by staff that had received training and had the skills to meet their needs.

People had access to health care services to maintain their health and well-being.

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

People were happy with the food provided. They were able to choose what they had to eat and drink and were provided with support according to their needs.

### Is the service caring?

Good

The home was caring.

People were supported by staff who were compassionate and kind.

People were involved in decisions that affected their lives and care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

## Is the service responsive?

Good

The home was responsive.

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

People could choose how they spent their time and the interests that they pursued.

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

## Is the service well-led?

Good

The home was well-led.

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

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

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

# Tripletrees

**Detailed findings**

## Background to this inspection

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

The inspection took place on the 27 April 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the provider does well and improvements they plan to make. Before the inspection we checked the information that we held about the home and the provider. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eight people, two relatives, three members of staff, three healthcare professionals, the registered manager and the provider. We reviewed a range of records about people's care and how the service was managed. These included the care records for five people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounge and dining area during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

The service was last inspected in May 2014 and no areas of concern were noted.

Good

# Is the service safe?

## Our findings

People told us that they felt safe and that this was due to the support they received from staff. One person told us "Yes, I feel very safe, they are good people". Another person, when asked what made them feel safe, told us "Everything, they look after me".

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Identity and security checks had also been completed and their employment history gained.

There were sufficient staff to ensure that people were safe and cared for. People, relatives and staff told us there were sufficient staff on duty to meet people's assessed needs. One staff member told us "There are enough staff to care for people and enough staff to spend one to one time with people". Another member of staff told us "Yes there are enough staff, we all have different roles and responsibilities throughout the day and it works well". People and relatives confirmed this. One relative told us "They [staffing levels] seem adequate, there always seems to be enough staff when I visit". Our observations confirmed that there were sufficient staff on duty to meet people's needs and that staff responded in a timely manner to people. A dependency tool was used, this assessed people's needs and abilities and helped the registered manager to identify the amount of support people needed from staff. This was used to inform the staffing levels within the home. Staff and records confirmed that these were adapted if people's needs changed. Following an incident, where two people had been involved in an altercation, it had been recommended following a reassessment of a person's needs that they be provided with one to one support from staff for a period of time. The registered manager had ensured that this was actioned and the person was provided with one to one support for the suggested amount of time.

Staff had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us "I'd talk to the manager if I was worried about anybody, if it wasn't resolved I'd report it to the CQC". Staff were aware of how to safeguard people from harm if there were altercations between people. One member of staff told us "I'd try to separate them, try to calm them down and take time to talk to each of them and see what they were arguing about and if I could help, I'd then offer them a cup of tea". There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. (A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace).

Suitable measures had been taken to ensure that people were safe but their freedom was not restricted. People were supported to undertake positive risks, and we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Risk assessments recognised people's physical health and mental health needs as well as environmental hazards and were reviewed regularly. They took into consideration the perceived extent of the risk, the likelihood of the risk

occurring and the measures in place to minimise the risk. They also identified the number of staff needed to assist the person and the necessary equipment to be used. Staff confirmed that they found risk assessments invaluable as they provided them with guidance about how to support people in a safe manner. Staff were asked how they ensured that people felt safe, one member of staff told us "I enable people to do things for themselves, I'll be there to assist them and offer assistance if needed". Observations confirmed this. Staff were observed encouraging some people to walk independently whilst walking alongside the person to provide reassurance. Accidents and incidents that had occurred were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements. When a healthcare professional was asked to comment on staff's ability to keep people safe, they told us "Yes, if anything they are sometimes too quick to call an ambulance. This is something that we have been working on with them and is improving. This is obviously better in terms of safety than delaying seeking help which we have never had a problem with at Tripletrees".

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered as each person had an individual personal evacuation plan.

People were assisted to take their medicines safely by trained staff and told us that they received their medicines on time. In order not to be interrupted the member of staff responsible for dispensing and administering the medicines wore a red tabard, this made everyone aware that they weren't to be disturbed, therefore minimising the risk of any medication errors occurring. People's consent was gained and they were supported to take their medicine in their preferred way. Safe procedures were followed when medicines were being dispensed. People were asked if they were experiencing any pain and were offered pain relief if required. People confirmed that if they experienced pain staff offered them pain relief. Each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Care plan records for one person showed that staff had been advised to avoid giving a person certain types of juice as it could alter the structure of their medicines. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Good

# Is the service effective?

## Our findings

People were cared for by staff that had the relevant knowledge and skills to meet their needs. People and relatives told us that they felt staff were sufficiently skilled to meet people's needs. One relative told us "Staff are obviously well trained, some staff are very experienced due to training, others have done this type of work before, and others just like to do it well, they know how to engage with people and are enthusiastic".

Staff had completed the provider's own induction training that consisted of new members of staff shadowing existing, more experienced staff. Staff told us that they found their induction training helpful and that it enabled them to get to know the needs and preferences of the people they would be supporting. One member of staff told us "I was able to look through people's care plans to know their history and find out who was independent, who needed more assistance and what people liked". The provider explained that the length of time staff were required to shadow existing staff was dependent on their experience within the sector. One member of staff, who was new to working in the health and social care sector confirmed this and told us that they had shadowed existing staff for one month before working on their own.

Staff had completed general training as well as courses that were specific to the needs and conditions of people. For example, courses were undertaken to support people who were living with dementia. Staff told us that training was effective and that they were able to implement what they had learned into practice. One member of staff reflected on their training, and told us "From the dementia training I learned that sometimes changes in people's behaviour could be associated with other conditions, not just because they're living with dementia. For example, I learned that this could be due to someone having a urinary tract infection (UTI). Because of this I was able to recognise changes in a person's behaviour and thought that they might have a UTI. The GP was contacted and the person did have a UTI and was prescribed antibiotics". Records confirmed this. There were links with external organisations to provide additional learning and development for staff, such as pharmacies, external training providers and the integrated response team from the local hospital. (The team provides advice, training and information for care homes that provide care to older people.) Some care staff had Diplomas in Health and Social Care and others were working towards them. Observations and discussions with staff further confirmed that their knowledge, skills and competence had a positive impact on people's experiences.

Supervision meetings took place every six months and were a chance for staff to be given feedback on their practice, discuss people's needs and identify learning and development opportunities. Annual appraisals took place to identify people's personal development needs. Staff felt that they were supported well, one member of staff told us "I've been supported 10/10 by the manager. I used to work in another home, when I came here I realised what my role was about. The manager helped me to access training so I knew how to do care plans and administer medication".

People's communication needs had been assessed and met. One person's care plan informed staff of the person's preferred communication methods as they were blind. It advised staff that the person was blind, and due to this and their cognitive impairment, they required reassurance all the time. It advised staff to ensure that background noises were kept to a minimum so that the person could hear properly. It explained

that the person responded well and enjoyed talking about their life when they lived oversees and that staff should enable the person to talk, ensuring they provided enough time for the person to communicate. Observations confirmed that staff knew the person's communication needs well. The person would often stand from their chair, showing signs of apparent anxiety. Staff immediately responded to the person's needs, they approached the person and used touch and speech to alert the person of their presence. One member of staff asked the person how they were and the person said "I can't see you darling, where are you? I can hear you, I recognise your voice darling". The member of staff touched the person's hand and sat with the person, talking about their time oversees when they used to run a restaurant.

Care plan records for another person, who was unable to communicate verbally, advised staff to ensure that they maintained eye contact with the person. Observations showed staff maintained eye contact, engaged with the person and explained their actions before offering support. The person's relative confirmed that staff demonstrated good communication skills when supporting the person. They told us "Staff know how to engage my relative and how to get a response from them". People were encouraged to communicate with one another. Observations in the communal lounge and during lunch showed people enjoying having conversations with one another. Staff encouraged this by engaging in conversations with people about their interests and preferences, contributing to a friendly and relaxed atmosphere.

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). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had arranged mental capacity assessments for some people and was aware of DoLS. They had made applications for some people who, due to their cognitive abilities, were unable to leave the home unaccompanied. Consent was gained before staff supported people. One person told us "Absolutely, I have put myself in their hands, my main concern is that my family are happy with my decisions". Care plans contained consent forms, these asked people for their consent for the use of photographs, these had been signed by people or their relatives during the initial assessment of their needs.

People's health needs were met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians, dieticians, speech and language therapists (SALT) and community nurses. People told us that if they were unwell, staff recognised this and they were able to see a doctor. Healthcare professionals confirmed that staff were responsive when people were unwell. One healthcare professional told us "There is good communication, they ring us or speak to us when we are here for other people if they are ever worried about anyone".

People's skin integrity and their risk of developing pressure ulcers were assessed using a WALSALL – Community pressure sore risk calculator. This identified people's level of consciousness, mobility, skin condition, nutritional status and bladder and bowel continence. These were completed on admission and were reviewed on a monthly basis. This assessment was used to identify which people were at risk of developing pressure ulcers. There were mechanisms in place to ensure that people at risk of developing pressure ulcers had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be on.

People's risk of malnutrition was assessed upon admission. People identified as being at risk were weighed regularly to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP, dietician and SALT. Advice and guidance provided by these healthcare professionals had been followed. For example, care records for one person showed that healthcare professionals had recommended that a pureed, fortified and higher calorie diet be followed. Observations confirmed that the person was supported in accordance with this advice and records confirmed that they had gained weight.

One person, who was a diabetic, was encouraged to follow a healthy diet. Staff assisted the person to maintain their blood glucose levels and records and healthcare professionals confirmed that these had been stable. One healthcare professional, who visited the person daily to offer assistance to administer the person's insulin, told us "They are meeting the person's needs as their blood glucose levels are always stable". Care plan records for this person advised staff of what to do if the person's blood glucose levels dropped too low and to be mindful of the person contracting infections and that if this occurred then they should seek advice from the GP. The registered manager had also ensured that staff were informed of the signs and symptoms of infection so that they knew when to contact the GP for assistance. A letter from the proactive care team had been included in the person's care plan, advising staff of the signs of infection and what to do if they occurred.

People were happy with the quantity and choice of food available. People had a positive dining experience. In the dining area soft music played and tables were laid with tablecloths, placemats, cutlery, napkins, condiments and vases of flowers. People were able to choose where they sat and we observed people engaging in conversations with one another. Food was attractively presented and people appeared to enjoy their food. People could choose where they ate their meals. Most people chose to go to the dining room, however three people were supported to have their meals in the lounge, with small lap tables. Observations showed staff asked people where they wanted to sit. One person asked a member of staff if they could stay in their armchair and have their lunch, the member of staff confirmed that the person could choose where they ate their lunch and the person replied "Oh lovely jubbly". For people who required soft diets, their meals were pureed, yet presented as separate food groups, enabling people to distinguish between the different textures and tastes.

People were able to be independent when eating and drinking. Staff offered support to cut up food for people who required assistance and did this in a discreet way. People who required support with eating and drinking were supported by staff in a sensitive and patient way. One person, who was blind, was supported by a member of staff to eat their meal. The member of staff informed the person of what the meal was and ensured that the person was ready for each mouthful when supporting them, offering explanations and asking the person if they were ready for another mouthful. The person clearly enjoyed their food. They said "I'm liking everything I'm eating, maybe I could shake hands with the chef". After the person had finished their meal the member of staff asked the chef to come and speak to the person. The person was overheard saying "I'm usually pernickety about food, but I've had a lovely time, such beautiful food".

Good

# Is the service caring?

## Our findings

People were supported by staff that demonstrated kindness and compassion in their interactions with them. It was apparent that staff knew people well and had developed relationships with them. People and relatives confirmed that staff were kind and caring. One person told us "I think they are fantastic".

There was a friendly and warm atmosphere in the home. People were cared for by staff that knew them and their needs well and were able to respond in a compassionate and sensitive way. The Alzheimer's Society advises that staff should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. Observations for one person, who was visibly upset, showed that staff took time to sit alongside the person and talk about their feelings. Staff demonstrated patience and enabled the person to talk. Staff were knowledgeable about how to support people during times of apparent anxiety. One member of staff told us how they supported one person when they became distressed or anxious. They told us "When [person's name] gets agitated it sometimes helps when we support them to spend some time walking around the garden".

One person, who was living with dementia, was showing signs of apparent anxiety. The person was concerned about their finances and property. Observations showed staff and the registered manager spending time with the person, listening and talking with them. They offered reassurance and it was apparent that they knew the person well, encouraging the person to talk about their concerns and explaining that they could contact the person's relative if they would like them to. Observations later in the day, showed the person to be much calmer and relaxed. Another person, who was blind, was offered constant reassurance from staff. Staff were aware of the anxieties not being able to see might cause the person and as soon as the person called out to staff or attempted to stand, staff responded immediately offering reassurance and asking what the person wanted.

People, relatives and healthcare professionals praised the caring approach of staff. One health care professional told us "I have to say staff come across as very caring, they seem to know residents well, and are keen to seek advice or ask our opinion". Results of a quality assurance survey sent to people's relatives further confirmed the caring nature of staff. One relative had commented 'It is a nice home that looks after my relative well". Another relative had commented 'Each visit I have been impressed with all I have seen and witnessed. There are many smiles, wonderful humour and laughter'. A relative told us "Staff spend time chatting with them even when they don't get a response". People also confirmed the kind and caring approach of staff. One person told us "They look after us well". Another person told us "They certainly seem to be from what I've seen".

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their religion if they wanted to. Care plan records for one person informed staff that the person enjoyed attending the local church at the weekends and would be collected by their friends from the church to enable them to attend. The records also advised staff that the person enjoyed watching songs of praise and advised staff to ensure that they assisted the person to put this on the television to watch. Staff told us that people were supported to practice their faith and records confirmed

this. Care records for one person informed staff that the person's religion was Church of England. It advised staff to respect this and inform the person if a church service was taking place in the home so that they could attend. One member of staff told us how staff supported people with their faith. They told us "Some residents have members of the church come to visit and one likes to do their prayer before bed and needs a prayer book and cross and will like privacy to do this".

People were encouraged to be independent. Observations of people, who had been assessed as being at risk of falls, showed them walking independently around the home. Staff offered reassurance and encouragement and were nearby if people required assistance. People confirmed that they were encouraged to do as much as they could for themselves and told us that staff respected this. People were involved in decisions about their care, they told us that staff were approachable and that they were always informed and asked about what they wanted. One person told us "Yes they always ask me, but I don't need much help". Another person also confirmed that staff enabled them to be independent. They told us "I think so, I can do most things myself though". Observations showed that one person had an electric scooter and the person and staff told us that they enjoyed going out of the home independently and meeting up with friends.

Regular resident and relative meetings, as well as care plan reviews, provided an opportunity for people to make their thoughts known. The registered manager recognised that people may need additional support to be involved in their care and explained that if people required the assistance of an advocate then this would be arranged. (An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.) One person, who was living with dementia, was unable to make their feelings known. Records showed that the provider had ensured that the person's power of attorney was consulted and involved in decisions regarding their care, the person's power of attorney also confirmed this. Relatives and people's visitors confirmed that they were kept informed of people's needs and were always able to visit. One relative told us "I am always welcomed at the door, I always feel welcome, and they seem very caring with them when I'm here". Another relative told us that the registered manager encouraged relatives to be involved in the home by inviting them to social events, including for example, a barbeque for people and relatives.

People's privacy and dignity was respected. Staff told us that they always asked people if they could assist them before doing so and that they provided people with privacy when supporting them with their personal hygiene. Observations showed staff knocked on people's doors and waited for a reply before entering their rooms. One person confirmed this and told us "They knock first and then come in". Staff were observed being mindful of people's dignity. One member of staff was assisting a person to walk to the dining room to have their lunch, the member of staff noticed that the person's trousers had ridden up and discreetly assisted them to rearrange their clothing to maintain their dignity. People and relatives confirmed that they felt that staff respected people's privacy and dignity. One person's relative confirmed this, they told us "They maintain my relative's privacy and dignity, they are always fully dressed when they are in the lounge and staff always speak to them rather than across them". One person told us "Yes they do, they take me to the toilet and help me". Staff demonstrated that they were mindful of the importance of maintaining confidentiality, information held about people was kept confidential, and records were stored in locked cabinets and offices. People confirmed that they trusted staff and felt that confidentiality was respected. One person told us "Yes I would tell them anything".

People were able to stay at the home until the end of their life. People were asked their preferences in relation to their end of life care. People's care plans showed that their end of life care had been discussed with them and their relatives and advance care plans devised. Healthcare professionals confirmed that people were cared for appropriately at the end of their lives. They explained that the registered manager

had liaised with them and ensured that the person had access to relevant equipment and resources to enable them to stay at the home and that staff followed any advice that the healthcare professionals provided. They told us "They are generally very good, they do two hourly turns if needed, we come and do the nursing care but they provide good care and keep up to date with what needs doing". One person's care plan showed that the person had expressed a wish to stay at the home until they passed away. Staff confirmed that people were cared for at the home, until the end of their life, if this is what the person wanted. One member of staff told us about a person who had lived at the home for many years, who had passed away. They explained that the person had a very peaceful death as staff knew the person's needs and preferences well and were able to support them in their preferred way. Staff told us that the registered manager and provider had been very supportive during this time, that they had acknowledged that staff might be upset and had offered to support them to attend the funeral if this is what they wished.

Good

# Is the service responsive?

## Our findings

People were treated as individuals. They were supported according to their needs and preferences and were able to choose how they spent their time, observations confirmed this. One person, who chose to spend some of their time sitting beside the entrance to the home, told us "Yes, I'm involved in operational matters. I look after the entrance and monitor who comes and goes".

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. The provider had taken this into consideration. People were supported to take part in a range of activities. Observations showed people taking part in group activities such as skittles and quoits and people appeared to enjoy these, smiling and showing enjoyment. People's right to choose how they spent their time was respected. Observations showed people declined to take part in activities, choosing instead to spend their time reading or in their rooms. People who were at risk of social isolation were encouraged and supported to spend time in the communal lounge. Records for one person, who due to their cognitive and physical abilities, was unable to take part in most activities, showed that they had been offered hand massages and had enjoyed watching others partake in the group activities. Observations and conversations with the person's relative confirmed this.

Staff told us that they used information from people's care plans as well as information gained from talking to people and their relatives to understand what people liked to do with their time and what they enjoyed. Observations confirmed that staff had a good awareness of people's preferences and interests. People were supported to listen to music and clearly enjoyed this, singing along with the songs and tapping their hands and feet. One person, who was starting to show signs of apparent anxiety, began to call out to staff. Staff immediately responded and sat with the person, talking with them about their favourite singer, reminding the person that they were soon going to attend the singer's concert with their friend and staff. The member of staff asked the person if they'd like to listen to some Vera Lynn songs, the person did and once these were playing appeared much calmer and began singing along with the songs and tapping their hands on their knees.

The Social Care Institute for Excellence (SCIE) report 'Dementia Gateway, keeping active and occupied' identified that the use of doll therapy can sometimes benefit people who are living with dementia. It states 'Benefits might include comfort and companionship for some people living with advanced dementia in care homes. That there may be a reduction in behaviour that others may find challenging, as well as increased communication and purposeful activity where attention is concentrated on caring for and tending to the doll'. Observations showed one person caring for a doll. The person clearly enjoyed this, they explained that they liked to care for the doll, that they needed to change the dolls clothes and were looking forward to cuddling up in bed with the doll later that afternoon.

People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes in regards to what time they wanted to get up, what clothes they wanted to wear, what

activities they wanted to do, what they had to eat and drink and what they needed support with. People were able to choose if they received support from male or female carers. Staff confirmed this, one member of staff told us that they had been asked to work a shift so that there was a female member of staff working to assist a person who only liked to be supported by female staff. There was mixed feedback regarding the décor of the home and people's rooms. Most people were happy with their rooms and were able to personalise these with their possessions, whereas others told us that they felt that their rooms needed redecoration. One relative told us "The bedrooms are very scruffy". Another person told us "It's just a bit tatty". Observations showed that people's rooms had been furnished according to their preferences and individuality and they were able to display their own ornaments and photographs.

People and their relatives were involved in devising and reviewing care plans to ensure that their needs were met. People's needs had been assessed when they first moved into the home. There were comprehensive, person-centred care plans in place detailing people's medical, physical, cognitive and social needs that put the person at the centre of the planning process. Records showed that people and their relatives had been asked to contribute to the development and review of care plans. Minutes of a resident and relative meeting showed that relatives had been asked to provide life histories for their relatives to promote person-centred care. Relatives had also been asked if they would read their relative's care plans and be involved in the process, ensuring they agreed with the plan of care suggested. One relative, who was legally able to make decisions on behalf of their relative, told us that they were regularly involved in the review of their relative's care plan. They told us, "We talk about the care plan and they are very responsive, they listen to me and respond to my wishes". Healthcare professionals confirmed that staff were responsive to people's needs. One healthcare professional told us "We have no issues with the staff following care plans".

Staff confirmed that people were involved in the review of their care plans. One member of staff told us "I've seen senior carers sit with people and look at their care plans, the people are able to agree to it and able to make choices". One person confirmed this and told us "I'm usually involved on a personal level, one to one discussions". Staff were aware of the changes in people's needs and information had been shared amongst the staff team at handover meetings as well as on information boards in some people's rooms. For one person, who was unable to communicate their needs verbally, an information board had been placed in their room informing staff of their communication needs and preferences in relation to food and drink and times they liked to go to bed. Information that was important to the person was also recorded on the board. This included names of people that were important to them and significant dates.

There was a complaints policy in place, however there had been no complaints since the last inspection. Records showed that people and their relatives were reminded of their right to make a complaint or raise concerns about the care people received. Minutes of a resident and relative meeting showed that they had been provided with information about the Care Quality Commission (CQC) as well as the local authority. People and relatives were aware of their right to make a complaint and told us that they would speak to staff or the registered manager if they ever had any concerns.

Good

# Is the service well-led?

## Our findings

People, relatives, staff and healthcare professionals felt that the home was well-led. One relative told us "I think that the home is well managed and well-led. I feel comfortable and able to approach the manager or seniors". A member of staff told us "The people who live here are so lucky, there is very good care, really good food, people are putting on weight, and there is a high standard of care. I would say this is because it is well-managed. Because if it was not led properly people wouldn't get proper care, and they do".

The home was managed by the provider, who also owned another home, a registered manager and senior care staff. The management team had a visible presence in the home and it was apparent that they knew people's needs and preferences well. Our observations and staff confirmed this. One member of staff told us "The manager often helps out, she is very hands-on, she often helps people with their lunch". Observations showed the management team interacting and communicating with people. They provided positive role models for staff. Staff told us that they felt that the home was managed well and they were supported within their roles.

In a leaflet advising people of the home, it stated 'We offer a homely atmosphere and community spirit'. This was observed to be implemented in the culture of the home and in staff's practice. The home had a homely atmosphere, people appeared to be relaxed and, on the whole, were seen to be enjoying each other's company. Staff told us that they were happy in their roles, that there was a good staff morale and that they enjoyed their work.

It was evident that the provider met the needs of people and that there were mechanisms in place for partnership working, enabling people, their relatives, relevant professionals and staff to be involved in people's care. Feedback gained was used to enhance practice and drive improvement. For example, in a recent staff meeting a member of staff had raised the issue of people not always getting their own clothes back once they had been washed and that sometimes these were muddled with other people's. The member of staff told us that they felt comfortable and able to share their ideas and make suggestions to improve practice. They told us "I raised it and I felt listened to, as a result the manager introduced a new document that shows what the person's key worker has done". This related to the roles and responsibilities of people's key workers. Part of the key workers responsibility was to ensure that people's rooms were clean and tidy and that their clothing was in their own rooms. Records showed that the registered manager had listened to the member of staff's feedback and had implemented a form for key workers to complete to show that they were undertaking the tasks required of their role.

People, relatives and healthcare professionals were equally as positive regarding their involvement in the running of the home and how it was managed. Relatives and records confirmed that they were sent surveys for their feedback. Results showed that one relative had commented 'They provide a caring and friendly atmosphere. My relative is happy and settled and is very well looked after'. Relatives confirmed that they felt able to approach both staff and the management team if they had any concerns or needed to discuss anything. People were involved in relative and resident meetings which provided them with the opportunity to share their ideas and suggestions about the type of food and activities that were provided. One person

told us "They attempt to resolve things, It's very open, whatever occurs is scrutinised". A healthcare professional, who visited the home regularly, told us "There have been clear improvements in the service provided to residents in the last few years. The registered manager has made a huge difference to the managerial side of the home".

The provider ensured that links with the local community were maintained. People were provided with entertainment from external entertainers and were sometimes supported on outings. There were links with external organisations to ensure that the staff and registered manager were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local hospital and managers forums. Staff were complimentary about the management of the home. One member of staff told us "I think overall the home is managed well. I haven't had any problems, they do things properly and correctly".

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

There were quality assurance processes in place to monitor the quality of the service provided to people. Regular audits took place to enable the manager to have oversight of the processes in place to identify what was working well, or if there were any trends or areas of improvement required. Quality audits were reviewed and discussed at regular meetings with the provider, who also made regular visits to the home to monitor the quality of care provided.