The Royal Masonic Benevolent Institution Care Company

Lord Harris Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 17 and 18 October 2017. Lord Harris Court is a care home with nursing which is registered to provide care for up to 90 people, some of whom may be living with dementia. There were 85 people resident in the service on the days of the inspection visits. Some people who live in the home are self-funding (pay for their own care) whilst others have financial support from the local authority. This is the first inspection of the service which was registered in October 2016 when the provider changed.

The service did not have a registered manager, at the time of the inspection visits. The provider was actively recruiting to the post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provided staff with training to assist them to keep people, staff and visitors to the service as safe as possible. People were protected from all types of abuse and/or poor practice by staff who knew what action to take if they had any concerns about people's safety or treatment. Health and safety policies and procedures were followed and ensured that as far as possible people who lived in, worked in or visited the service were safe. Any risks to safety were identified and managed to minimise them.

People were provided with staff who had been recruited through reliable recruitment processes which ensured that as far as possible they were suitable to provide safe care to people. However, there were a large number of temporary staff used. People were not confident with the care provided by some temporary staff specifically those who covered night shifts. Improvements were needed to the way night care was monitored. There were enough staff to meet people's needs safely. People were not always supported to take their medicines safely and whilst improvements had been made further improvement was needed in this area.

People were provided with effective care that respected their diversity, preferences and choices and met their needs. People were supported to make decisions and choices about their care. Staff upheld people's legal and human rights with regard to decision making and choice.

People's rights were protected by a management and staff team who understood the Mental Capacity Act (2005). This legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People's needs were met by a caring staff team who worked together in the best interests of the people they offered care to. Staff built positive relationships with people and others who were important to them.

People's individuality and differences were recognised and respected and they were treated with kindness, respect and dignity at all times. Any special needs were taken into account and people were offered the appropriate care.

People were offered a variety of well organised and meaningful activities which enhanced their lifestyle. They were encouraged to enjoy and participate in them by specialised staff.

The service was well-led by an interim manager, in the absence of a registered manager. The management team were described as open, approachable and supportive by the majority of the staff. The service had a large number of ways to monitor and assess the quality of care they offered. Any shortfalls or improvements needed were identified and acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service required improvement.

People did not always feel safe when temporary staff were offering them care without the presence of permanent staff. They felt particularly vulnerable at night.

Staff did not always help people to take their medicines safely and had made a large number of errors in the preceding 12 months.

People who used the service, visitors and staff were kept as safe as possible by robust policies and procedures and well trained and knowledgeable staff.

Staff were trained in and knew how to keep people safe from all types of abuse. They were confident in their ability to keep people safe.

Staff were recruited in a way which meant that the manager was as confident as he could be that the staff chosen were suitable and safe to work with vulnerable people.

Is the service effective?

Good

The service was effective.

People's right to make their own decisions was encouraged and respected.

Staff were provided with training and supported by senior staff to ensure they were able to offer good quality care.

Staff met people's needs effectively, in the way they preferred.

Is the service caring?

Good

The service was caring.

People were supported by a highly committed, kind, respectful and caring staff team

People's needs were met by a staff team who treated people with respect and promoted people's privacy, dignity and independence.

The staff team understood the importance of positive and caring relationships between them, the people they cared for and their families.

Is the service responsive?

Good

The service was responsive.

People were offered individualised care in the way they preferred.

People's needs were regularly assessed and support plans were changed as and when necessary. People were involved in the assessment and care planning processes.

People knew how to use the complaints procedure and were confident that complaints would be acted upon and resolved as quickly as possible.

Is the service well-led?

Good

Overall, staff felt they were well supported by the management team.

The provider, interim manager and staff team made sure that the quality of the care they offered was maintained and improved.

People, staff and others were listened to and their views were valued, respected and acted upon, as appropriate.

Lord Harris Court

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 18 October 2017. The first day was unannounced and the second day was announced.

The inspection was carried out by two inspectors, an expert by experience and a pharmacist inspector. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection we looked at the Provider Information Return (PIR) which the provider sent to us. 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 also looked at all the information we have collected about the service. This included notifications managers had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we observed care and support in communal areas of the home and used a method called the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Additionally we spoke with 13 people who live in the service and three of their families. We spoke with other relatives after the inspection visits. We spoke with the interim manager, the deputy manager, the in-house trainer, several staff from head office and nine other staff members. We received comments from four, including a representative of the local authority, of 13 other professionals contacted.

We looked at a sample of records relating to the people's care and general management of the service. These included seven people's care plans, records of medicines administered, records of various audits, ten staff recruitment files and the service's training records.

Requires Improvement

Is the service safe?

Our findings

People were, generally, protected from abuse and poor practice by staff who were trained to understand and take action if they had any concerns about people's safety. People we spoke with told us that they felt safe at the home. They said, "I feel very safe here" and "Yes I am safe and well treated." Another said, "I feel safe and very comfortable, staff look after us well." "Oh yes dear I feel very safe here, nothing is too much trouble." Another told us, "I have no concerns about the staff. They always make me feel safe and comfortable." Relatives told us, "We are so pleased we have [relative] here. Because we know that she is happy and safe …" Three professionals who responded to our questions agreed that people were safe and well-treated and they had never seen anything they were uncomfortable with. The other did not comment.

However, five of the thirteen people we spoke with told us they were not always happy with the care that temporary staff provided at night. They described a small number as abrupt, aggressive and with a poor attitude. One person said, "I dread going to bed at night". Relatives told us that night staff did not always discharge their duties appropriately. They gave an example that there had been 10 incidents in four days of night staff taking more than six minutes to respond to a call bell. Another was a temporary staff member 'pretending' to shoot a person.

The interim manager was taking specific actions to address these concerns. These included, reviewing the way temporary staff were supervised and the way people could bring concerns to the attention of the management team. They agreed to immediately try to identify the particular staff members, investigate the issues reported and take the appropriate action. Staff were being recruited and trained as quickly as possible to reduce the necessity to use high numbers of temporary staff.

Improvements were needed to ensure that temporary staff adhered to best practice, the values and expectations of the staff to ensure a safe standard of care is always given.

Staff we spoke with were knowledgeable with regard to safeguarding people and were able to describe different types of abuse and how they would respond to any concerns. They described unexplained bruising and changes in people's behaviour as examples that would raise concerns. They were aware of their responsibilities with regard to protecting people in their care, including the whistleblowing policy and procedure. Staff knew where they would find telephone numbers for various agencies and who they could report to if they were not satisfied with the actions taken by the service. Staff told us they had never seen any type of abuse and they were confident senior staff would take immediate action if any was identified.

A local authority representative told us they had concerns because the manager had left in August 2017 and noted 12 safeguarding alerts made in the past six weeks. Eight alerts were for no harm medicine errors, two were for falls and two were for pressure sores. The service had investigated the safeguarding concerns and the local authority had taken no further action. The total safeguarding alerts since registration in October 2016 was 29, the majority being medicines errors (21). The service had reported all issues to the appropriate authorities and had taken and continued to take action to try to reduce the amount of medicine errors. A local authority representative told us the previous registered manager was always, "very co-operative" but

they had not had very much contact with the interim manager.

People's medicines were mostly stored and administered safely. Information relating to medicines was not always recorded accurately, which could increase the risk of administration errors. We found that in one instance staff had administered a prescribed medicine for longer duration than prescribed and with incorrect dosage. There were errors with missing information on hand written medicine administration records (MAR) Charts. On the second day of the inspection this issue had been addressed.

Several people had medicines prescribed to be used 'as required'. Although protocols were in place to support staff to know when to administer these medicines, they did not include personalised information. For example, how a person might display symptoms of pain was not explained to help staff offer and administer pain relief medicine. However, people's individual care plans and as required protocols included whether the person could verbalise their need for pain relief. If they were unable to ask for or display when they needed it their care plans included a nationally recognised pain assessment tool. We looked at the MAR charts of 10 people for pain and other when required medicines. However, only one person was recorded as receiving when required medicine on one occasion, which was in the 10th day out of a 28-day cycle. During the afternoon medicines round one person who was prescribed when required medicine for pain but was not offered the medicine. There was a potential risk that people were not receiving adequate pain relief as prescribed.

Staff were able to describe good practice in medicines administration techniques and we observed staff giving medicines to people safely. Appropriate arrangements were in place for the recording of medicines administration. We reviewed 10 MAR charts and found them to be completed appropriately apart from errors in transcribing where printed charts were not supplied by the pharmacy and staff had to hand write the charts. People who had been prescribed creams or ointments had MAR charts in place to record application of creams and ointments.

Overall systems were in place for the safe receipt, storage and disposal of medicines. However, we noted that some unwanted medicines were not promptly returned to the pharmacy for disposal. On the second day of the inspection the pharmacy had been contacted to collect the medicines as a matter of urgency.

People's medicines were stored in locked medicines cabinets within their own rooms and access to medicines was restricted appropriately. However temperature was not monitored for these. Medicines have to be stored at room temperature not exceeding 25*C or some medicines may lose efficacy. The interim manager told us temperature checks for people's private rooms had been written into the medicines policy. Thermometers had been purchased for all rooms to follow best practice guidance.

Medicines were stored in a fridge where necessary. Fridge temperatures were being monitored and were within the required range. However, in some instances one column of the record had been incorrectly completed and the room temperature had been entered. On the second day of the inspection the service had addressed this issue and produced a detailed protocol to ensure staff completed the form correctly.

We reviewed records of people living with diabetes. Insulin is sometimes prescribed to people who have diabetes and their body does not produce enough insulin to control blood glucose levels. We reviewed a care plan for people prescribed insulin and found there was no protocol on how to manage potential episodes of hypoglycaemia. Hypoglycaemia occurs when blood glucose level drops below the minimum level and can cause serious harm. An additional individualised care plan to advise staff how to deal with both abnormally high and low blood sugar levels was in place on the second day of the inspection.

There were systems in place to report and minimise the risk of medicines errors. Staff checked all the MAR charts at the end of each shift to make sure people had been given their medicines. Staff told us this had reduced the number of missed doses of medicines.

The service was fully aware of shortfalls in the effectiveness of their medicine administration processes and had reported 21 medicine errors since registration in October 2016. They had shared the detail of these with the local safeguarding team and the Care Quality Commission. They had taken various actions to try to reduce the amount of errors. These included staff disciplinary actions and re-training, requesting assistance from the provider's medicines and dementia lead and discussing medicines administration in team meetings. The provider's medicines lead had developed an action plan that the management and staff team were working through. None of the errors had resulted in any actual harm although there was potential for harm.

Improvements were needed to reduce the amount of medicines recording and administration errors to ensure people were given their medicines as safely as possible.

Risks to individuals were identified and included in individual's care plans. They provided detailed guidance for staff on reducing the identified risks to people when giving care. Assessments included falls, skin integrity and various mobility issues such as moving from a chair to a bed. Nationally recognised assessments were used where appropriate.

People's safety was further enhanced because the service learned from accidents and incidents. These were recorded, investigated and discussed at various staff communication meetings. Actions were taken to minimise the risk of recurrence such as reviewing care plans and amending risk assessments. An example was the actions taken if a fall occurred. Falls were recorded on individual care plans and on a falls audit form. The interim manager or senior staff member analysed the falls log every month to look for common factors and patterns. A specialist from the care home support team (independent professionals who supported care homes in the area) audited falls at three month intervals and made recommendations to help the service try to reduce the amount of falls.

The service made sure people's, staff and visitors' health and safety was looked at. Health and safety policies were supported by detailed safety procedures and general risk assessments. Risk assessments included transporting passengers in vehicles, use of mechanical beds and young workers in the home. Maintenance staff were responsible for health and safety checks and audits which were completed at the required intervals and were accurate and up-to-date. External contractors completed any technical maintenance checks such as legionella and gas safety.

The service had all the necessary fire equipment which was appropriately maintained. This included an automatic fire alarm system, portable firefighting equipment and fire retardant materials in use, as required. The service held regular fire drills in the day and night and had a robust evacuation procedure that all staff were aware of. Fire awareness training was completed annually.

People and staff were further protected because the service had a detailed contingency plan in place to assist staff to deal safely with emergency situations. The plan included emergency contact numbers, evacuations safe haven partners, loss of catering and power supply disruptions.

People were supported by staff who had been recruited following robust procedures to ensure they were suitable to work with people. Checks included those to confirm that candidates did not have a criminal conviction that prevented them from working with vulnerable adults. A minimum of two references were

taken up and verified, identity checks and right to work paperwork were reviewed. Application forms were completed although some had some small omissions. The interim manager ensured these were rectified before the end of the inspection visits.

The service ensured there were enough staff to provide the correct amount of time and care to meet people's needs and provide safe care. One person told us there were not enough staff around but others felt there were always enough staff to care for them safely. Staff told us there were enough staff to offer safe care. The management team regularly completed dependency tools and discussed people's needs at clinical meetings to determine the number of staff that was required to meet people's needs safely. The service had identified the ideal number of care staff (including registered nurses) during daytime hours as 13 in the morning and 11 in the afternoon/evening. Night hours were covered by six care staff. During October 2017 seven shifts did not reach the ideal number but the interim manager told us they did reach the required number to keep people safe.

Some staff worked 13 and a half hour shifts. The interim manager told us this was under review by the provider. They said that staff were supervised and monitored to ensure they were safe to give care. The interim manager agreed to record these observations, in the future. Care staff were supported by managers, housekeeping, maintenance, activities, administrative and catering staff. The interim manager agreed to ensure management staff appeared on the daily rota.

Good

Is the service effective?

Our findings

People's health and well-being needs were assessed and met by the staff team in conjunction with external professionals. Care plans clearly described the responsibility care staff had for people's health and well-being. Referrals were made to other medical and well-being professionals as appropriate. These included the G.P, the community mental health team and specialist nurses such as for Parkinson's and tissue viability.

Staff had detailed knowledge of the people using the service. They knew what people liked to do, the type of thing that may upset them and what would help to calm them down if they became anxious or distressed. They told us they were kept fully informed and up to date with any changes in people's support requirements. This was achieved through handover meetings. One staff member told us that communication with the shift leader could be improved by them keeping all staff on the unit up to date with developments as the shift progressed. This comment was discussed with the interim manager and other senior staff.

People had a variety of opinions on the food provided. Four of the 12 people we spoke with told us the food was not always good. They complained about food being cold and wanting more variety. One person said, "It's a bit iffy, it sometimes tastes like frozen rather than freshly homemade." However, others said, "The food is very good, quite what I'm used to" and "Yes the food's fine". Another said, "The food is excellent and I mean excellent, I'm eating as well as I did at home, fantastic." The service had introduced new plate warmers which were supposed to keep food hot for forty minutes, the management team felt they were working efficiently. However, a staff member did not feel this was the case as there weren't enough staff to help people to eat their meals within the forty minutes. We did not see any evidence of this on the days of inspection.

People who chose to eat in the dining room were assisted by hostesses and lunch time was a very pleasant experience. Tables were laid and people appeared to thoroughly enjoy their food. People were chatting amongst themselves and with staff and smiles and laughter were seen and heard throughout the lunch period. Staff discreetly supported people when they needed help or sat and contributed to the social atmosphere. Throughout the day drinks and snacks were available and offered. The service had developed a food forum as a way of people working with the chef to make sure they could voice their opinions and views about the food.

People's nutrition and hydration needs were identified and risk assessed. Monitoring systems were in place, as necessary. Referrals were made to professionals such as the GP, dietitian and speech and language therapy team, as necessary.

People's rights were upheld by the management and staff team who understood consent, the Mental Capacity Act 2005 (MCA)and Deprivation of Liberty Safeguards (DoLS).The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do

so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can 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 DoLS. The service had made appropriate DoLS applications to the local authority.

Training provided staff with a knowledge of the MCA and they were able to tell us how it related to their day to day work. They confirmed they had received MCA and DoLS training and described how they supported people to make decisions and respected their right to refuse. They described how they would return to people who refused personal care at a later stage and offer again.

People were supported to make their own decisions and choices about their daily lives. Individual plans of care included a mental capacity assessment, if required. Additionally how to offer choice and how to help people make decisions was noted. We saw staff asking people's permission before supporting them with personal care or any other tasks. People confirmed that staff always asked them if it was alright to offer them help.

The design of the premises was not particularly relevant to people living with dementia. However, staff made the best of the facilities provided. Special equipment was provided to meet people's specific individual needs. For example motion sensor mats hoists and wheelchairs. The service was to be re-provisioned with the building of a new residential service starting in the Spring of 2018. The new build will be designed taking into account guidelines on the appropriate environment for the people who will be living in the service. Some full length windows opened on to balconies. We noted that at least one of these was only protected by a waist height rail and was easily accessible to people living with dementia. The interim manager agreed to risk assess the balconies as a matter of urgency and keep the windows locked until they were assessed as safe.

People's diverse and changing individual needs were met by staff who had received appropriate training. Staff told us they had received very good training opportunities and could ask for additional training if they did not feel confident with particular tasks. They said they had regular one to one meetings with their supervisors and could seek assistance whenever they needed it. Most of the staff felt well supported by the management team but a very small number told us the service didn't utilise their knowledge and experience. They also said one of the senior staff members was a ''bully'' and senior staff ''played favourites''. This view was not reflected by other staff, visitors or other professionals. For example one staff member said, "[interim manager] is extremely approachable and I never feel dismissed. She listens to what I have to say." We discussed the issues raised with the interim manager who told us they would check staff morale and how individual staff were feeling.

People told us that permanent staff were very well trained and knew exactly what they were doing, however they were less confident that the same applied to temporary staff. One person said, "when I need to be hoisted and one agency recently did not know how to put my sling on. Fortunately as they have to have two people, the other carer checked it, before they hoisted." The service tries to ensure temporary staff do not work alone unless they have worked in the home on a longer term basis.

People were offered care by staff who received a full induction prior to beginning work to enable them to confidently perform their tasks. Staff told us they had a detailed induction and felt they were well prepared when they started working with people. The service used a nationally recognised induction tool (the care certificate) that staff had to complete during their probationary period. Staff competencies in different skills and knowledge were checked at the recommended intervals. These included medicine administration and

various nursing tasks.

Staff were given opportunities to progress and develop their careers. However, this meant there were several grades of staff. Not all the grades of staff were included in all meetings and handovers. This created some lack of cohesion and had the potential to cause communication omissions between staff. However, the service used a variety of means to convey important information to all staff. These included the individual daily records for people, diaries and communication books.

Good

Is the service caring?

Our findings

People were offered support by staff who were, generally, caring and committed to providing kind and compassionate care. People told us about some issues with some temporary staff but described most staff as, "Courteous and kind", "Like angels" and "friendly and helpful." People told us, "Regular staff seem to want to go the extra mile" and "It's like heaven here." There was happy banter between carers and with residents. People told us that they thought the staff were excellent. One person told us, "They are excellent, always work so hard and can never do enough. This is like home to me now." A relative told us, "This is such a happy place. There is always banter and laughter and I am always greeted and welcomed when I arrive."

People were shown dignity and respect throughout the inspection visits. Interactions between people and staff were positive and respectful. During the inspection visits we observed staff knocking on doors before entering. Staff always greeted people as they met them and people sought the company of staff showing they were relaxed and comfortable with them. We observed people involved with various activities such as tai chi and armchair exercise and we saw that people were treated with respect and dignity. Support was offered in a calm and patient manner. Staff always asked people for their opinion and offered choice and help when required.

People told us they were treated with respect and dignity and their privacy was protected. One person said, "The carers knock on my door and call out before they come in and wait for me to say come in." Another said, "When they help to shower me, they use my towels to keep my privacy."

People were supported by care staff who established effective and positive working relationships with people. Their diversity was respected as part of the strong culture of individualised care. The day staff we spoke with knew people well and were able to describe people's interests and life history. Support plans and behaviour support programmes gave very detailed descriptions of the people supported. There had been input from families, historical information, and contributions of the staff team who knew them well with the involvement of people themselves. Individual care plans included people's specific cultural beliefs, spiritual and other diverse needs. For example plans included family trees, detailed life histories and noted people's strengths and abilities. One person commented, "They know what I like and what I need." People were provided with activities, food and a lifestyle that respected their choices and preferences.

People were supported to maintain as much independence as they were able to for as long as possible. Care plans had a section called maintaining control. This referred to how care staff were to help people in ways which promoted their independence and control over their lifestyle. One person said, "They [staff] help me to be independent and encourage me to use my walker."

People were given information about the service in user friendly formats and individuals had specific communication plans. For example people with sensory difficulties or loss were provided with appropriate equipment and communication systems such as hearing aids and spoken word tapes. People were provided with information in a way that ensured they had the best chance of understanding it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework

put in place from August 2016. It is a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand, as far as possible, information they were given.

People were encouraged to give their views of the service in various ways. For example, the service had a resident's committee, resident's food forum and caring rating surveys. A committee member described the work they do for the rest of the people in the service. They told us that they alerted the management team to any concerns and the managers discussed it with them at the committee meeting.

If people chose to they discussed their wishes for care at the end of their life and where details had been provided they were recorded in a specific care plan. People had a do not attempt pulmonary resuscitation in place if they chose to. This was discussed with the relevant people and signed by the appropriate medical professional.

Personal information relating to people was kept securely and confidentially in the office and at care stations in the individual units and available only to those with authorised access. These were locked away when staff were not present. The provider had a confidentiality policy which care staff understood and adhered to.

Good

Is the service responsive?

Our findings

People's needs were met by a responsive staff team. People told us staff were always available should they require assistance. People told us, "Staff can't do enough, you can ask for anything." Whilst another commented, "The staff go all out to please us. They tell us that this is our home."

People and most relatives told us the call bells were answered quickly and said they never had to wait very long for attention. One person reflected the views of others when they said, "If I ring my bell, they come quickly." However, some family members told us that call bells were not always answered quickly enough, especially during the night time. They felt the call bell system was 'antiquated', not always well-maintained and not fit for purpose. They were in communication with the management about this issue. Call bell audits were completed daily to ensure they were answered within six and a half minutes of being pressed. Anything over that time was investigated and the management team decided if any action was required.

People's needs were assessed and care was planned and delivered in line with their individual care plan. Care plans were person centred and provided detail of the person's wishes and preferred routines. A pre-admission assessment was completed prior to people moving into the service and provided good detail on which to establish the care plan. People, their families and other interested parties were included in the assessment and care planning process (with the permission of the individual). Further detail was added as the person settled into the service and staff became familiar with their needs and wishes.

People's care plans were reviewed monthly and if there was any change in people's needs. Plans were up-dated in a timely way to ensure staff were able to offer care to people's current needs. The service was beginning to offer regular reviews to which families and other relevant individuals were invited. Some people and families told us they were attending reviews which had been arranged after they had expressed some concerns about the service.

People benefitted from a variety of activities. People chose whether to participate in communal activities or not. The service had specific activities staff who organised and led activities. One of the activities co-coordinators was accompanying an individual on a cruise and another was taking people to the new local shopping centre. Some people were involved in one to one activities. Some people told us two carers took them to the local private spa to go swimming in the heated pool there. People engaged in and appeared to enjoy the activities such as the gentle Tai Chi session being held in the morning of the inspection visit. One person told us they did not feel they got out in the fresh air enough because there were not always enough staff free to accompany them. Others however, told us they were assisted with activities of their choice and there were plenty of activities.

Some family members said, "She likes playing carpet bowls here and has been on an outing to Henley. Another positive thing we have noticed is that we think her dementia has plateaued since she has been here. We think that her brain has been stimulated with activities and with the staff coming and chatting to her, when they pass by the lounge or the reception area or it seems anywhere the residents and visitors are sitting." A person told us, "I go to the indoor bowls, hairdresser, the shop here and I do enjoy the reading

Shakespeare sessions." Another said, "I join in several of the activities and outings."

The service had a complaints folder which included the detailed complaints policy, instructions for staff of how to deal with complaints and a full explanation of why complaints are important to a service. The file noted open and closed complaints and a log of complaints which the management team used for monthly analysis to identify any trends or recurring issues. The complaints log had been put in place in August 2017 to improve the way complaints were dealt with.

People and their relatives and friends knew how to complain and were comfortable to do so, if they felt it necessary. However, some people felt they did not want to make a fuss because generally they received good care. Staff were aware that some people were unable to make a formal complaint without assistance and were able to describe how people would let them know if they were not happy. The service had received and recorded nine complaints and concerns about the service since registration. The majority of these were about the food and the laundry service. The complaints about temporary staff had not been raised as issues prior to our visit. Complaints were recorded, investigated and any action taken was noted.

People and their families generally used an independent social media site (which verified all information they displayed) to note commendations and compliments. 51 compliments had been 'posted' on the site since October 2016. These included comments such as, "My Father passed his final years at Lord Harris Court in comfort and dignity. The standard of care was very high…Towards the end, as his needs changed more rapidly the home responded promptly to the changing circumstances and I was never left uninformed or concerned about the care he was receiving." "She has been given a lot of support and love from all the staff. Her overall health and well-being has improved since being here. My friend never faults the home, she only praises how good it is." "My father is being treated well and with dignity. The staff are excellent." Additionally there were seven compliments written directly to the service. These included, "We would like to thank you for the care and thoughtfulness you gave [name] throughout her time at Lord Harris Court."

Good

Is the service well-led?

Our findings

People benefitted from a service that was well-led, even though it did not have a registered manager. The registered manager left the service in August 2017 and cancelled their registration in October 2017.The service was being managed by an experienced interim manager. Immediately the previous registered manager resigned the provider had begun an active recruitment campaign to find a suitable person to become the registered manager for the service.

A small number of family members and staff told us they were not happy with the service but the majority told us they thought it was well-led and the leadership was improving. People made comments such as, "It is a very good place. I call it my happy top of the ladder home" and, "I am very comfortable and pretty happy here."

People, their families and most of the staff spoken with described the interim and deputy managers as "open", "supportive" and "willing to listen". A small number of staff felt the staff team lacked support from management and there was low morale. We discussed these issues with the management team who were surprised but told us they would take actions to try to check current morale and staff satisfaction. They told us there had been some unpopular disciplinary decisions made around medicine errors which they felt may have impacted on the morale of some staff.

The majority of staff were positive about the new management team. They told us there was "good team working" and staff morale was much higher than it had been. One staff member said, "Things are getting better and better." Staff were aware of their responsibilities and understood how they related to the wider team. The majority of staff informed us the interim manager and senior staff were always available to provide guidance and advice when required. Most of the staff we spoke with, confirmed there was a good team spirit that encouraged staff to work well together for the benefit of people using the service.

The principles, ethos and objectives staff were expected to work to was clearly displayed throughout the service to remind staff of the objectives they were trying to meet. These included, "Every person will be treated in a manner that respects his/her personal privacy and dignity. Every person is assured that any information pertaining to themselves or their care will be treated with the utmost confidence." During the inspection visits we observed staff working to these and the other eight objectives. The registered manager told us these were being reviewed with regard to being simplified.

People who use the service, their families, friends and staff members were encouraged to express their views and opinions. The service held various meetings to give people and staff the opportunity to put forward their views. These included resident forums, resident and relatives meetings and staff forums. There were a number of staff meetings which included different levels of staff. Additionally the service had begun to introduce a review system where people, other professionals and families (with people's permission) could discuss the care people were being given. A resident's committee was in place to try to ensure that people could be involved in and have some control over the development of the service. A relative told us, "We have been to Residents' meetings. These give the residents a voice." A person said, "I am on the Residents'

committee which I enjoy. Residents will tell us an issue and then we will tell the manager and they report back to us at our meeting…"

People benefitted from an improving service because the quality and development of the service was regularly assessed and monitored. The management and staff team completed a number of audits and checks and developed a continuous improvement plan for the service. Head of departments took responsibility for some of the routine checks such as health and safety and medicine audits. The provider's representatives such as the assistant director of health and safety completed compliance audits. Additionally the interim manager completed regular compliant audits in areas such as number of complaints, number of falls and number of safeguarding incidents. Senior staff completed random night spot checks and regular supervision of staff, including taking timely disciplinary actions, if necessary.

The service made improvements to offer better quality care to people as a result of listening to people, families, friends and staff and the auditing systems. The continuous improvement plan noted who was responsible for the improvement and a date by which it should be completed. Developments completed included the introduction of a formal reviewing system, the review of call bell response time, a more varied activity programme and weight monitoring charts to be completed more effectively.

The service was supported to keep up-to-date with developments in social and health care by the provider. For example they received support and advice from expert staff such as the organisation lead on dementia and medicines and health and safety specialists.The manager attended home manager's meetings to discuss and share best practice. Additionally champions were being appointed and developed to look at various aspects of care. These staff were nominated to receive additional training to cascade best practice to colleagues. Additionally a staff trainer had been appointed to work in the service to ensure all staff training was up-dated as required and new developments were disseminated.

One of the service's objectives was that, "Every person will be actively assisted to access their rights as a citizen and to play the part in society as they wish. "The service encouraged people to use community facilities such as local restaurants, sports facilities and other places of interest. Minibuses were provided to facilitate community outings and activities. People were also involved in community projects such as a summer activity completed by national citizen service (NCS) volunteers. NCS is a government-funded initiative that brings together schools, community organisations, businesses and individuals to build a stronger and more cohesive society. The 15- to 17-year-old volunteers helped organise a British-themed tea party and quiz and other activities at the home. People enjoyed the contact with the young people.

The quality of care provided to people who use the service was supported by individualised and accurate records. Records related to other aspects of running a regulated service were well kept and fully completed. They were easily accessible to relevant staff but kept confidentially if necessary. The interim and deputy managers were aware of legislation relating to the running of a registered service such as the duty of candour and health and safety legislation and adhered to the requirements. The manager notified the appropriate agencies, such as CQC and the local authority about any incidents or issues, in a timely way and as required by law or good practice.