Burgh House Residential Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 6 June 2018 and was unannounced. The last inspection was in February 2017, where we found two breaches of regulation relating to medicines and governance of the service. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. At this inspection in June 2018, we found improvements had been made and the service was no longer in breach of regulations.

Burgh House residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The care home accommodates up to 43 people in one adapted building. At the time of this inspection there were 34 people living in the service.

Short stays were also provided to people who required a period of reablement. The purpose of reablement is to help people who have experienced deterioration in their health and have increased support needs to re-learn the skills required to keep them safe and independent when they return home. The short stay beds were located in a separate unit called 'Oak Lodge' on the grounds of the site. Physiotherapists and occupational therapists supported the care and treatment people received during the period of reablement. The average stay for people receiving reablement was two to six weeks. Three people were receiving re-ablement at the time of our inspection.

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

Improvements had been made to ensure people received their medicines safely, and there was evidence of learning from incidents. Additional audits were put in place to monitor medicines systems, which were now overseen regularly by the registered manager.

Care plans had been improved significantly, and contained detailed assessments of people's health and social care needs, and their hopes and wishes for the future.

A schedule of activities that people enjoyed were provided, and people were supported to pursue their hobbies and interests. However, we did observe that at times during the day some people were sat for long periods with no meaningful interaction from staff. We have made a recommendation that the service ensures it is meeting people's individual and specialist needs on a day to day basis.

People were supported to remain comfortable, dignified and pain-free at the end of their lives. We found some care plans in relation to people's end of life care could be more detailed to ensure the full scope of

people's wishes were known. The registered manager told us they were planning to implement the Gold Standard Framework for end of life care to improve current arrangements further.

People were safe because there were effective risk assessments in place, and systems to keep them safe from abuse or avoidable harm.

There was sufficient numbers of staff to support people safely. However, some feedback indicated that at certain times of the day more staff may be needed. However, the registered manager was monitoring this, and would adjust staffing levels accordingly if a need was identified.

Staff took appropriate precautions to ensure people were protected from the risk of acquired infections.

Staff had regular supervision and they had been trained to meet people's individual needs effectively.

The requirements of the Mental Capacity Act 2005 were being met, and staff understood their roles and responsibilities to seek people's consent prior to care and support being provided. They were supported to have maximum choice and control of their lives, and the policies and systems in the service supported this practice.

People had been supported to have enough to eat and drink to maintain their health and wellbeing. They were also supported to access healthcare services when required.

People were supported by caring, friendly and respectful staff.

The provider had an effective system to handle complaints and concerns.

The service was well managed and the provider's quality monitoring processes had been used effectively to drive continuous improvements. The manager provided stable leadership and effective support to the staff. They worked well with staff to promote a caring and inclusive culture within the service.

Collaborative working with people, relatives and external professionals resulted in positive care outcomes for people using the service. Feedback was positive about the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service had improved to Good.

There was a robust system in place to recruit staff.

There were effective systems in place for managing medicines.

The provider had procedures in place designed to protect people from abuse.

We observed there to be sufficient staff to meet people's needs. However, some feedback suggested that staffing levels were sometimes not sufficient. The registered manager was closely reviewing this.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and knowledgeable about people living at the service.

Capacity and consent were considered, and where people were deprived of their liberty the correct authorisation had been applied for.

There was effective liaison with health care professionals.

Is the service caring?

Good

The service was caring.

Staff treated people in a caring and compassionate manner. Staff agreed that this was important and spoke kindly about the people they supported.

People's privacy and dignity was respected.

Visitors were welcomed into the service, and could visit at any time.

Is the service responsive?

Good

The service was Good.

The service had systems in place for receiving, handling and responding appropriately to complaints.

There was a structured activity programme in place. However, we observed that some people had minimal meaningful interaction during the day and we have made a recommendation about this to ensure individual and specialist needs are met.

Care plans reflected people's needs and how they would like their care to be delivered.

Is the service well-led?

Good

The service has improved to Good.

The management provided staff with strong leadership and led by example.

The registered manager had a good working knowledge of the day to day running of the service. There was a positive culture within the staff team.

There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

The service worked with other agencies to improve people's health and wellbeing.

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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 6 June 2018 and was unannounced. The inspection team consisted of two inspectors, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding and quality team prior to the inspection.

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

At the time of inspection there were 34 people living at the service. To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with six people who lived at the service, three relatives, two health professionals, the registered manager and provider, care co-ordinator, and three members of care and catering staff.

Good

Is the service safe?

Our findings

At our previous inspection in February 2017, we rated this key question as 'Requires Improvement', and we found the provider to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider was unable to demonstrate that they had safe arrangements in place to ensure that people received their medicines as prescribed.

At this inspection in June 2018, we found that systems and processes in relation to the management of people's medicines had improved, and the provider was no longer in breach of regulation 12. We have rated this key question as Good.

The service used an electronic medicines management system, which over the past year staff have become more familiar and confident with using. Since our last inspection additional audits had been implemented to ensure stock levels of people's medicines were correct, and that any errors were identified promptly. There were two staff members allocated to oversee the medicines systems, weekly and monthly audits were also being undertaken, including one which was carried out by the registered manager. They had also arranged for the local pharmacist to carry out a full audit periodically throughout the year as an additional check.

Staff handling and giving people their medicines had received training and competency checks. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw staff correctly following guidance to make sure that people were given the right medicines at the right times.

The temperature of the medicines storage room was monitored, and these were within the recommended safe limits. However, some people's medicines were stored in their rooms in a lockable cabinet, but the temperatures of these medicines were not being checked. We fed this back to the registered manager who provided assurances this would be implemented immediately.

We also found that where people came to the service for a temporary period of re-ablement, their medicines were being hand written on a medicine administration record (MAR) chart by one staff member. However, these were not being checked by a second staff member to reduce the risk of errors. Following the inspection, the registered manager confirmed that the policy had been updated, and this process was now in place.

When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities.

Medicines were stored securely in lockable facilities for the protection of people who used the service. This

included medicines associated with higher risk, such as controlled drugs, and we found these stock levels were correct.

At our previous inspection in April 2017, we found that although risks were being assessed, such as the likelihood of developing pressure ulcers, there was not always sufficient guidance in place to show how the risks were being mitigated. At this inspection we found improvements had been made. For example, where people had been assessed as being at risk of developing pressure ulcers, guidance stated what was in place to mitigate risks, such as pressure relieving equipment and periods of bed rest.

Nutritional risks were also assessed, and included taking regular body weights to identify any losses. Where this was identified, there was guidance in place, such as high calorie diets, or where necessary, referral to other professionals for advice. Reference to choking risks were included in the nutritional risk assessments. However, we advised that risks associated with choking should be separate so staff can quickly find the guidance on what action they should take in the event that a person chokes. Following the inspection the registered manager sent us information that showed these had been updated.

Several people living in the service experienced regular falls. We had received anonymous information that the management of falls was poor within the service. We followed up this information with the registered manager. They discussed with us the three people who were at high risk of falls, and who had regularly fallen in the months of April and May 2018. Prior to the inspection the registered manager had shared information with us and asked how they might improve their current documentation in relation to falls. They had also requested advice from the falls prevention team. We saw that where people had fallen advice was promptly sought from specialist falls teams and health professionals who visited the service regularly.

Care plans contained risk assessments in relation to falls, and the registered manager had started to implement, 'Falls Avoidance' forms. This was a more comprehensive assessment of why people might fall, risks to consider, and actions to take. We saw that actions were taken to reduce further falls, such as low beds and crash mats, pressure mats (which alerts staff if the person stands up) and regular checks by staff. We saw that accident reports had been completed appropriately for people and each report explained the risks identified, the action taken and the safety measures put in place.

The service had ensured that hoists and other equipment used to assist people had been serviced to confirm their continued safe use. Personal evacuation plans were in place which outlined the support people would need in an emergency situation. Fire safety checks had been carried out, and staff had received training in this area. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

We asked people if they felt there were sufficient staff working in the service. One person said, "No, they could employ more people at certain times of the day, in the evening, sometimes in the afternoon. I think [registered manager's] got it pretty well right, it's just little times when there could be some more". Another said, "I can hear when my neighbour is moving around so I press the buzzer, normally [good response] but sometimes they can take a while. That would be at night". A relative said, "At certain times of the day there are not enough staff, and the staff have told me that. There seems to be a period after tea, possibly 6pm to 8pm, when they seem a bit thin on the ground."

A Staff member told us, "Staffing levels are fine in the mornings but the afternoons get a bit stretched." And a second staff member said, "It's always very busy but as people are ageing their needs are increasing, so I think we could do with more staff."

We spoke with the registered manager about the feedback. They were using a dependency tool to calculate staffing levels, and also flexed staffing to meet people's needs. We saw that people's dependency assessments were regularly reviewed and updated by the manager and care staff. We saw that one person's dependency had gradually increased over time. It was also noted that the person's dependency fluctuated due to their illness. The service had purchased 'pagers' which staff carried to see who was calling for assistance, without having to go to a call panel to get this information, therefore saving them time. The registered manager took the feedback on board and said they would start working later in the day to monitor staffs ability to be responsive to people's needs. If concerns were identified, they would increase staffing accordingly.

We saw that safeguarding information was readily available for people living in the service, visitors and staff. Staff had received training in safeguarding adults and knew how to report any concerns. One staff member said, "I'd have no problem reporting anything if I thought something was wrong. I'd just go to the manager or [provider]. We've got the numbers for safeguarding as well if we need them." Another said, "I would raise any worries I had about people being not cared for properly. I think we all would."

People were protected by procedures for the recruitment of new staff. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions.

We observed that most areas of the service were clean and fresh on the day of the inspection. However, we found that one hoist had not been cleaned effectively, and we brought this to the attention of the registered manager. There were adequate supplies of personal protective equipment, such as aprons and gloves, and we observed staff used these appropriately. There were hand washing facilities throughout the home.

The service had developed their practice to ensure that lessons were learned and improvements made when things had gone wrong. Following the last inspection the registered manager and provider had acted promptly to improve areas we found as requiring improvement. They sent us an action plan with timescales for improvements they planned to make. They had ideas about future plans which would improve service provision overall, and the importance of ensuring people's views were at the forefront of any new systems and processes.

Good

Is the service effective?

Our findings

At our previous inspection in February 2017 we rated this key question as Good. At this inspection we found that standards had been maintained, and the rating of Good continues for this key question.

People's needs were holistically assessed prior to coming to live in the service. Detailed pre-admission assessments were carried out for people before they moved into the service and we saw that these formed the basis of people's ongoing care plans. When people moved into the service we saw that there was a checklist in place to confirm that they had been introduced to all staff and all staff signed to confirm they had read the person's care plan. In addition, we noted confirmation that the kitchen staff had taken a copy of the section of the care plan that covered diet and nutrition. People's needs were assessed and planned on an on-going basis to ensure the service met their needs and requirements.

People told us they felt the staff were well trained. One person said, "The young staff [new] fit in very quickly, supported yes, by the older [more experienced] ones." A relative said, "I think the staff do understand the needs of the residents, information is passed down to the staff. You can see [registered manager] tell staff what [person] needs. I feel the communication is good."

Records showed that staff had received training in safeguarding adults, first aid, manual handling, health and safety, infection control, food hygiene, safe administration of medicines, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had also completed courses in specific areas such as diabetes and pressure area care. These enabled staff to develop skills to care for people with specific conditions. One staff member said, "The district nurses are really good. They did some tissue viability training with us recently and it was really effective and enjoyable."

Senior staff were all trained in dementia care, and the service planned to provide this training to all staff in September 2018. This will include 'virtual dementia' training, where staff wear a simulated suit to experience the world around them as people living with dementia might. This type of training gives staff a better understanding of the difficulties people may face in their day to day routines.

Some staff were completing the Care Certificate, which is the standard for new social care workers. Staff confirmed their induction helped them improve their knowledge and skills for the job. Staff told us that they received regular supervisions and that these were supportive. They said that they were encouraged to identify areas they would like training in which would then be organised if possible. One staff member said, "[care co-ordinator] is my mentor [for supervision] but I can go to any of the seniors or the manager, everyone is really supportive."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Appropriate DoLS applications had been made where people were being deprived of their liberty. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records generally showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests. We did however find that where one person had fluctuating capacity, and a best interests decision had been made in relation to their medicines. We advised that this decision could have been made by the person when they were experiencing a period of lucidity, and would therefore ensure their views about the care they received were maximised.

We saw that the service had closed circuit television (CCTV) in several areas of the service, which could impact on people's privacy. There was a surveillance policy in place which stated that where people lack capacity to consent to the use of surveillance, principles of the MCA would apply. However, there were no mental capacity assessments or best interests decisions in place in relation to the use of the CCTV. Some people living in the home would not have been able to understand or consent to the use of CCTV. We discussed this with the registered manager, and following the inspection, they informed us that they were in the process of sending letters to all people and family members regarding the fact that Burgh House uses CCTV and explaining the reason why and what it is used for. They had also carried out best interests meetings with family members for people who were unable to consent.

Staff had received training of the MCA and DoLS. Our observations confirmed staff promoted choice and acted in accordance with people's wishes. One staff member told us, "It's [MCA] about people making choices for themselves. We don't assume anything. Sometimes people have capacity to make a decision but then sometimes they get a bit confused but that doesn't mean they can't still make choices. Sometimes it's a case of offering people easy choices with yes or no answers." Another said, "I always ask people first before I do anything and I wouldn't make anyone do anything they didn't want to."

People had access to a range of healthcare services to meet their needs and to keep them well. The service had a GP linked to the home who visited each week, and when required outside of the weekly visit. People told us and records confirmed that people had regular visits from community nurses, dietitians, and specialist falls teams. A health professional told us, "A very forward thinking service, very 'on the ball', and always follow any recommendations I make."

People received well-coordinated care and support when they moved between services, and relevant information was passed on to other professionals.

People's nutritional, dietary and hydration needs were met as they received sufficient food and drink to nourish them and maintain their health and well-being. People told us their views on the food. One person said, "Quite a few of us eat breakfast in the dining room. I generally eat porridge, If I fancy porridge for tea they'll give it to me". Another said, "The food is very good, plenty of variety, it's good quality". And a third person, "I know it's difficult when you're cooking for a large number. The food itself is good quality, fresh veg. I would have used frozen veg but they won't." A relative said, "I suggested smaller plates for those who don't eat much as it puts them off too much on the plate. They are going to introduce smaller plates."

We observed the lunchtime meal. We saw that lunch time in the dining room was a relaxed and sociable experience and it was evident that people who chose to eat in this room looked forward to the collective

meal times.

We noted that the décor and layout of the dining room created a café atmosphere, which people looked comfortable in. We saw that tables were laid with wipe-clean cloths and place mats, cutlery, glasses and a selection of condiments.

We saw people engaging cheerfully with each other and members of staff before, during and after their meal. We observed that staff were attentive and quick to acknowledge and respond to people's requests or needs. Where some people required assistance to eat their meals, we saw that staff did this in a kind and caring manner, giving great regard to ensure that each person's dignity was respected and promoted. We heard staff explaining, to people needing assistance, what the food was and asking what they would like to taste next.

For people who wished to eat in their rooms, we saw that staff were well organised, prompt and efficient in collecting people's chosen meals and delivering them. We walked around the home during the lunch period and noted that the people who had chosen to eat in their rooms had received their meals in a timely way and all looked to be enjoying what they had been served.

Care records contained people's nutritional needs and requirements which the care staff communicated to the kitchen staff. People's allergies were also known to staff. People's individual dietary needs were also catered for in respect of being diabetic, vegetarian or religious or cultural requirements. Care staff and kitchen staff were knowledgeable in respect of how people required their food to be prepared and served. For example, some people required their food to be cut up; some required a soft or 'fork-mashable' meal and some needed their food to be pureed.

The home was well maintained, well decorated and welcoming. There were communal and private rooms available for people to relax, socialise and entertain their loved ones. Each person had their own furnished bedroom which was decorated with their personal items such as photographs and ornaments. Toilets were installed with grab rails and call bells in case people needed them, and there was lift access to the first floor. We noted that one carpet upstairs was heavily patterned which may cause a trip hazard for some people living with dementia. (Patterned carpets can cause confusion if you have dementia, as it becomes increasingly difficult to distinguish between design and actual objects that they need to pick up or step over, and could potentially cause a person to fall). We brought this to the registered managers attention, and they agreed to review if this posed a hazard to anyone using the upstairs area.

Good

Is the service caring?

Our findings

At our previous inspection in February 2017 we rated this key question as Good. At this inspection we found that standards had been maintained, and the rating of Good continues for this key question.

People told us staff treated them with kindness and respect. One person told us, "It's the way it's delivered [the care], the girls are always happy to help you, nothing seems to be a problem. [Registered manager] should be commended for the people he employs, they're all very happy." Another said, "We're like a family here, sometimes they over-help people." And a third said, "They're all lovely [staff], they never mumble and grumble." A family member told us, "I cannot fault the care here. I've got no fault with any of the care staff here. Over the years this whole place has become part of my family. It's like walking into your own home, with a family, from the top down they're all perfect". A staff member said, "I would definitely recommend it here. I'd be more than happy if any of my friends or family lived here." And, "There's a lot of negative press about care homes. I'm proud of my work and know we look after people really well but not everybody knows that."

People were supported by staff who understood their needs and preferences. Care records contained information about what people liked to be called, the time they preferred to go to bed, things they could do and with whom and how they liked to be supported with their personal care. Staff could tell us about people's needs and preferences as described in their individual care plans. Our observation also confirmed that staff knew people well and delivered care to them in line with their requirements.

Care plans confirmed the caring approach of the service. For example, we noted that one person wore an item which was very important to them and which had great sentimental value. We saw guidance which explained this fact and emphasised that staff must not remove it. We also noted how the person occasionally panicked if the item moved and they thought they had lost it. For this reason, staff needed to be observant and reassure the person it was still there by placing the person's hand on it.

We saw that a member of staff had escorted and supported one person to attend a family members wedding. We saw beautiful photographs in which the person looked happy and these were treasured memories for the whole family. We saw that, at the request of the family, the service had arranged for an experienced member of staff to assist the person to the wedding and remain with them for the whole day. This member of staff ensured that the person was well cared for throughout the day. The member of staff also took some photographs, which were given to the family for the wedding album.

Peoples care plans contained a 'wish list'. People could add to the list things they wanted to do, places they wanted to visit, or just day to day wishes which staff could support them with. We saw that when the registered manager arranged trips out during the year, this was collated from people's wish lists.

People's privacy and dignity were respected by staff. All the staff we saw looked relaxed and cheerful and we observed numerous and consistent examples of staff engaging with people and treating them with kindness and respect.

People had their own self-contained rooms which afforded them the privacy they needed. They told us they could choose to stay in their rooms anytime and nobody would bother them. We saw that staff carried out any intimate tasks in private behind closed doors to ensure people's dignity was maintained always. We noted that staff always knocked on people's bedroom doors and awaited a response before entering. One person told us, "They [staff] always ask first [to help with personal care], always gentle and properly. They talk to me like anyone else." Another said, "Yes they do [respect our privacy], they [staff] won't tell you about the other people". And a relative said, There is respect for the individuals, very much here, never once have I seen any of the staff frustrated. They seem very tolerant."

People's cultural and religious needs were considered. We observed a service being conducted during the morning of our visit, and during the afternoon a person of faith was observed talking to two people and performing a small ceremony. One person said, "They have a church service once a fortnight, in the dining room, my [relative] always goes to that." Another said, "I'm a [named religion], they give us communion so that's good for me, and a lay preacher supports songs with their violin."

'Residents' meetings were held in the service regularly so people had the opportunity to give their views about the service. We saw that relevant items were discussed, including the use of CCTV, trips out, and menus. Visitors were permitted to visit the service at any time, and we saw relatives coming in and out during the day.

Good

Is the service responsive?

Our findings

At our previous inspection in February 2017 we rated this key question as Good. At this inspection we found that standards had been maintained and therefore the rating for this key question remains Good.

The inspection in February 2017, found that care plans were generic in nature, and needed personalisation in respect of people's health and support.

At this inspection in June 2018, we found that a lot of work had been undertaken to ensure that people's care plans were detailed, what their needs were and how needs would be met. These included the support people required to maintain and manage their physical and mental health, skin integrity, personal care, mobility, social, and any future wishes and goals.

Clear and detailed information was recorded regarding people's specific health conditions, including symptoms and treatment. This information helped staff to understand the person's individual needs better and ensure their comfort and wellbeing was maintained.

People's care plans also highlighted their backgrounds, histories, likes and dislikes and what was important to them individually. This helped staff gain insight into people's personalities and behaviours. Staff and the registered manager were very knowledgeable about the needs of each person living in the service and were able to explain how individual risks were identified and managed, whilst enabling people to remain as independent as possible.

There was not a dedicated activity co-ordinator working in the service. Activities were delivered by the registered manager and staff when time allowed. There was a structured activity programme showing activity that was happening through the month. Not all days were filled with activity, and there was none planned during the weekend periods.

We asked people if they felt there was enough to do. One person told us, "There's something most days, I join in with the bowls and bingo. Yes it's adequate, I think so." Another said, "They don't do nothing in here for entertainment. The other night a bloke came here singing, it was good, they should do it more often." A relative told us, "They've got their timed activities, carpet bowls, and bingo. The music [described music and movement exercise] has gone, that was good, something like that should be re-introduced. [Registered manager] is very 'hands-on' with the activities, they bring two little dogs and the resident's love that. They have a visiting singer, fortnightly, and at Christmas everyone was taken out to dinner, to the local carvery, and to a pantomime at the local theatre. They [residents] eat their tea outside in the summer, have outings to the beach, fish and chips and ice cream, we have a family and residents afternoon, with a barbeque and music."

There were also some good examples of how people had been given tasks to do in the grounds of the service, which they enjoyed. One person said, "They're [staff] ever so good, provide me with all the tubs and compost [to look after plants in garden] a girl [carer] helped me."

Whilst planned events were available, we did observe that some people sat for lengthy periods without benefiting from any form of meaningful interaction by staff members. Day to day stimulation and just chatting with people will avoid people becoming bored and withdrawn.

We recommend that the service reviews the provision of activity, to ensure it is meeting people's individual and specialist needs on a day to day basis.

Care plans made reference to people's end of life wishes, such as where they wanted to be cared for, and who to contact. However they did not always reflect the full scope of people's wishes, such as how they wished to spend their last days. There was not always additional information on how staff could provide comfort during these last days such as music the person liked or calming aromas.

The registered manager told us they were already looking to improve this aspect of people's care, and was planning to implement the Gold Standard Framework for end of life care by August 2018. We did see that for one person the GP had written up a care plan for anticipatory medicines and a drug chart for a syringe driver (a small battery-powered pump that delivers medication at a constant rate) to be put in place promptly if needed. One relative told us, "I've been reassured by the doctor and [registered manager] today that the medicines [palliative care] are all available, and that the doctor can be called at anytime if and when their condition deteriorates." This demonstrated that the service was responding to people's end of life needs and liaising with relevant professionals.

The service had not received any complaints, but had a complaints procedure in place. The procedure for making a complaint was displayed around the service. The registered manager told us that any feedback, good or bad, was an opportunity to improve the service. We saw a high number of compliments received from families over the past 12 months. A relative told us, "[Registered manager] does a brilliant job, they're a friend, someone you can go to and reassure you not to feel bad about complaining." A second said, "[Registered manager] phones us and talks to us. They always resolve [any issues], or they take a problem to the next level."

Good

Is the service well-led?

Our findings

At our previous inspection in February 2017, we rated this key question as 'Requires Improvement'. This was because the provider had failed to implement effective systems to assess, monitor and improve the quality of the service. At this inspection we found that improvements had been made, and we have now rated this key question as 'Good'.

Following our last inspection in February 2017, the registered manager had put structured processes in place to monitor that medicines were being managed correctly and that there was sufficient stock available. They also carried out medicine audits monthly. This led to improvements in the systems and processes associated with medicines. Care plan audits had been improved to ensure information was up to date and relevant. Audits of care plans were seen to have been carried out regularly and showed consistent and effective oversight by the registered manager. A lot of work had taken place to ensure care plans were more person-centred, and we found that they reflected people's preferences well.

There was a clear vision and credible strategy to deliver high quality care and support at the service. The registered manager was an effective leader. They had developed and embedded positive relationships with staff and there was an open, inclusive, and person centred culture throughout the service. Staff were compassionate and caring in their approach and felt supported by the management team.

Staff were clear about what was expected of them in their roles and were motivated to provide effective care. The staff we met with all spoke very highly of the registered manager, the provider and the staff team as a whole. Staff were enthusiastic in their work and comfortable in their roles. We also saw that the entire staff team worked cohesively together.

The registered manager was aware of the day to day culture in the service, and operated an 'open door' policy, ensuring they were available to people, staff and visitors at any time. One person said, "He's always got time for you. I went into his office, he was having his lunch. He stopped eating, left his dinner and came and talked to me." Another said, "[Registered manager] praises and thanks people, he does it openly. If he doesn't like something he'll take authority, you wouldn't walk over him, he's a strong person." A third told us, "I recommend [the service] to others."

There were quality monitoring systems in place which ensured that practice was reviewed regularly and changes were made to continually improve the service. Audits were carried out in areas such as medicines, environment, night audits, care plans, health and safety, infection control, and 'walk-around' audits daily, to speak with people and staff, and check the safety and cleanliness of the service.

Surveys were issued to people (including those receiving reablement), relatives, and professionals as a way of gaining feedback about the service. We saw these were positive, and the registered manager had created action plans as a result of feedback where needed.

The service held quarterly multi-disciplinary meetings (attended by a GP or nurse) to discuss particular

concerns about people's health, and the service's processes generally. These meetings helped to develop certain areas of practice within the service.

Professionals we spoke with praised the service. One health professional told us how the registered manager had improved the systems for gathering information prior to their visit. This meant that visiting professionals would be given detailed and relevant information to help them assess what treatment people may require.

Following the inspection, the registered manager sent us an improvement plan they had created, which highlighted further areas for improvement. This included improving diabetic care plans, choking risk assessments, the implementation of the Gold Standard Framework for end of life care, dining audit, and the inclusion of people when interviewing new staff. They also sent an update to us, showing where improvements had been completed. This demonstrated a responsive approach to our feedback, and a continual drive for making future improvements.

The registered manager knew about and referred to best practice guidance, ensuring that the delivery of care was reviewed against these. For example, they had reviewed guidance relating to falls, so they could implement an improved care plan and risk assessment.