Care Quality Commission

Bupa Care Homes (ANS) Limited

Stamford Care Home

Inspection report

21 Watermill Lane
Upper Edmonton
London
N18 1SH

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19 February 2018

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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 19 and 20 February 2018 and was unannounced.

Stamford Care Home is a care home providing nursing care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stamford Care Home is registered to provide nursing care and accommodation for a maximum of 90 adults, some of whom may have dementia. There are 27 bedrooms on the ground floor (Oakwood Unit); 30 bedrooms on the first floor (Broomfield Unit); and 33 bedrooms on the second floor (Woodside Unit), which is dedicated to people living with dementia. At this inspection there were 82 people living in the home.

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

At our previous inspection of this service on 1, 2 and 3 February 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the safe management of medicines. Due to the seriousness of the concerns found we issued a warning notice to the provider and registered manager on 14 February 2017, requiring compliance with the Regulation by 1 March 2017. On 4 April 2017, we carried out a focused inspection to check if the provider had made the necessary improvements to how the service ensured medicines were safely managed. We found that the provider had made significant improvements. However we identified some areas for further improvement. At this inspection, we found that medicines were safely managed and improvements made following the February 2017 inspection had been embedded and sustained.

This service is now rated as Good.

Accidents and incidents were appropriately recorded and investigated, and risk assessments were in place for people who used the service that described potential risks and the safeguards in place to mitigate these risks.

People's needs had been assessed and personalised care plans developed. Care plans were evaluated to check they reflected people's needs.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

People received a nutritious diet and enough to eat and drink to meet their individual needs. Timely action was taken by staff when they were concerned about people's health. Referrals had been made to other healthcare professionals to ensure people's health was maintained.

Staff training, supervisions and appraisals were monitored and updated regularly. Systems had been implemented to ensure oversight of when staff training, supervisions and appraisals were due.

People and relatives were positive about the service and the staff who supported them. People told us they liked the staff that supported them and that they were treated with dignity and kindness.

People told us they felt safe living at Stamford Care Home. Staff understood the importance of safeguarding and the service had systems to help protect people from abuse.

The service was clean throughout and there were hygiene controls in place to ensure that the kitchens were kept clean and food was safely stored. Utilities such as electricity and gas and health and safety checks were undertaken regularly and records kept.

A complaints procedure was in place which was displayed for people and relatives. Staff, residents and relatives meetings were held regularly and surveys were completed by people and relatives.

People, relatives and staff spoke positively of the management team. Quality assurance processes were in place to monitor the quality of care delivered.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. The policies and systems in the service supported this practice. Care plans contained appropriate documentation confirming consent to care had been obtained.
Where people's liberty was deprived, the registered manager had applied for authorisation from the appropriate authority.

People were supported to attend activities and there was an activities timetable in place. We observed particularly caring interactions between the activities co-ordinator and 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 service was safe. Improvements made to how medicines were managed had been embedded and sustained.

Risk assessments in place identified and provided guidance to staff on people's risks and how to reduce and/or mitigate identified risks.

Appropriate staffing levels were observed throughout the inspection. Staff were safely recruited.

Accidents and incidents were recorded, investigated and analysed to ensure lessons were learnt to prevent any further reoccurrences.

Is the service effective?

Good

The service was effective. Care staff were regularly supported in their role through training, supervisions and appraisals.

Care staff understood and provided care and support according to the key principles of the MCA.

People were provided with sufficient food and drink and were supported to eat and drink where required.

Care plans were developed in partnership with people, relatives and healthcare professionals.

Is the service caring?

Good

The service was caring. People had developed caring relationships with certain care staff.

People were treated with dignity and respect.

Care staff knew people well and had a good knowledge and understanding of their needs, wishes and choices.

Is the service responsive?

Good

The service was responsive. Care plans were person centred.

People had access to a variety of activities.

The home had a complaints policy in place; complaints were investigated and responded to. People and relatives knew how to complain if they needed to.

Is the service well-led?

Good

The service was well-led. People, relatives and staff spoke positively of the management structure in place at the home.

Quality assurance measures were in place with regular audits carried out by the registered manager, deputy manager and provider.

Systems were in place to support people, relatives and staff to provide feedback and improvements were made following analysis of the feedback received.

Stamford Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 19 and 20 February 2018 and the first day of the inspection was unannounced.

This inspection was carried out by two adult social care inspectors, a specialist nursing advisor, a pharmacist and two experts by experience who obtained feedback from people and relatives during the inspection and by telephone. 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 information that we had received about the service from health and social care professionals, notifications that we had received as well as the provider information return (PIR) that the provider had sent to the Care Quality Commission (CQC). A PIR 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.

During the inspection we spoke with 20 people who used the service, 19 relatives, the registered manager, deputy manager, regional support manager, clinical nurse manager, six registered nurses, six care staff, the activities co-ordinator, head chef, head housekeeper, maintenance operative and one health professional visiting the home on the day of the inspection.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We looked at 11 people's care files and risk assessments, daily care records, 36 Medicines Administration Records (MARs), 12 staff files, staffing rotas and records relating to the management of the service such as quality audits, complaints and staff rotas.

Good

Is the service safe?

Our findings

People and relatives told us they felt that they and their loved ones were safe living at Stamford Care Home. A person told us, "I was lucky to get into this home. I was offered it twice before I came in, and I have no regrets." A second person told us, "The staff are respectful and I feel safe." A relative told us their relative was, "safe and well looked after". Some people told us that sometimes other people living at the home were aggressive but they said they did not feel unsafe and that staff managed the situations.

The provider's safeguarding policy clearly defined the different types of abuse and the actions to be taken where abuse was suspected. Staff demonstrated a good level of understanding and were able to clearly describe the steps they would take to protect people from abuse. Staff also knew how to 'whistle blow' and the external agencies that could be contacted to escalate their concerns.

At our last inspection of the service in February 2017, we found that the provider was in breach of the regulation relating to medicines management. We found that some medicines were not stored and disposed of safely. People's Medicine Administration Records (MAR's) were not always completed in full or accurately. Medicines were not always administered as prescribed. We issued a warning notice to the provider and registered manager on 14 February 2017, requiring compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 1 March 2017. When we carried out a follow up focused inspection on 4 April 2017, we found that the provider had made significant improvements to how medicines were managed.

At this inspection, we were satisfied that improvements to how the service managed medicines had been implemented and sustained. The home had the appropriate systems in place to manage medicines safely. We saw evidence of people's currently prescribed medicines on the MAR's. These correlated with the GP prescriptions kept by the home. We looked at recording of medicines and saw no omissions in the recording of receipts of medicines, administration of medicines and disposal of medicines. The allergy status for all people was clearly stated on the MAR so that people were not given a medicine which could cause an adverse reaction. We did see one person allergic to penicillin and discharged from hospital on a penicillin based antibiotic. The home followed this up with the hospital at the time of the inspection.

Storage of medicines in all units was well-organised and secure. Temperature monitoring of rooms and fridges ensured that medicines were kept at the right temperature to maintain their potency. Controlled drugs were all kept securely and records were accurate.

Several people were prescribed 'as required' medicines to be taken for example if they were in pain or very agitated. We saw clear protocols to describe how and when these medicines were to be given and a separate record was kept of the benefit or effect of giving each dose. Variable doses such as one or two tablets were recorded accurately so that the prescriber could determine the effectiveness of the medicine.

Some people were not able to swallow safely and we saw that they were either fed through an enteral tube directly into the stomach or by a pureed diet. There was evidence of dietician involvement with detailed

protocols for those people fed by tube with care plans and risks assessments to ensure safe practice. Fluid balance charts were kept in the person's room and we observed that all liquids were recorded and daily intake was as the dietician recommended. We observed that for all people with swallowing problems liquid medicines were prescribed where appropriate so that medicines did not need to be crushed. Some people needed their medicines given to them hidden in their food. The home had consulted with the persons GP, pharmacist and family and obtained agreement that this was in the person's best interest.

When people were in pain we saw pain charts and monitoring and care plans which were updated monthly. Other charts in use were for recording where to administer creams and other topical medicines and where to apply a patch to the skin. People with diabetes had their blood glucose monitored according to individual care plans and target levels.

Records of all visits by healthcare professionals and discharge letters from hospital were kept in the person's care plan and we saw that reviews of medicines were carried out and recorded appropriately.

We looked at records of people prescribed blood thinners to prevent blood clots and needing careful monitoring. We saw that there were regular blood tests carried out and the latest blood test and dosage was kept with the MAR. All records and audits of tablets showed that they were being given as prescribed.

We carried out 20 stock counts in total from the 36 MARs we examined. All were accurate. The home was carrying out daily checks of the MAR charts to ensure accurate recording and weekly and monthly audits where the medicines systems were scrutinised and random stock checks were made. We viewed audits for the last three months and saw that action was taken and recorded when concerns were noted.

We heard from two nurses they were well supported with medicines training which was confirmed by records seen. All nurses had regular competency assessments.

Risks associated with people's care and support needs were assessed and there was clear information and guidance to all care staff on how to support people appropriately in order to reduce or mitigate any risk identified. Examples of risk assessments that formed part of the care plan included falls, moving and handling, bed rails, skin integrity and malnutrition. Individual risks associated with people's care and support needs were also identified and assessed, such as the risks associated with diabetes or the use of a feeding tube.

For people at risk of or receiving treatment for pressure ulcers, accurate records were kept to demonstrate how the service was reducing the risks to the person, for example for one person we saw that pressure relieving equipment was in use, regular repositioning was taking place, staff were applying barrier creams on a regular basis, the person had been referred to the Tissue Viability Nurse (TVN) and dressings were changed on a regular basis. Records demonstrated that the person's pressure ulcer had improved. The person's wound was assessed on at least a weekly basis, their care plan was updated on a weekly basis and staff were following guidelines.

For people at risk of malnutrition of dehydration, we saw that food and fluid charts were completed to monitor their intake. These were totalled at the end of the day and checked by the person in charge. We saw that people were referred to the appropriate health professionals such as a dietician or speech and language therapist (SaLT), where concerns were noted. A staff member told us, "When people's weight are 2 and above on the MUST score, we refer the person to the dietician and weigh them weekly. The dietician normally recommends fortified food and nutrients."

On both days of the inspection, the inspection team observed there to be sufficient numbers of care staff available around the home. Care staff did not seem rushed and were able to attend to people's need in a timely manner. Rotas seen for the days of the inspection, confirmed that the stated number of care staff were present in the home. However, we received mixed feedback from people and relatives about the staffing levels at the home, with people telling us, "There are always staff around to do things I need done. They come quickly if I ring a bell", "If I ring the bell sometimes I have to wait but generally they come" and "There's not enough people to do things for you." A relative told us, "Staffing has gotten a lot better noticeably." A second relative told us, "There are always staff about but they always seem different people." A nurse told us, "The staffing levels are fine. We work well with each other." Another staff member told us, "We are supposed to be five on this floor. One in the lounge and two each side. Sometimes if we are short, it's busy" A third staff member told us, "Sometimes busy but it's okay."

Staff were safely recruited. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. Confirmation of nurses professional registration and validation was monitored.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Accidents and incidents were recorded and investigated. We saw signs displayed throughout the home to encourage staff to report any concerns, accidents or incidents. The registered manager reviewed all accidents and incidents and also produced management reports on a monthly basis to review all accidents and incidents for trends and patterns in order to implement improvements to prevent re-occurrences where possible.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella, lifts and hoisting equipment were undertaken.

Personal Emergency Evacuation Plans were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

People were protected by the use of safe infection control procedures and practices. Staff were trained and kept up to date with good practice. The home was clean and well maintained. Staff had access to personal protective equipment. A relative told us, "They do their work, sometimes I touch and it's always clean. I've even seen a man scrubbing the floors, corridors and sitting areas."

Good

Is the service effective?

Our findings

People and relatives were complimentary about the care staff that supported them and felt that they were adequately skilled and trained to carry out their role. One person told us, "By and large people are good, if you ask they help you. They are supportive." A second person told us, "The staff are lovely and they have good attention to detail." A relative told us, "The Nurses/Sister are very knowledgeable. They see things."

The service had systems in place to keep track of which training staff had completed and future training needs, staff supervisions and appraisals. Staff told us that they had received regular training which was confirmed by records seen. Training courses included; nutrition and hydration, behaviour that challenges, MCA/DoLS, safeguarding, pressure ulcer for carers, falls management and infection control. A staff member told us, "We do training over and over again." Newly recruited staff received a period of induction which consisted of mandatory training, period of shadowing up to three weeks depending on the staff member's experience and a period of probation with regular review meetings.

Staff told us and records confirmed that they received regular supervision and an annual appraisal. They felt appropriately supported in their role. The supervision and appraisal process at the service was a continual process and each staff member had their own individual supervision and appraisal book which detailed their yearly development plan and personal objectives. Supervisions were individual to the staff member and we saw instances of where supervision acknowledged good performance or identified areas for improvement.

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). We checked whether the service was working within the principles of the MCA. Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for authorisation. Records confirmed that where appropriate, people consented to their care and where people lacked capacity a best interests decision had been taken with the involvement of their relative or appropriate health professional.

Training in the MCA and DoLS had been provided. The staff we spoke with had a clear understanding of the principles of the MCA and how it was applied.

Most people told us that they enjoyed the food choices on offer and that there were sufficient quantities of food and drink available. Feedback from people regarding the food included, "The food is okay. It keeps me

alive", "The food's good. I can eat properly and enjoy it now", "The food is reasonably good – they give us a choice" and "I'm very fussy, I like the food here, good choice of food. It's like a nice 1930s fine dining." We saw staff explaining the menu options to people and asking them whether there was anything else they would like to eat. Snacks and drinks were also provided to people throughout the day. We saw people provided with alternatives if they did not like the choices on offer on that particular day. Where people required assistance with their meals, this was provided by staff in a prompt but caring and unhurried manner.

The kitchen was clean and well maintained. There were daily temperature checks completed of fridges and freezers which were clean and well stocked. Opening dates of food were recorded and use by dates also noted. The head cook told us they had important information in the kitchen about people's specialist diets and dietary requirements, as well as their individual preferences. This included having regard for people's cultural and religious dietary requirements. Where there was input from the speech and language therapy team or dieticians, this guidance was known by the cook and by staff and was adhered to.

Where there were concerns about people's weight loss or gain, there was weight monitoring in place. People at risk of malnutrition and dehydration had food or fluid charts to monitor people's food and fluid intake. These were documented and signed appropriately. This information was routinely reviewed and monitored so that any changes could be acted upon, such as referrals to GPs or dieticians. People who received nutrition via a percutaneous endoscopic gastrostomy (PEG) feed regime were supported by trained nursing staff.

The service carried out comprehensive pre-admission assessments to ensure that they understood and were able to meet people's health, care and medical needs which included assessments of communication, mobility, skin integrity, nutrition, breathing, medication and pain score, cognition, psychological wellbeing, behaviour and end of life care. For one person, we saw that a multi-disciplinary team including TVN, dietician and PEG nurse was involved in their care assessment. People's care needs were reviewed on a monthly basis and updated as and when people's care needs changed.

There were three daily handovers, which were in the morning when the night staff handed over to the day staff, in the evening when the day staff handed over to the night staff and at 10am when there was a daily feedback and update session with unit leads and home management team. This meant that any concerns or updates regarding people's care needs were communicated throughout the home and escalated to senior staff in a timely manner. The registered manager also had a weekly meeting with their manager and other home managers in the area where ideas were discussed and concerns raised.

People were supported to maintain good health and have access to healthcare services and received ongoing healthcare support. Care plans detailed records of appointments with health and care professionals. We also saw evidence that following appointments, people's care plans were updated accordingly. A relative told us, "I believe there's a doctor there on a Wednesday. When he's had a temperature or a rash, they've shown it to the doctor."

The Home was purpose built and all areas of the home were wheelchair accessible. People's bedrooms were decorated to their taste with family photos and ornaments. People were seen to be able to access the outside smoking areas when they so wished.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and spoke positively about the relationships they had with staff. Feedback from people included, "By and large people are good: if you ask they help you. They are supportive" and "It's nice to have someone to talk to." Relatives were happy with the care their loved ones received. One relative told us, "They care for her very well." A second relative told us, "They are kind and helpful." A number of written compliments about the service were seen which thanked staff from all levels for the care provided to people who had recently passed away. One compliment read, 'To all the staff, especially [named unit]. We will be forever grateful for the care you gave our mother in her last years.' A second compliment read, 'Thank you for the care, compassion and kindness in looking after [person].'

We observed many kind and caring interactions between staff and people throughout the two days of the inspection. We saw a member of care staff gently rub a resident's shoulder to calm her. We saw a resident become distressed about her missing handbag at breakfast and a care staff immediately reassured her that he would find it and he did so straight away. The member of staff running an activity session knew all of the people by name. She was affectionate to the residents. We also observed both care staff and a member of the office staff reassure a person who had become upset due to a family bereavement. A relative also told us of how staff at the home supported them. They told us, "When she first came here I was struggling. They talked me through the changes happening to her and helped me get a perspective. When she didn't recognise me, they were very comforting to me."

The atmosphere at the home was calm, but upbeat. We saw people enjoying staff company and enjoying laughs and jokes with them, and staff knew people well. Most staff told us they had time to chat with people as they provided care and assistance. A staff member told us, "The interaction with the residents is very good. The way we engage the residents is very good."

Staff respected people's privacy and dignity. We saw that doors were kept closed when people were receiving personal care. The majority of people we spoke to stated that staff were respectful and careful when undertaking personal care tasks. A person told us, "They are respectful."

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. Care plans also detailed people's cultural and religious preferences and whether people practised a faith and whether members of the local religious community visited the home on a regular basis. One person told us there was a church service in the home every week. People were addressed by the staff using their preferred names. A relative told us that staff referred to their loved one using an endearing term which the person liked. Staff told us they had read peoples care plans. A person told us, "They look after me; they all know me." A relative told us, "They know his quirks."

The provider had an equality and diversity policy in place and staff had received training in this area. Staff we spoke with understood what equality and diversity meant and how that affected the care they provided for people who use the service. A relative told us that the home had been helpful when they wanted to install satellite television for the person to be able to watch programmes in their own language.

People's friends and relatives were able to visit and keep in contact without being unnecessarily restricted. We observed a steady stream of visitors throughout our inspection who told us that they could visit the home freely and were welcomed by staff and management.

Good

Is the service responsive?

Our findings

People and relatives told us they had been involved in the implementation of their loved ones' care plans, as well as any subsequent reviews. Most relatives told us that they thought the home communicated well with them regarding their loved one. A relative told us, "They ring me all the time, whenever she has a blister or if she is not well." A second relative told us, "If he's seen the doctor, they ring my daughter and son and keep us informed."

People using this service and their relatives told us that the management and staff responded to any changes in their needs. Two relatives told us that their loved ones health was pro-actively monitored by staff. One relative told us, "When he went into hospital he came back with a lot of sores: they've healed perfectly now. They ring me if he needs a bandage or anything like that. They keep in touch." The second relative told us, "Sometimes she has sores but they manage to look after them quickly."

All care plans that we looked at contained a detailed life history document which included information about the person's background, their life, relationships and their health. Care plans were found to be detailed and person centred and gave information about people's likes and dislikes, choices and preferences. The care staff team knew the people they supported and demonstrated knowledge and awareness of people's likes and dislikes and how they wish to be cared for. Care plans were reviewed and updated where required on a monthly basis.

However, we found that for two people, with learning disabilities, the care plans lacked the detailed support the person needed. For example, where the person displayed behaviours that challenged, their care plans lacked detail around how staff should reassure and calm the person. All staff we spoke with regarding these two people knew their care needs and were able to give examples of how they worked with the person and reassured them. However, the knowledge staff had had not been recorded in the person's care plan to provide guidance for less experienced staff. We discussed our concerns with the registered manager who told us they would review their care records.

People were supported to engage in activities if they chose to do so. We received positive feedback from most people and relatives about the activities on offer. A person told us, "I enjoy the television and I join in activities if I can." A relative told us, "The daily entertainment far exceeds what I thought was going to happen." A second relative told us, "Although [person] is bed bound they do take her to music sessions. She can't participate but she enjoys it." Some people told us they would like access to a more varied selection of newspapers.

Although activities mainly took place on the second floor of the home, people from other floors were supported to attend the planned activities. The provider employed three dedicated activities co-ordinators who were enthusiastic about ensuring they made the days at the home enjoyable for the people living there. Activities on offer included music sessions, comedians and entertainers and daytrips. We saw that people were encouraged to attend day trips. Recent day trips included the seaside, Buckingham Palace and local attractions. A relative told us their loved one had been to Southend, the British Museum and Forty Hall.

Themed days took place on a regular basis which included cultural event and festivals. There were regular themed days called 'European Express Days' which were themed around a particular European country where food, activities and entertainment was arranged around the country in question, for example a Bavarian Beer party. We observed an activity on one day of the inspection where twelve residents were encouraged to join in gentle ball throwing. The activities coordinator spoke to each of the residents by name and modified the activity according to their individual needs, for example a different ball for some people and helping with throwing for other people. The deputy manager told us they were working to make the home more welcoming and a livelier place which was observed by the inspection team throughout the inspection.

People and relatives told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. A person told us, "If I had a complaint, I'd approach that lady carer over there." A second person told us, "There are one or two that you'd prefer to speak to, but I am comfortable to raise issues." A relative told us that although they had never raised a complaint, they had raised issues now and again, such as missing clothes which was resolved swiftly. There was a system in place for capturing and responding to complaints, comments and suggestions. We found that all complaints received had been investigated and responded to. Complaints, comments and feedback were all used as ways of learning and to further develop and improve the service provided.

Care plans documented that advanced care planning and end of life care was discussed with most people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared for and preferred funeral arrangements. Some people preferred to let their next of kin make the decision which was documented. Relatives told us staff had advanced care planning conversations with them. A relative told us, "They asked me how I wanted things done and they gave me time to think about things."

Good

Is the service well-led?

Our findings

At our previous inspection in February 2017, we rated this key question as Requires Improvement. At this inspection, we found the provider had made sufficient improvements and this key question is now rated Good.

People and relatives spoke positively of the overall service provided and registered manager. Feedback from people and relatives included, "The home takes good care of me; they see everything goes smooth for me. They do their best." A second person told us, "It's a friendly environment." A relative told us, "I think the care is excellent. They like her. She went there to die and she's lived more than five years!" A second relative told us, "She had a shaky start and has settled in really well. Everyone's involved. The receptionist will know how she is as I come in. They all know me and they know her." A third relative told us,

Staff spoke positively of the management team and the support they received. One staff member told us, "[Deputy Manager] is very good. She listens to us. The unit manager is very good. The way she treats us is very good. [Registered Manager] listens." A second manager told us, "We are well managed. The home is well run." A third staff member told us, "[Registered Manager] is supportive. He points out things and we learn from him."

At this inspection we found that the management team were very committed to ensuring that the home provided a safe, effective, caring and responsive service and that the necessary and on-going improvements were made where required. We found that managers engaged with the inspection process and were aware of and agreed with the minor concerns that we had identified. The deputy manager told us, "It's a changed culture. We realise this is the residents' home and we need to respect them." Staff told us they were supported to raise concerns and ideas for continuous improvement. Posters were placed around the home stating that the home had a 'no blame culture, just lessons learned.'

Staff were regularly consulted and kept up to date with information about the home and the provider via staff meetings and an annual staff survey. The home had introduced a staff reward scheme and a rewards day where staff achievements and long service was celebrated. Staff champions for infection control, nutrition and dementia was introduced to encourage staff to challenge poor practice and assist with staff development.

We looked at the arrangements in place for quality assurance and governance. These included audits of care records, risk assessments, medicines management as well as health and safety compliance. Where issues had been identified as requiring improvement, these were being addressed appropriately and required action was recorded. In addition, the management team completed monthly unannounced night visits, call bell response time audits, a daily clinical walk around and weekly clinical review meetings.

The registered manager submitted a monthly report to their line manager. This ensured the provider was aware of how the service was doing. The report included accidents and incidents, home acquired pressure ulcers, significant weight loss, mortality rates, medicines errors, hospital admissions, safeguarding's and

DoLS, instances of infections and complaints.

Management at the home placed a strong emphasis on lessons learned resulting from complaints, incidents or accidents. Examples of improvements following a lesson learned exercise was group supervisions with staff regarding communicating with families, improving the process around labelling clothes and holding meetings with people and relatives.

Regular meetings took place for people and their relatives. Minutes showed areas discussed included menus, activities and laundry. At one recent meeting, relatives were encouraged to come along to mealtimes to support their loved one with their meal and they would be offered lunch free of charge. People and relatives were asked for feedback on a yearly basis. We saw the results from a survey completed in December 2017 where the feedback was overall positive.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including the Care Home Assessment Team (CHAT). The CHAT regularly visited people who had complex health needs or who were at risk of deteriorating and also liaised with the wider multidisciplinary team and supported care staff and nurses to coordinate care. The service was also involved in a university study and pilot called 'BHiRCH: Better Health in Residents in Care Homes' to develop and test a complex intervention to reduce rates of avoidable hospital admissions from nursing homes.