Colten Care (1993) Limited

Canford Chase

Inspection report

40 Western Road
Branksome Park
Poole
Dorset
BH13 6EU

Tel: 01202766182
Website: www.coltencare.co.uk

Date of inspection visit:
17 September 2018
18 September 2018

Date of publication:
04 December 2018

Ratings

Overall rating for this service	
Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

This comprehensive inspection took place on 17 and 18 September 2018. The first day was unannounced.

Canford Chase 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.

Canford Chase accommodates up to 55 older people in purpose-built premises. Nursing care is provided. There were 46 people living or staying there when we inspected.

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

The service was committed to excellence in end of life care, working closely with health professionals so that when the time came people had a comfortable, dignified and pain-free death. Staff were particularly skilled and confident in caring for people who were dying and their loved ones. The service collaborated with a local hospice for staff development and to obtain specialist advice on symptom control when needed.

There was a vibrant activity programme based on people's hobbies, interests and wishes and tailored to their individual needs. There were regular trips out for those who wished and were well enough. The service had established links with the local community and continued to develop these.

There was a strong emphasis on the importance of eating and drinking well. Positive relationships with staff encouraged people to eat and drink, particularly those who might be reluctant. Waiters and waitresses were employed to ensure that people who spent most of their time in their room had the same service as people who came to the dining room. The chef met people regularly to obtain their feedback and gather up-to-date information about dietary needs and preferences. The chef also spoke regularly with clinical staff to review people's weights and individual nutritional needs. The provider had produced a comprehensive nutrition resource folder for care and catering staff.

People were supported to live healthily and obtain the care and support they needed from other health professionals. Where people had complex health needs, staff sought to optimise care by identifying and implementing best practice. Staff 'champions' actively supported colleagues to make sure people experienced the best possible health and wellbeing in view of their conditions.

The service worked in partnership with other organisations to keep up to date with new research and make sure staff were trained to follow best practice. Care was planned and delivered in line with current good practice and standards. Standards of nursing care were very high. People and where appropriate their

families were meaningfully involved in planning care. Their choices were reflected in detailed, comprehensive care plans and staff understood their needs and preferences well.

People were protected against abuse and avoidable harm. Staff understood their responsibility to report concerns about abuse and knew how to do so. Medicines were stored and managed safely. We have made a recommendation about the scope of medicines audits.

Risks to people were regularly assessed and they were helped to stay safe in the least restrictive way possible. The premises and equipment were in good condition and there was regular maintenance. The building smelt pleasant throughout. Effective processes were in place to control and prevent infection.

There were sufficient skilled and competent staff on duty to provide the care people needed. Appropriate recruitment checks were made before staff started working at the service, such as criminal records checks and taking up references from previous employers. Staff were supported through training, supervision and appraisal to perform their roles effectively. Nurses were supported to maintain their professional registration with the Nursing and Midwifery Council.

Lessons were learned, and improvements made when things went wrong.

The building and garden had been adapted and decorated to a high standard, providing a comfortable, homely environment that suited people's needs. The premises were accessible for people with mobility difficulties, with passenger lifts, wet rooms and adapted bathing facilities. The large garden had seating areas, raised beds, wheelchair-friendly paths and an accessible summer house.

Staff understood and worked within the principles of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards.

People were treated with kindness, respect and compassion. Their independence was promoted as far as possible. Staff were attentive and upheld people's privacy and dignity. People were encouraged to personalise their room with items of their own to help it feel homely. There were no restrictions on visiting times.

People, and where appropriate their relatives, were consulted and kept informed about their care. Information was available for people and their relatives about outside organisations and sources of support.

Everyone we spoke with or had feedback from was positive about the way the service was run and said the registered manager was readily available. Communication was good. Staff were motivated in their work and proud of the service. Staff turnover was low.

The service had a positive, person-centred, open and inclusive culture. It worked openly and collaboratively with other agencies. The voices of people and staff were heard and acted upon. There was regular consultation, informally and through meetings and quality assurance surveys.

There was continuous learning and improvement through the monitoring and review of accidents and incidents, and through a programme of audits to assess and monitor the quality of the service. People's concerns and complaints were listened and responded to and used to improve the quality of care.

Legal requirements were understood and met. The previous inspection rating was displayed prominently in

the reception area. The service notified CQC of all significant events and the registered manager was aware of their responsibilities in line with the requirements of the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People were protected from abuse and avoidable harm.

Risk assessments were person-centred and reviewed regularly. Risks were managed so that people felt safe but had as much freedom as possible.

There were enough staff on duty to provide the care people needed without being rushed.

Is the service effective?

The service was very effective.

There were champions within the service who actively supported staff to optimise people's health and wellbeing, within the constraints of their health conditions.

There was a strong emphasis on the importance of eating and drinking well. Positive staff relationships were used to encourage people who were reluctant or had difficulty eating and drinking.

The service worked in partnership with other organisations to keep up to date with new research and make sure staff were trained to follow best practice.

Care was planned and delivered in line with current good practice and standards. Standards of nursing care were very high.

Is the service caring?

The service was caring.

Staff treated people with kindness and respect.

People's privacy and dignity were upheld.

Staff got to know people well.

Is the service responsive?

The service was very responsive.

People and where appropriate their loved ones were meaningfully involved in decisions about their care. Care was tailored to people's individual needs and preferences. There was a vibrant group and individual activity programme, which met people's individual needs and fostered community links.

The service worked closely with healthcare professionals and provided outstanding end of life care.

People were confident that if they raised a concern it would be taken seriously and dealt with properly.

Is the service well-led?

The service was well led.

We received consistently positive feedback about the way the service was run.

The service had a person-centred, open and inclusive culture.

The registered manager and provider strove to improve further the quality of the service, through learning from accidents and incidents and complaints, and listening to people who used the service, their loved ones and staff.

Care Quality Commission

Canford Chase

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 was a routine comprehensive inspection. It took place on took place on 17 and 18 September 2018. The first day was unannounced.

We reviewed the information we held about the service and took this into account while planning the inspection. This included statutory notifications from the service about significant events such as deaths and 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

The inspection team was made up of two adult social care inspectors, a pharmacist special advisor and a specialist advisor in general adult nursing. We made general observations around the service. We spoke with six people about their experience of the care they received, two relatives, six staff, the registered manager. We also spoke with the provider's operations, clinical and quality managers. We viewed six people's care records, seven people's medicines records and stocks of further people's medicines, three staff files, and other records relating to the quality and management of the service.

Following the inspection, we obtained feedback from seven health and social care professionals who have contact with the service.

Good

Is the service safe?

Our findings

People were protected against abuse and avoidable harm. Staff understood their responsibility to report concerns about abuse and knew how to do so. Information was displayed about reporting concerns within the provider's organisation and to statutory agencies concerned with safeguarding adults.

Risks to people were regularly assessed and they were helped to stay safe in the least restrictive way possible. Risks relating to falls, the use of bed rails, moving and handling, developing pressure sores and malnutrition were routinely monitored. People also had up-to-date personal emergency evacuation plans, which set out the support and equipment they would need to leave the building if there were a fire or similar emergency. Prompt action was taken to manage any risk in a way that was acceptable to the person. This included the use of technology that alerted staff to when people at risk of falls got up from their chair or bed, so staff could go to assist them. Where people were identified as being at risk of malnutrition, advice was sought from health professionals and a nutritious diet provided. A person was identified as being at risk of falls but had opted not to use bed rails to prevent falling from bed, and this wish was respected. Staff knew about risks to people's wellbeing and how to manage them.

There were sufficient skilled and competent staff on duty to provide the care people needed. Staff supported people without rushing them and looked calm and happy as they went about their work. People told us their call bells were generally answered promptly, although on occasion they had to wait if staff were busy. Appropriate recruitment checks were made before staff started working at the service, such as criminal records checks and taking up references from previous employers.

The premises and equipment were in good condition and there was regular maintenance. Current certification was in place for checks on gas safety, electrical wiring, portable electrical equipment, the lift and lifting equipment. The registered manager checked every month that the fire log book, which included records of checks and servicing of fire safety equipment, was up to date. Timed fire drills had taken place at different times of day in July, August and September 2018. There was a programme in place to reduce the risk of legionella colonising the water system; legionella are bacteria that can cause serious illness. Staff were easily able to obtain extra equipment, such as slings for moving and assisting people, if needed.

People were protected through the control and prevention of infection. The service had attained a rating of five (the highest) in a food hygiene inspection a year before. Staff were trained in food hygiene. The building was kept clean and smelt fresh throughout, including sluice rooms and the laundry. Domestic staff undertook cleaning tasks throughout the inspection. Handwashing facilities and hand sanitiser were provided around the building. Disposable aprons and gloves were readily available for staff. Staff had training in hand hygiene and their handwashing technique was regularly checked. However, during a medicines round, the member of staff administering medicines did not always clean their hands when moving on to the next person. We drew this to the attention of the management team. The member of staff was horrified when they realised their omission, as they understood good hand hygiene and generally strove to maintain this.

Overall, medicines were managed safely. They were stored securely and in an organised fashion. Where people arrived for a respite stay with their own supplies of medicines that did not contain clear instructions for staff, staff liaised with their doctor to obtain a fresh prescription. During the inspection, staff also liaised with GPs to query medicines that had been prescribed on an 'as necessary' basis but not used. Records accounted for the quantities of medicines in stock and there were regular checks to ensure this was always the case. However, a tube of skin cream that needed refrigeration had been placed in an ordinary cupboard. We drew this to the attention of the management team and staff requested a replacement. Additionally, we found a box of tablets that expired in December 2017, and eye drops opened in May 2017 that should have been disposed of 28 days afterwards. These were no longer in use, but their retention meant there was a risk people could receive them.

We recommend that medicines audits specifically check for out of date medicines and medicines that are no longer required.

Lessons were learned, and improvements made when things went wrong. Staff understood their responsibility to report concerns and near misses, and when they did, these were taken seriously. Each incident was reviewed as soon as possible by the registered manager or clinical lead to ensure measures were in place to ensure people's safety. The registered manager reviewed accidents and incidents every four weeks for any trends that might suggest further action was needed. The provider's senior management team were alerted to incidents and near misses as soon as reports were logged and reviewed for possible trends across their services.

Outstanding ☆

Is the service effective?

Our findings

There was a strong emphasis on the importance of eating and drinking well. The service provided a choice of appetising, good quality food, with flexibility to accommodate people's needs and preferences. People were positive about the food, particularly the main meal at lunchtime, and ate their meals with enjoyment. The menu was devised centrally but prepared by the service's chefs and tailored to suit choice and needs. There was a range of options for each course including a vegetarian option. People were offered the portion size they preferred, which meant people with smaller appetites were not put off by a large meal. People selected their choices the day before for lunch, which was the main meal, and supper. If they did not want what was on the menu they could choose an alternative. However, the kitchen was able to cater at short notice for people who changed their mind, including people who had special diets. For example, someone who needed a soft meal did not fancy what they had chosen when it was presented to them; they decided to have an omelette instead. Presentation was seen as important for people's enjoyment and to stimulate their appetites; meals in the dining room and served to people in their rooms were all set out attractively. The provider's nutrition guide gave precise instructions as to how staff were to set out trays for people who ate in their rooms, to make sure these looked inviting. Staff went around with the "Jolly Trolley" before meals, offering aperitifs or wine with meals where appropriate.

People were supported to drink enough and to maintain a balanced diet. Whilst lunch and supper were served at set times, snacks were available at other times, including overnight, according to people's needs and preferences. One person talked with pleasure about "constantly being offered something to eat". It seemed odd to them that food was available at night. A quality manager explained there was a 'night owl' menu with food that was straightforward for care staff to prepare. Many people chose to eat in the dining room whilst others preferred to eat in their rooms. Meal service in both settings was calmly organised, with the same attention to people's specialist dietary needs. People who needed support to eat their meal received this in a dignified way, at their pace. Staff were attentive, sensitively encouraging people to eat, helping cut up food if people wanted this and asking if people wanted seconds. People had detailed eating and drinking care plans that reflected their needs and preferences. Staff had a good understanding of these. People's weights and risk of malnutrition were monitored, and professional advice sought promptly if there were concerns about weight loss. Fortified meals and drinks, including milkshakes and smoothies, were available if indicated. Dietary needs were clearly communicated to kitchen staff, such as modified texture diets for swallowing difficulties and diets for wound healing and cultural needs. The chef and clinical lead met at least every four weeks to review people's weights and individual nutritional needs. The chef was also included in a daily meeting of managerial and senior staff to communicate key information.

Positive relationships with staff encouraged people to eat and drink, particularly those who might be reluctant. Waiters and waitresses were employed to ensure that people who spent most of their time in their room had the same service as people who came to the dining room. They took meals, snacks and drinks to people in their rooms, essentially providing room service, although any assistance to eat and drink was given by care staff. An important part of their role was to spend time talking with people about what they might want to eat and drink, explaining what was on the menu and helping them choose or find a suitable alternative. People greeted these staff by name and evidently enjoyed their company. People also knew the

chef, who often chatted with people to get to know them and get feedback about the meal. The chef met all new residents to discuss dietary needs, food preferences and portion sizes. This happened within 24 hours of admission provided the person was happy to do so. These meetings were repeated every six months.

The provider had produced a nutrition resource folder for care and catering staff. The folder helped all staff understand people's nutrition and hydration needs and how to provide the necessary support. It included comprehensive information about general principles of nutrition and hydration, fortifying food to increase the calorie content, dietary requirements for health such as food allergies and intolerances, cultural requirements such as Halal and vegan diets, malnutrition and dehydration in older people, managing swallowing difficulties, nutrition and hydration at the end of life, and creating a positive dining experience.

People were supported to live healthily and obtain the care and support they needed from other health professionals. A health professional commented, "All the staff at Canford Chase I have found very helpful in their communication and always very informed and caring regarding their residents... Advice is always noted and to the best of my knowledge acted on." Where people had complex health needs, staff sought to optimise care by identifying and implementing best practice. For example, when staff noticed someone was experiencing increasing short-term memory difficulties they referred to the provider's Admiral nurse, who carried out a cognitive assessment. Admiral nurses are specialist dementia care nurses who give practical, clinical and emotional support to families who have relatives living with dementia. They were also able to offer support and advice to staff. Staff sought medical advice promptly if people were unwell and liaised with other health professionals involved in their care, such as community mental health nurses. For example, a person was demonstrating increasing emotional and behavioural needs. Staff asked the GP to review them; the GP diagnosed depression and prescribed antidepressant medication to good effect.

Staff 'champions' supported their colleagues to make sure people experienced the best possible health and wellbeing given their conditions. They included staff with specialist moving and handling training who were designated as "ergo coaches". This was part of a fresh approach to moving and handling people that sought to maximise people's independence, benefitting their health, and, in the words of an ergo coach, "keeping them feeling safe and comfortable" during transfers. Ergo coaches observed, coached and trained nurses and care staff and provided advice on moving and handling issues.

The service worked in partnership with other organisations to keep up to date with new research and make sure staff were trained to follow best practice. There was close working with a local hospice to keep abreast of developments in end of life care and to provide training in the care of people who were dying. The clinical team regularly reviewed and updated their documentation and assessment tools to encourage excellence in practice and continual improvements in care. An example of this was their recent collaboration with a major supplier of continence products to produce continence assessments. At the time of the inspection they were reviewing their skin integrity documentation and trialling the use of another recognised pressure sore risk assessment tool. There was a very proactive approach to falls, including the introduction of falls 'huddles' to review why a fall had happened and any changes that might be needed as a result.

Care was planned and delivered in line with current good practice and standards. Standards of nursing care were very high. Assessments of need were comprehensive and person-centred, reflecting equalities information such as ethnicity and sexuality, where people wanted to give this information. They included details about people's wishes, hobbies and things that were important to people. They were documented in the person's All About Me folder and were used to develop personalised, detailed care plans. Assessments and care plans were kept under regular review with the involvement of people and where appropriate their families. They covered areas including skin integrity and pressure ulcer risk, eating and drinking, nutrition, oral health, moving and handling, continence, falls risk and advance care planning. In relation to skin

integrity, there was clear evidence of the use of assessment tools and best practice in care, which helped to promote wound healing and to minimise the incidence of pressure sores. Where a person's skin was broken, staff had quickly taken appropriate action resulting in healing or a reduction in skin damage for people with complex health needs, or those approaching the end of their life.

The building and garden had been adapted and decorated to a high standard, providing a comfortable, homely environment that suited people's needs. People were encouraged to decorate their rooms with their own personal items and pictures. A person told us how pleased they were to have been able to bring special items of furniture with them when they moved in. Communal areas had been refurbished within the past year, including the provision of wet rooms, a café area for people and their visitors and a quiet lounge for people to spend time quietly or host celebrations with their families and friends. The premises were accessible for people with mobility difficulties, with passenger lifts, wet rooms and adapted bathing facilities. The large garden had seating areas, raised beds, wheelchair-friendly paths and an accessible summer house. The registered manager and staff told us the garden was much loved and well used. The first day of the inspection was sunny and people spent time outside.

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.

The service worked within the principles of the MCA. Staff had training in this as part of their core training. Wherever possible, people's consent to their care had been recorded and staff checked whether people were happy to receive assistance before providing care. If there were doubts as to a person's mental capacity to give consent to a particular aspect of care, a mental capacity assessment had been recorded. If the person was found to lack capacity, a best interests decision was made with involvement from the person and their family or close friends.

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).

The service had identified where people were deprived of their liberty and were unable to consent to this. In line with the requirements of the MCA, they had applied to a 'supervisory body' (local authority) for this to be authorised under the DoLS. Some DoLS authorisations had been granted without conditions and others awaited assessment by the local authority. The service had a system for monitoring when DoLS authorisations would expire and applied for fresh authorisations in good time.

Staff had the skills and knowledge to provide effective care and support. People expressed confidence in the nurses and care workers. Staff told us they had plenty of development and education opportunities, for example commenting, "The training's second to none". There was a comprehensive induction for new staff, and staff who were new to care were expected to attain the Care Certificate. The Care Certificate is based on a nationally agreed set of standards for health and social care work. Key training took place at induction and was refreshed at regular intervals thereafter. This covered topics such as moving and handling, safeguarding adults, infection control, food hygiene, basic life support, fire safety and equality and diversity. The provider had a system to monitor when staff were due for training and to ensure this was provided. Staff who were not nurses were encouraged to obtain relevant vocational qualifications. The provider had forged links with a further education college to encourage further training.

Nurses were supported to maintain their professional registration with the Nursing and Midwifery Council. Professional revalidation was taken seriously; for example, a nurse told us spontaneously how they had reflected on feedback from an outside professional and had recorded this in their professional portfolio for revalidation purposes. The provider supported nurses with subscriptions to an on-line nursing journal with activities for developing clinical knowledge and skills. The provider held an annual clinical excellence day to update nurses with current practice.

Supervision and appraisal were used to develop and motivate staff. Staff had regular supportive supervision meetings with their line manager to reflect on their work and discuss any concerns. Appraisal took place annually to review performance and plan for training and professional development.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. People and their visitors spoke highly of the caring approach of staff, saying things such as, "Everybody's very nice", "I can always talk to them", and "The people [staff] are lovely, they really are." Staff including managers came across as welcoming and happy. Throughout the inspection they interacted with people in a friendly and respectful way, treating them as individuals rather than as patients. This was not solely while they were providing care; staff took time to chat with people and their relatives as they passed. People called staff by name and staff addressed people by their preferred name.

People, and where appropriate their relatives, were consulted and kept informed about their care. There were no restrictions on visiting times. Information about people's life histories, preferences and what was important to them was recorded in their care records. This helped staff to support them in the way they liked. Information was available for people and their relatives about outside organisations and sources of support. For example, a firm of solicitors held regular Mental Capacity Act, power of attorney and will clinics at the service.

Staff respected people's dignity. They were attentive and swiftly went to help people when they were in discomfort or in obvious need of support. For example, someone had their door open and was sitting on their bed wearing just underwear and looking disorientated, as if they had just woken up. Staff walked past shortly afterwards and noticed this; they went to assist the person, explaining what they would do to help them. The person looked reassured by this. Assistance with personal care, such as using the toilet, was offered discreetly, and all personal care took place behind closed doors.

People's independence was promoted. People told us they received the right level of support, rather than too much help with things they could do for themselves. For example, one person said they valued being able to stay as independent as they could. Care plans stated what people could do for themselves and where they needed prompting rather than actual assistance. For example, a person with visual impairment was able to brush their own teeth but needed staff to tell them where their toothbrush and toothpaste were positioned in front of them.

People's privacy was maintained. Whilst people were offered group activities and were encouraged to socialise, staff respected their decision to spend time alone in their rooms. They knocked on people's doors before entering their rooms. Keys were available for people who wished to lock their doors. Staff understood the importance of confidentiality and were mindful of these when discussing people's care. The call bell screen on the second-floor corridor showed people's first names and room numbers. When we highlighted this to the management team, they immediately changed it so only the number was displayed.

Outstanding ☆

Is the service responsive?

Our findings

The service was committed to excellence in end of life care, working closely with health professionals so that when the time came people had a comfortable, dignified and pain-free death. It had maintained the highest level of accreditation with a nationally-recognised end of life care accreditation scheme. To be accredited at this level, "a home must show innovative and established good practice" across at least 12 of the 20 standards assessed. In addition, the service had won a national award earlier in 2018 for its participation in a prestigious programme that supports services to develop their capacity for delivering a high-quality experience of end of life care for people, families and staff. Staff were particularly skilled and confident in caring for people who were dying and supporting their loved ones. There were numerous compliments from families of people who had died, praising the person's care at the end and the way staff supported the relatives. Staff collaborated with a local hospice, for example to obtain specialist advice on symptom control when needed. They had identified scope to improve further their care of recently bereaved families and were developing a link with a local funeral director aimed at helping people and families feel more comfortable talking about death.

Staff had the specific skills to provide emotional support and practical assistance at the end of a person's life. End of life wishes and choices were clearly and comprehensively recorded in care plans. Where appropriate, Do Not Attempt Cardio-pulmonary Resuscitation notices were in place to ensure people's wishes were respected. Care plans documented, and staff told us about, the importance of supporting the loved ones of a person who was dying as well as the person themselves. For example, they offered relatives to stay over and to be as involved in the person's care as they wished. The service had purchased a Z-bed and had reserved parking spaces, to help make urgent call outs less stressful for families. Many nurses had a qualification in the verification of death, which helped make the after-death process more efficient as it avoided a sometimes long wait for a paramedic or doctor to attend. An annual Celebration of Life provided an opportunity for bereaved families to visit the service and take part in a multi-cultural service.

Compassion was also shown to staff. A forget me not sign was put up both on a deceased person's door as well as near the kitchen so that all staff were sensitively informed when someone died.

People received care that met their needs and was personalised according to their individual preferences. People and where appropriate their families were meaningfully involved in planning care. Their choices were reflected in detailed, comprehensive care plans and staff understood their needs and preferences well. People, relatives and professionals consistently praised the standard of care. A person talked about how they felt totally involved in decisions about their care, had been able to discuss their future wishes and were not lonely. A health professional commented on "excellent patient care and very efficient and responsive staff".

People's care was reviewed each month, and in between if necessary. Care plans were updated as people's needs and preferences changed. Care plan reviews were part of the 'resident of the day' process, where one day a month each person, and their family as appropriate, were involved in a review of all aspects of their life at Canford Chase. Matters such as health concerns and forthcoming appointments with health professionals

were discussed at a daily morning meeting of senior staff. This information was also handed over to staff coming on duty at handover meetings at the start of each shift. Staff had a good understanding of people's current needs.

There was a vibrant activity programme organised and run by a team of activities coordinators. These were based on people's hobbies, interests and wishes and tailored to their individual needs. There were regular trips out for those who wished and were well enough. As we arrived on the second day, a day trip to the Tank Museum was about to start; there was much laughter and banter as people were helped to the minibus, which was shared with some of the provider's other homes. The month's activity programme was prominently displayed around the service. An activities coordinator told us people tended to voice strong views about what they liked and disliked, and that the activity programme was adapted according to how people felt that day: "We work around the residents depending on their moods." Activities based at the service included quizzes and games, arts and crafts, coffee mornings and tea parties, visiting singers and musicians, visiting animals and therapeutic pets, and a gardening club facilitated by the service's gardener. People often chose to sit in the reception area occupying themselves with newspapers, puzzles and knitting. People said there was plenty for them to do if they wanted. Whilst people were encouraged to join group activities downstairs, their choice not to was respected. A person told us how they preferred to stay in their room. Their relative said activities staff always asked the person if they would like to join in, including going on trips out. To help counter social isolation, personalised one-to-one activities were provided daily for people who were unable to come downstairs.

The service had established links with the local community and continued to develop these. Some relatives of people who had previously lived at the service served as volunteers, assisting with activities and trips out. Volunteers ran a successful 'knit'n'natter' group and a bridge club that was open to the wider community. A student from one of the secondary schools in the area regularly spent time with people as a volunteer. Children from a nearby nursery visited from time to time, for example, participating in an Easter egg hunt. Fish and Chip Friday provided an opportunity for new visitors in particular to spend time meeting people who lived at the service and enjoy lunch. The home sponsored a bowls club, as a person living at the home had been a member and their relative was president. People visited the bowls club and people from the club often used the service for respite. Some people were fans of the AFC Bournemouth football team, so earlier in the summer the team's community trust had visited for a kickabout activity. The mayor of Poole had attended someone's 100th birthday celebrations, staff having agreed this with the person. The service had close connections with local churches and Jehovah's Witness and Jewish communities had also given pastoral support. Visits from the Samaritans provided informal opportunities for people to discuss any concerns.

The service met the Accessible Information Standard. This is a legal requirement for providers to ensure people with a disability or sensory loss are given information in a way they can understand and have the communication support they need. Assessments, care plans and hospital transfer information flagged people's communication needs. Staff provided the support people required, such as with cleaning and wearing glasses. A relative told us how staff knew how to deal with their family member's hearing aids: "They make sure they're in every day." Staff completed the person's hearing aid chart each day to record the support they had given.

People's concerns and complaints were listened and responded to and used to improve the quality of care. Information about how to raise a concern or make a complaint was readily available and was prominently displayed around the service. People and relatives told us they would feel confident to complain to the registered manager if necessary. There had been two formal complaints in 2018. These had been addressed promptly in line with the provider's policy. They resulted in learning about the importance of clear

communication.

Good

Is the service well-led?

Our findings

Everyone we spoke with or had feedback from was positive about the way the service was run and said the registered manager was readily available. For example, a person who used the service said of the registered manager, "She's around; you can always ask to see her." A relative commented, "[Registered manager] runs a tight ship. She's very good with all her staff." Staff said, "You can go to [registered manager]. There is an ear if you need it" and "[Registered manager] is very supportive". Health professionals told us they experienced good communication with the service and that messages were always passed on; one commented, "I have never had a situation where messages haven't been delivered." A health professional described the service as "an exceptionally well run and managed care home". The provider used a well-known public review website, which gave the service a rating of 9.8 out of 10.

Staff were motivated in their work and proud of the service. Staff turnover at the service was low, with most staff having worked there for several years. Long-serving members of staff told us they stayed because they enjoyed their work and valued Canford Chase. One described it as a "lovely" place to work. Staff talked about good teamwork and having "excellent support". For example, a member of staff talked about the well-established team being like "a happy family". The provider had celebrated outstanding employee contributions earlier in the year through its first Colten Champion Awards. One of the registered nurses was a finalist in the 'clinical excellence' category.

The service had a positive, person-centred, open and inclusive culture. Its atmosphere throughout the inspection was homely, happy and friendly. Staff promoted the provider's promise of "Cherishing You"; they understood and upheld the provider's values of "friendly, kind, reassuring, individual and honest". These values were clearly displayed around the service. Residents, visitors and staff entering the building were welcomed warmly, as was the inspection team, and everyone was treated with dignity and respect. Correspondence between health professionals referred to how welcoming and helpful staff had been in relation to the issue they were discussing. Staff had training in equalities as part of their mandatory training. The staff team was diverse in relation to race, gender, sexual orientation and age, and the service had experience in providing care for lesbian and gay people.

The service worked openly and collaboratively with other agencies. It had developed links with a local hospice to enhance its already high standard of end of life care. We received positive feedback from health professionals and other social care providers about the transparent way in which the service worked with them.

The service involved people and their loved ones in a meaningful way. The registered manager and staff were proud of how a person who lived at Canford Chase had been involved with the provider's staff awards and had attended the awards ceremony to present the award for resident engagement. There were quarterly residents' and relatives' meetings, and also food committee meetings, at which people were encouraged to give their views. Their views were listened to and used to shape developments. Annual surveys also provided an opportunity for feedback. The registered manager analysed comments made and devised an action plan through which they addressed any areas for improvement. Themes from the survey

were displayed in reception in a "You Said, We're Doing" document.

Staff voices were heard and acted upon. There was regular consultation with staff through supervision and staff meetings. Staff meetings were held every couple of months for different groups of staff such as nurses and care workers and activities staff. They were used to share good practice and discuss the wellbeing of people who used the service. Staff were able to raise issues and contribute ideas. There were also daily "10 at 10" meetings between senior staff from each department to help maintain good communication.

There was continuous learning and improvement through the monitoring and review of accidents and incidents. When staff reported a near miss or something that had happened, this was promptly recorded on the provider's computerised monitoring system. The registered manager or their delegated senior staff reviewed each incident to ensure all necessary immediate actions had been taken to keep people safe. Accidents and incidents were also monitored by the provider's clinical and quality managers to identify any themes or trends that needed further information. Learning from accidents and incidents was shared with the staff team.

There was also ongoing learning and improvement through a programme of audits, which assessed and monitored the quality of the service. These included audits overseen by the registered manager, which covered matters including medicines, care planning, call bell response times, and infection control including hand hygiene. There were also regular visits by the provider's operations manager, clinical manager and quality manager, who spoke with people and staff, and made their own checks through observation and examining records. Action plans were drawn up where these checks identified any shortcomings or areas for improvement. The registered manager ensured staff were informed accordingly. Remedial action was taken promptly and progress with action plans was closely monitored.

Legal requirements were understood and met. The previous inspection rating was displayed prominently in the reception area. The service notified CQC of all significant events and the registered manager was aware of their responsibilities in line with the requirements of the provider's registration. Due to the introduction of the General Data Protection Regulation, a data protection officer had been appointed to help ensure robust information governance. Records were archived systematically, in a timely fashion.