Care UK Community Partnerships Ltd

Forrester Court

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

We conducted an inspection of Forrester Court on 19 and 26 February 2018. The first day of the inspection was unannounced. We told the provider we would be returning for the second day.

At the last inspection on 12 and 15 December 2016, we asked the provider to take action to make improvements in relation to maintaining safe staffing levels and good governance and this action has been completed.

Forrester Court 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. Forrester Court provides care and support for up to 113 people who require nursing and personal care. There were 98 people using the service when we visited. There are three floors within the building and each floor consists of two units. Three of the home's units are for people who have nursing needs, two of the units are for people with residential care needs, some of whom have early onset dementia and the remaining unit is home to those with palliative care needs.

There was a registered manager at the service. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were enough suitably trained staff scheduled to work during our inspection and prior to this. The provider operated safer recruitment practices by carrying out appropriate pre-employment checks.

Care staff were appropriately inducted and received ongoing training and support through supervisions and appraisals to conduct their roles safely.

The provider identified and appropriately managed the risks to people's safety. Where incidents occurred, the provider had a good system in place to record and learn from these to minimise the risk of a reoccurrence.

People told us they felt safe within the home. The provider operated a transparent safeguarding process to keep people safe.

Good infection control practices were operated throughout the building. There was a dedicated sluice on each unit for the hygienic removal of disposables such as incontinence pads.

People were supported to maintain a healthy diet. Care records contained a good level of detail about people's health and nutritional needs. Kitchen staff were also aware of people's nutritional requirements

and offered people choices with their meals.

People were supported with their healthcare needs. People's care records contained a good level of detail about their current needs and care staff assisted them to access external healthcare professionals when needed.

People using the service and their relatives were involved in decisions about their care and how their needs were met.

The organisation had good systems in place to monitor the quality of the service. Feedback was obtained from people through monthly residents and relatives meetings as well as annual questionnaires and we saw feedback was actioned as appropriate. There was evidence of further auditing in many areas of care and action was taken to rectify any issues identified as a result.

There were good systems in place for the safe management and administration of medicines. Staff had completed medicines administration training within the last year and were clear about their responsibilities.

Staff a good understanding of their responsibilities under the Mental Capacity Act 2005. Mental capacity assessments were completed when needed and we saw these in people's care files. Authorisation had been sought and obtained from the local authority where staff felt it was in a person's best interests to deprive them of their liberty.

People told us care staff were caring and our observations supported this. Care staff demonstrated they knew people's likes and dislikes in relation to their care and demonstrated an understanding of people's personal circumstances. Care staff respected people's privacy and dignity and people's cultural and religious needs were met. People's end of life care needs were sought and followed.

People knew how to make complaints and there was a complaints policy and procedure in place.

The service employed five activities coordinators who delivered a varied activities programme. People's feedback was sought in relation to the activities on offer and the timetable was altered in accordance with people's views.

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. There were enough suitably trained staff working at the service.

Risks to people's safety were identified and appropriate risk management plans were implemented.

The provider recorded and learned from incidents that had taken place in order to minimise the risk of a reoccurrence.

The service had adequate systems for recording, storing and administering medicines safely. The provider operated safer recruitment procedures by carrying out appropriate pre-employment checks of candidates.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred. Good infection control practices were operated throughout the home.

Is the service effective?

Good

The service was effective.

People's care records included a good level of detail about their health and nutritional needs. People were supported to maintain a healthy diet and people's care records were updated to reflect their current healthcare needs.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff had a good understanding of their responsibilities under the legislation and authorisations were in place where people were being deprived of their liberty for their safety.

People were supported by staff who were trained and had the skills required to support them. Staff received an induction and regular supervision, appraisals and training to carry out their role.

Is the service caring?

Good

The service remains Good.	
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service was well-led. Care staff told us they were well supported by the management team. The provider had effective quality assurance systems in place. The provider sought and acted appropriately on feedback from people using the service.	**Good**

Forrester Court

Detailed findings

Background to this inspection

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

The inspection took place on 19 and 26 February 2018. The inspection team consisted of one inspector, a bank inspector, an expert by experience and a specialist advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection the specialist adviser was a nurse with expertise in dementia care. The first day of our inspection was unannounced, but we told the provider we would be returning for a second day.

Prior to the inspection we reviewed the information we held about the service. We spoke with the service GP and a member of the falls team and contacted a representative from the local authority to obtain their feedback.

During the inspection we spoke with 12 people using the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 11 care workers, four team leaders (two of whom were nurses), one activities coordinator, the regional head chef, the deputy manager, registered manager and regional manager for the provider. We looked at a sample of 10 people's care records, five staff records and records related to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection we found there were not enough staff available to meet people's needs. At this inspection people gave mixed feedback about whether they felt there were enough care staff on duty. People's comments included "They have enough staff here", "Sometimes they're short of staff and they're very busy anyway" and "Sometimes they get a bit short at weekends." From our observations, review of staff rotas and conversations with care staff, we found the provider was now meeting their obligation to ensure sufficient numbers of staff were on duty to assist people.

We spoke with the registered manager about staffing levels. She explained that people's dependency needs were assessed upon admission. This assessment determined the amount of assistance each person required with their care needs, including whether people needed the assistance of two people with personal care or moving around. This information was used to determine the appropriate numbers of staff needed based upon the overall needs of people per unit. The registered manager agreed that during the previous inspection there were not enough staff and explained that those numbers had been increased immediately and maintained since. From our observations we found there were enough staff to assist people. Care staff did not seem rushed. They responded promptly to people's specific requests and had the time to have meaningful conversations with people.

We spoke with care staff about staffing numbers. They consistently agreed that there were enough staff on duty for them to do their jobs. Their comments included "We do have enough staff working", "I don't think there are any problems with how many of us are on shift" and "Sometimes people call in sick and you can be short for a bit, but we try to move people around or get bank staff to fill in." Another care worker told us and the registered manager confirmed that they rarely used agency staff who did not know people using the service. The registered manager confirmed that bank staff were inducted into the service in the same manner as regular staff members and were familiar with people.

We reviewed the staffing rota for the month of our inspection. We found an appropriate number of care staff had been scheduled to work and this reflected our observations during the inspection.

The provider followed good infection control practices. Prior to our inspection we were notified of some food hygiene issues within the kitchen at the service. We spoke with the regional head chef who had been working at the service for approximately two weeks prior to our inspection. They showed us a food safety action plan that had been devised and fully implemented by the time of our inspection. We checked the kitchen and found all areas were clutter free and clean.

Each unit had a dedicated sluice, which was accessed by a keypad. The sluice contained wash facilities for bedpans as well as space for laundry trolleys or cleaning equipment. Cleaning products subject to the Control of Substances Hazardous to Health (COSHH) regulations 2002 were stored appropriately and securely. COSHH regulations 2002 provide a framework to help protect people in the workplace against health risks from hazardous substances. We also saw data sheets supplied by the manufacturers of cleaning materials were available for housekeeping and care staff to refer to if necessary.

Domestic staff were seen at work during the inspection, and all areas were found to be clean and tidy. Care staff told us they were provided with sufficient personal protective equipment (PPE) such as gloves and aprons for use when providing personal care and had received training in infection control procedures. Records indicated that staff had received appropriate training within the last year.

Care staff told us they washed their hands regularly to prevent the spread of infection and one nurse told us "We oversee what carers are doing with regard to infection control practice such as use of PPE and hand washing". We noted that hand wash facilities were available in each bedroom as well as in shared facilities such as bathrooms and toilets. There were hand sanitiser pump dispensers located throughout the home.

People told us they felt safe using the service. Comments included "It's very safe and I'm well looked-after by everyone", "I do feel safe" and "It's a mild place... It's a calm place"." Care staff were able to confidently define their duty in relation to safeguarding procedures, including how to raise concerns and ensure the safety of people at the care home. Care staff were also able to correctly explain the organisation's whistleblowing procedure. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. Care staff told us they had received annual safeguarding training and records reflected this. Care staff told us they felt supported by the registered manager and senior management team with regard to raising concerns, and were confident that any such concerns would be dealt with appropriately. We looked at the records kept of safeguarding concerns and we saw these had been reported appropriately. We spoke with a member of the local authority and they confirmed they did not have any concerns about the safety of people using the service.

Care staff confirmed they had received training in handling emergency situations. This included fire safety, first aid and health and safety training. They confirmed they were aware of how to respond in the event of someone having a cardiac arrest and explained that some people required resuscitation and some did not. One care worker told us "People's files have a red sticker on if they're not for resuscitation, but we all know which people aren't for resuscitation anyway."

Care workers demonstrated they were aware of the particular risks to people's safety and how to respond to these in the event of an accident or incident. One care worker told us "Some people here are at risk of falls. We try to stop this from happening but know what to do if it does." The care worker explained they would assess the situation, call the nurse on duty and if necessary, an ambulance. We spoke with a member of the falls team at the local authority during our inspection. They explained that care workers had improved in their ability to respond appropriately to falls as well as helping to prevent falls taking place.

The provider had adequate protections in place to help prevent the risk of fire. Fire extinguishers and fire blankets were situated throughout the home and the extinguishers were serviced annually. Fire escape routes were clearly marked, and the procedure for safe evacuation to the fire assembly point in case of a fire was displayed throughout the home. Care staff were aware of the fire escape procedures, including the use of fire doors to maintain a safe and protected space. A fire drill occurred during the inspection and the automatic fire doors were observed to close as part of the home's fire safety procedure. There were personal emergency evacuation plans (PEEPs) within each person's care record. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. These documents were detailed and showed the number of staff and type of equipment required for the safe evacuation of each person.

Risks to people's safety had been appropriately assessed and management plans were in place. We found there were a number of risk assessments in people's care records, including their risk of malnutrition,

choking, falls, and breakdown of pressure areas. The assessments were personalised, detailed and were reviewed monthly. These identified the action staff should take to reduce the risk and were also reflected in people's care plans. For example, one person's mobility and falls risk assessment included information on the person's history of falls, current abilities, medical history, medicines and nutrition. It also included recommendations for care staff about how to safely support the person while mobilising, including any equipment to be used.

We reviewed another person's pressure ulcer risk assessment and noted that the pressure ulcers they had were assessed to determine the most appropriate and effective treatment. This was then reflected in the plan of care. Care staff monitored the effectiveness of the treatment using photographs to chart healing and reviewed the treatment at each dressing change. The need for onward referral to a tissue viability nurse (TVN) was noted, and actioned. Advice from the TVN was incorporated into the person's care plan. The care plan and risk assessment also included measures to further protect the person's skin integrity, including referral to a dietitian for optimum nutritional support, and a repositioning programme, to ensure the person was supported to change position regularly. The person used a pressure relieving mattress and their Waterlow score was checked on a monthly basis. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore.

We observed that people cared for in bed had call bells within reach. Care staff had completed a risk assessment to identify potential risks where people had been assessed as being incapable of using their call bell. We found that control measures were put in place and were carried out by staff and documented, for example hourly checks on the person by care staff.

Accidents and incidents were documented clearly, along with any actions taken to ensure the person's safety. For example, falls were recorded and notes were taken of the time and place of the fall, any behavioural changes associated with the fall and any pain or injury. Care staff told us they also used body maps to chart any wounds and we saw evidence of this. Appropriate action was taken to manage the risk of people falling and learn from incidents that had occurred. This included increased observations of people, ensuring they had the appropriate equipment if any was needed as well as a referral to the falls team where more specialist advice was required.

Staff were aware of their responsibility to record all incidents and accidents, and told us they documented all incidents in the care plan, the communication book and on incident forms. The communication book was used to record all pertinent events and included reminders for care staff to read on a daily basis.

Safety was promoted in recruitment practises as senior staff carried out appropriate pre- employment checks of candidates. We reviewed the staff files of 10 care staff. We saw these included evidence of criminal record checks, at least two references (one from the person's previous employer) application forms which detailed people's previous employment history as well photographic identification and people's right to work in the UK. Records for nurses also included their Nursing and Midwifery Council registration details.

We discussed the provider's checks of staff criminal records with the registered manager. She explained that a process was in place for a candidate who had a criminal record to have this reviewed and risk assessed by an internal committee. The committee assessed whether the candidate posed any risk to people using the service as a result of their criminal record and depending on the committee's findings, they determined whether the candidate could be a offered a position.

Medicines were managed safely, and records showed that staff adhered to the organisation's policy and procedure. The policy provided information and guidance on all aspects of safe medicines management,

from ordering, receipt, administration, record keeping, controlled drugs, and disposal. There was a section within the policy for the use of "as required" (PRN) medicines, which covered the rationale for their use, record keeping and when to discontinue the medicine (under medical supervision).

There were protocols in place for when medicines were prescribed on a PRN basis. These provided guidance for staff on how to administer these medicines safely, and included information on dosage, the manner of administration, frequency and maximum dose for each PRN medicine. Medicines classed as controlled drugs were appropriately and securely stored and managed. There was a log book which detailed each time a controlled drug had been administered, which was signed by two trained members of staff.

Medicine administration records (MAR) showed that medicines were administered as prescribed, with signatures for each administration and appropriate omission codes used when a person did not receive their prescribed medicine. Staff told us that medicines audits were carried out weekly, and stock was checked daily. We saw a copy of recent weekly audits which demonstrated this. We carried out a stock check on two units of the home and saw both regular and controlled drugs balances tallied with those recorded in MAR charts and in the controlled drugs book.

Medicines were stored appropriately and each unit kept a record of daily checks of the medicines fridge and clinical room. We checked the temperatures on the first day of our inspection and saw these were within an appropriate range.

Medicines were administered in a person-centred manner. For example, each person had an information sheet which detailed how they preferred to receive their medicine, such as tablets to be offered on a spoon, or to be taken with milk instead of water. Staff told us this was based on the person's stated preferences, or information from the person's family.

Nurses and trained senior care staff administered medicines to people. They told us they had completed medicines administration training within the last year and records demonstrated this. When we spoke with nurses and care staff, they were knowledgeable about how to correctly store and administer medicines.

Good

Is the service effective?

Our findings

At our previous inspection we identified some issues with records relating to people's nutrition as these were lacking in detail and sometimes contained mistakes or inconsistencies. At this inspection we found people were supported to eat and drink enough to maintain a balanced diet and their care records were sufficiently detailed to support care staff in achieving this.

People's care records included a nutrition care plan. This specified whether people had any specific nutritional needs and how these should be managed, their likes and dislikes in relation to their meals as well as any personal preferences in relation to how they wished to eat their food including the location they preferred to eat. Where required we found choking risk assessments were in place and where necessary we found the provider had consulted with a multi-disciplinary team including speech and language therapists and dietitians. We also saw people's weights were checked on a monthly basis and a Malnutrition Universal Screening Tool (MUST) was used monthly. The MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese.

For example we saw one person's care plan which detailed that the person was required to take their nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG feeding tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation. This person was at high risk of choking and for this reason required the use of a PEG feed. We found an appropriate choking risk assessment was in place and this advised care workers that the person could not eat by mouth. We saw written evidence that a Speech and Language Therapist had been involved in identifying the person's needs and their recommendations had been incorporated into the plan of care. This included clear guidelines for care workers about how to identify the risk of the person choking and how to use and maintain the PEG tube. We also saw that monthly MUST scores were also taken.

Kitchen staff were aware of people's nutritional needs. We visited the kitchen and saw a whiteboard containing details of people's particular needs, for example which people required a soft diet and which people required supplements to their diet. We spoke with the regional head chef and they explained that they had good lines of communication with care staff who informed kitchen staff of whether people had any allergies or other specific needs in relation to their diet.

People told us they liked the food that was provided. Their comments included "I like the fish – its soft", "The food is nice" and "They ask me what I want and give it to me. It's nice."

People were supported to maintain a healthy diet as the food available was nutritious. The regional head chef explained that they monitored the weekly menus on offer to ensure there was an assortment of fruit and vegetables available for people. The regional head chef also explained that people's likes and dislikes were taken into account when preparing the menu and people were asked for their feedback at the end of every meal. The food was seasonally appropriate and included a choice of two meal options, one of which was vegetarian. We sampled the food on the first day of our inspection and found the food to be appetising

and served at the correct temperature.

We observed people being given their meals within three units of the building on the first day of our inspection. People were shown sample plates of the food available and chose what they wanted to eat. Mealtimes were relaxed and care staff calmly helped people. Care staff supported people who were unable to eat their meal independently and this was done with care and dignity. Care staff sat next to the people they were supporting, and had conversations with them throughout their meal. Care staff paid attention to each person at the meal. For example we saw one person fall asleep just as their food was being served and care staff were observed to wait until the person woke up a few minutes later and ask again which menu option they wanted, before serving a fresh portion. Where people did not like the food on offer, they were able to request a simple alternative.

The provider accessed external healthcare professionals as required and any recommended changes to people's care were incorporated into their care plans. People's care records included sufficient detail about people's medical histories and ongoing healthcare needs. For example, one person was noted to be at increased risk of falls and staff made a referral to the falls clinic. It was noted that further support measures were put into place as a result, including physiotherapy and extra support from care staff when the person was mobilising. All other healthcare professional visits or interactions were clearly recorded within the person's care plan, including screening programmes for diabetes, and chiropody visits.

We spoke with a general practitioner who visited the home on a weekly basis. They spoke positively about the relationship between their local GP surgery and the care staff and praised the communication skills of staff at the home. The GP also stated that the home worked well with the local hospice to provide palliative care, and had access to multi-disciplinary team discussions to ensure care was provided appropriately.

Care staff had a good level of knowledge about people's healthcare needs. For example we spoke with one care worker and they gave a good description of the healthcare needs of numerous people in one unit of the building.

Care staff sought people's consent to their care and treatment and decisions were made following best interests processes where this was appropriate. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care staff understood the requirements of the DoLS, and documents demonstrated that the appropriate procedures had been followed. One care worker told us "Some people cannot leave their unit for their own safety and the document that confirms this is in their file" and another care worker told us "We make sure these decisions are made legally."

We found people who were subject to a DoLS authorisation had appropriate documents in their care records detailing the restriction and any conditions on this. Mental capacity assessments for specific tasks or events were also in people's care records. Records showed that mental capacity assessments were conducted appropriately and included the involvement of the person's next of kin or advocate, as well as their doctor or healthcare professional.

We saw there was restricted entry and exit to and from all the units, via use of keypad codes. The codes were displayed by the entrance to each unit, albeit hidden in a picture which was displayed on the wall. Care staff explained that people were reminded of these codes provided their movement was not restricted by a DoLS authorisation. We observed some people using these codes in order to leave their unit.

Care staff told us they received a wide range of training courses on a mandatory and developmental basis. One staff member said "We get lots of training here". Training modules included moving and positioning including the use of specific equipment such as hoists and wheelchairs and infection control. Specialised training topics were also provided depending on people's specific care needs and this included topics such as catheter management where the need arose. We looked at the provider's training records and saw care staff were up to date in their completion of mandatory training.

Care workers told us they received the appropriate support to perform their jobs well. The registered manager told us and care workers confirmed there was a regular system of supervision of care workers performance which took place every two months. Records demonstrated that this was taking place and care workers told us they found these useful to their roles. Care staff told us their supervisions were used to discuss what they were doing well and what they needed more support with, which they found helpful and constructive. One care worker told us "I feel very supported in my role" and another care worker stated "The supervisions are very useful."

Care staff received an annual appraisal where they had worked for the service for over a year. We saw records to indicate that these were taking place. Care workers told us they received appraisal meetings. One care worker told us "These do happen. They're quite a big deal. You agree on what your targets are and work towards this over the next year." We saw a sample of care workers appraisal forms and saw these detailed their targets, any areas for improvement as well ongoing training needs.

Good

Is the service caring?

Our findings

People gave positive feedback about their care workers and told us they were treated with kindness and respect. Their comments included "The staff are nice here" and "I have my favourites, but they are all nice" and "We all get on well".

We observed care staff responding to people's requests kindly and promptly throughout our inspection. We observed people and care staff interacting in a manner which indicated that they knew one another well. This included people asking care staff about their families and care staff jovially discussing subjects such as television programmes and sports with people using the service.

Care staff demonstrated a good understanding of people using the service. They gave us examples of people's personal preferences in relation to their care and gave a description of their life histories and the circumstances which led to them requiring permanent care. For example, one care worker gave us the details of the distinguished former profession of one person using the service as well as the details of their family background. Another care worker gave us descriptions of how people liked to take their hot drinks, what snacks they enjoyed and when, their pastimes and people important to them who visited them regularly. The care worker told us "You really get to know people when you're working here."

Care workers understood how to respond to people's emotional needs. We observed one care worker responding quickly to one person who appeared to be anxious. They explained the reason for the person's anxiety and the types of actions that tended to make the person feel better which included sitting with them and talking and bringing them a cup of tea, which we saw they appeared to enjoy. People's care records also included details about whether they experienced anxiety or mental health issues and included known actions care workers could take to manage this. This included allowing people the time to express themselves fully or to suggest they participate in activities they were known to enjoy.

Care staff made efforts to communicate appropriately with people in a way that they could understand and care records confirmed this. For example, for one person who did not speak English, staff had worked with the person's family and used a few common phrases in the person's native language to ask questions about the person's immediate needs, such as whether they needed a drink or the toilet. These phrases were displayed on the wall in the person's room, so all staff had a way to communicate with the person.

Care staff were aware of people's right to personal choice in relation to their care. Care staff encouraged people to make choices where possible, especially for decisions such as meal options or which clothes to wear. One care worker told us "I always ask people what they want and do what they say." Care staff told us they spoke with people and their families where appropriate, prior to providing care to determine their history, likes, dislikes, and preferences and to involve them in care planning. We saw that care plans contained details of people's choices. Each care plan had a "This is me" section, which had been completed with the involvement of the person or their family. This section provided key information about the person's life, hobbies, preferences and cultural or social needs.

The provider conducted monthly 'resident meetings' to obtain people's feedback in relation to various areas of the running of the home. This included details of a refurbishment programme which was due to take place imminently as well as the food being provided and the activities being held. We saw the details of these meetings were displayed on the notice board of the home and minutes were kept. The registered manager also held weekly clinics where she encouraged both people and their relatives to come to discuss any matters they wished. We received feedback from a contact at the local authority and they told us they felt these clinics worked well to allow the registered manager to engage with people.

Care staff spoke with compassion and respect about people who used the service, and understood the necessity of respecting their privacy and dignity. Care staff told us they carried out personal or intimate care in a closed environment to protect the person's privacy and gave us examples of how they ensured the process was as dignified as possible. One care worker told us "I use a towel to cover the person when an area does not need to be exposed." We observed care staff knocking on people's doors and waiting for a response before entering.

Care records included details of people's cultural and religious requirements. The registered manager gave us examples of people who were supported to maintain their religious observance and this included having contacts with senior religious leaders within the local community.

Good

Is the service responsive?

Our findings

People told us they were given choices in relation to their care and had their requests met. One person told us "I'm given choices like what I want to wear and when I get up" and another person said "I do get the help I want." Care records included details of the person's preferred routine, for example where they preferred to have their meals and these had been signed by people using the service or their relatives.

Care records were person centred, and provided specific information on how to support people. Care records included an initial assessment of needs prior to admission, followed by a comprehensive care plan. The initial assessment included a detailed medical history and current medical needs. A variety of risk assessments were also completed as part of the initial assessment process to ascertain what the person's initial needs were.

The care plan provided staff with further details of people's current needs and abilities. For example, whether or not the person was able to carry out part or all of their personal care. The care plans covered a variety of daily activities or needs such as continence, mobility and medicines. Care records were reviewed monthly to ensure they remained relevant. We found care plans were individualised, and had been written with the person's usual routines in mind, including when they preferred to go to bed, or if they usually had a hot drink at night.

People were encouraged to pursue their interests and take part in a varied activities programme. The service employed five activities coordinators who assisted in the delivery of both organised and ad hoc activities. We observed organised and impromptu activities during our inspection. For example, we saw a cinema session was in progress on the second day of our inspection and people appeared to enjoy the movie being played. We also observed an impromptu quiz, which involved the use of pictures to promote people's memories. One team leader also arranged an impromptu singing session and we observed people joining in, singing, dancing and clapping. People were laughing and appeared to be enjoying themselves.

The scheduled activities programme included a coffee morning within an onsite coffee room, pampering sessions and attending church. We spoke with one activities coordinator. They told us that people's involvement in activities was monitored and recorded in their daily notes. We looked at a sample of people's care records and found people's involvement in activities was clearly recorded as well as their level of involvement and whether or not they enjoyed themselves.

People's feedback was requested in relation to the activities offered. Where people gave negative feedback about a particular activity, this would be removed from the schedule. Regular celebrations took place on an annual basis and this included a specific activities programme for Christmas and a celebration of each person's birthday. The activities coordinator explained that people's birthdays would be celebrated in accordance with their wishes. They told us "One person wanted an entertainer to come in. So we arranged this and everybody enjoyed it so much they all want [the entertainer] to come in on their birthdays." The provider arranged special events both on and off site. These included a tea dance and a music show which both received good feedback. One to one sessions were also arranged for people who could not leave their

rooms. This included music sessions, reading and general companionship visits.

The provider had an effective complaints policy and procedure in place and we saw this was displayed within the building. People told us they knew who to complain to if necessary and were confident that their complaints would be dealt with. One person told us "I talk to [the unit manager] if there's a problem. She gets things sorted" and another person told us "I just tell one of the girls [if there is a problem]. I've never had to go to the manager."

The complaints policy stipulated how complaints were to be dealt with and this included the necessity to record complaints and promptly respond to the complainant. We looked at complaints records that were kept by the management team within the service. These demonstrated that complaints were logged and details were monitored including the length of time taken to respond to a complaint ensuring this was done within the time stipulated in the complaints policy. We saw complaints were responded to promptly, to the satisfaction of the complainant and where necessary, appropriate changes were made to deal with these.

People's end of life wishes had been recorded so care staff were aware of these. People residing in one unit of the building were receiving care towards the end of their lives and their care records included details that were pertinent to this. This included whether they wanted care staff to attempt resuscitation in the event of cardiac arrest. People's care records were clearly labelled on the front to indicate what people's needs were in this instance and when questioned, care staff were aware of who required and did not require resuscitation. Details of this decision were written within appropriately authorised legal documents. People's spiritual needs were also recorded within these documents as well as information such as whether they wished to be buried or cremated. There was also information about who should be contacted when the person was at the very end of their life as well as other specific requests from the person.

Care staff had received training in end of life care. This was confirmed by care workers we spoke with and documentation we looked at.

The provider worked in partnership with organisations such as Northwest London Specialist Palliative Care and people's GPs. Anticipatory drugs were available to use when people needed this and appropriate pain management tools were used to assess and document people's needs.

Good

Is the service well-led?

Our findings

At our previous inspection we found quality assurance systems did not identify the issues in relation to staffing levels. At this inspection we found the provider had good quality assurance systems in place to support the delivery of care. Various audits were completed and these included, but were not limited to a monthly health and safety audit, a monthly review of five care records and a monthly medicines audit. Further checks were conducted within the home and these included a daily manager's audit which involved a check that the correct number of staff were working and whether people's call bells were in place and in working order among other matters. A monthly internal review was conducted by the registered manager which included a check on accidents and incidents within the home and whether these had been appropriately dealt with as well as a review of care records. Where issues were identified, we found action plans were in place to address these.

Care workers told us they felt the provider was supportive and had a positive culture. One staff member told us "The service is managed well; no improvement is needed" and another staff member told us "The deputy manager is very supportive".

Care staff told us they felt confident about raising concerns and felt sure they would be appropriately addressed. One care worker told us "I have reported things to the manager before and it has been dealt with" and another care worker said "I've never needed to go to the manager, but I've gone to the unit manager before and she's sorted things out for me."

We found the provider to be open and honest about areas of the service that needed improvement and demonstrated they had taken appropriate action to deal with this. For example, the provider was honest about food hygiene concerns that had been reported to us. We saw a detailed action plan had been devised which was overseen by the regional head chef who had been working at the service to implement this. We found this person to be very honest about the issues that were identified and explained how these had been dealt with. They explained that further monitoring would be carried out to ensure these standards were maintained.

The registered manager and regional manager were also honest and clear about improvements they felt needed to be made to the decoration of the building. They showed us plans that were in place to redecorate areas of the home and explained that these were due to begin imminently.

Care workers gave good feedback about the registered manager. Their comments included "She is really good" and "She is very approachable, a really good manager." The registered manager was visible throughout our inspection. We saw her interacting with both care staff and people using the service and their conversations indicated they knew one another well. The registered manager explained that she conducted a weekly clinic for both staff and people using the service to speak to her. She explained that these sessions helped her to engage with people and created an additional forum for people to discuss their concerns directly.

The provider had a clear governance framework that supported the delivery of a well-managed and transparent service. We met both the registered manager and the regional manager on the first and second days of our inspection. The registered manager was clear about her responsibilities within the organisation, but also received support from the regional manager one day per week. This ensured that higher levels of the management team were aware of what was happening within the service and that the registered manager had direct, senior management support to manage any issues.

Care staff demonstrated a good understanding of their roles and responsibilities in terms of their caring duties and their duties within the organisation in general. They told us that their roles were fully explained to them before they started working for the provider and this was reinforced in supervision sessions and team meetings during their employment. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

The law requires that providers of care services send notifications of changes, events or incidents that occur within their services to the Care Quality Commission. The provider was aware of their obligation to submit notifications of significant incidents and we found information was reported to the Care Quality Commission (CQC) as required.

The provider had effective systems in place to ensure that people and staff were engaged and involved in the running of the service. Residents and relatives meetings took place on a monthly basis. We saw minutes of these meetings and saw a variety of matters were discussed including matters such as the food available and the activities on offer. Various staff meetings also took place regularly. For example, daily handover meetings took place for morning and evening staff to exchange pertinent information about issues that had effected people during the day. Monthly unit manager meetings also took place where relevant information could be handed over about the running of each unit and there were general staff meetings which took place every six months which included all staff and care staff.

The provider had robust systems in place to ensure confidential data was protected. People's care records and daily notes were input onto the provider's computer system. Staff members could only access this with a personal, secure password. There were also paper records available of people's care records and these were safely stored within the unit manager or nurse's office on each unit of the building. Access to this room was only via a keycode entry system.

The provider worked effectively with other organisations. This included the GP, physiotherapy team, occupational therapists, speech and language therapists and other healthcare professionals as required. Where issues were identified, improvement plans were put in place. The provider also worked closely with the local authority by participating in monthly quality meetings where overall required quality objectives were discussed. This included discussing matters such as any incidents that had occurred as well as staffing levels. The provider was also working with the local authority to deliver the 'Ladder to the Moon' initiative. This involved the delivery of training particularly in activities provision to encourage the development of a personalised service.