Healthcare Homes (LSC) Limited

Sandown Park Care Home

Inspection report

61 Vale Road
Windsor
Berkshire
SL4 5JY

Tel: 01753833140
Website: www.healthcarehomes.co.uk

Date of inspection visit:
09 January 2018
10 January 2018

Date of publication:
27 February 2018

Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Outstanding** ☆
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

Our inspection took place on 9 January and 10 January 2017 and was unannounced.

Sandown Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and both were looked at during this inspection.

Sandown Park Care Home can accommodate 95 people across three floors, each of which has separate adapted facilities. The service cares for adults, including people living with dementia. The premises are modern and purpose-built. People live in their own bedrooms and have access to communal facilities such as a dining, lounge and activities areas. There is an expansive landscaped sensory garden surrounding the building. At the time of our inspection, there were 84 people living at the service.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was a registered manager in post.

The risk of harm to people was significantly reduced by the systems and processes in place at the service. This included prevention of harm by abuse, neglect, discrimination, injuries and accidents. People's care documentation and the support they received ensured their maximum safety. When harm occurred, this was swiftly acted on and the service used any incident as a point for reflection and to put strategies in place to prevent similar events in the future. There was a safe amount of staff deployed and robust recruitment processes. People were protected from the risk of infections. The service was clean and well-maintained. The management of people's medicines was robust.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practise.

Staff induction, training, supervision and performance appraisals were extensive and ensured workers had the necessary knowledge and skills to effectively support people. People's care preferences, likes and dislikes were assessed, recorded and respected. We found there was appropriate access to other community healthcare professionals. People were supported to maintain a very healthy lifestyle. People complimented the food and drink and we found the risks of malnutrition and dehydration were satisfactorily managed.

The service remained very caring. There was overwhelming complimentary feedback from people who used

the service, their family and community healthcare professionals. People told us they were able to participate in care planning and reviews and we saw evidence of decision-making that promoted people's independence. People's privacy and dignity was respected when care was provided to them. We observed respectful care by staff.

The service continued to provide outstanding person-centred care. Care plans were thorough and contained information of how to support people in the best possible way. We saw there was complaints system in place which included the ability for people to contact any staff member or the management team. Questionnaires were used to determine people's satisfaction with the care. People and their families had a say in the everyday decision-making and operation of the service.

The service was run by a committed management duo and care was provided by a passionate, effective team of staff. There were numerous positive opinions about the management and leadership of the service. There was an excellent workplace culture and we saw the staff worked cohesively to ensure good care for people. The turnover rate of staff was low, which demonstrated staff liked to work at Sandown Park Care Home. Audits and checks were used to gauge the safety and quality of care. The provider met the conditions of registration and complied with other relevant legislation related to the adult social care sector.

The service consistently strived to ensure that people had the best possible care, and that they were supported in a compassionate, dignified and safe way. The service had forged successful partnerships with an array of other stakeholders, was actively involved in research and innovation and aimed to provide an excellent care experience for people. The service frequently referred to best practise guidelines to formulate the type and style of care provided for people. Learning from projects and studies at the service were shared with other care operators, both locally and nationally. The service's staff were often nominated for, and commended in, national care sector awards. These factors demonstrated that Sandown Park Care Home was a outstanding service for adult residential social care in England.

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.

Effective systems were in place to protect people from the risks of abuse or neglect.

Appropriate risk assessments about people's care were completed and regularly reviewed.

There were sufficient staff deployed to meet people's needs, although people expressed there should be better continuity.

People's medicines were safely managed.

Lessons were learned and improvements made when incidents occurred.

Is the service effective?

Good

The service was effective.

People's likes, preferences and routines were considered and used during the provision of care. People and relatives were actively involved in their care.

There was good staff support, with extensive staff induction, training, supervision and performance reviews.

People's nutritional and hydration needs were met and risks of malnutrition or dehydration were proactively managed.

The service was compliant with the Mental Capacity Act 2005. People were assisted to make informed decisions or decisions were made in their best interests.

The premises and decoration were specially adapted for people living with dementia.

The service worked well with other community healthcare professionals.

Is the service caring?

Outstanding

The service remains outstanding.

Is the service responsive?

Outstanding ☆

The service remains outstanding.

Is the service well-led?

Outstanding ☆

The service was well-led.

People and relatives described a strong, visible leadership presence.

Research and innovation was used to continuously improve people's care experiences.

Best practise knowledge and experience was embedded in people's support and shared within the wider adult social care landscape.

Effective partnerships with local community partners ensured enriched experiences of care for people.

Quality and safety were continuously at the forefront of the care people received.

Sandown Park Care Home

Detailed findings

Background to this inspection

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

Our inspection took place on 9 January and 10 January 2018 and was unannounced.

Our inspection was completed by two adult social care inspectors and an expert-by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge of people living with dementia.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also checked feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House, the Information Commissioner's Office (ICO) and the local fire inspectorate.

We spoke with eight people who used the service and seven relatives who visited during our inspection.

We spoke with the registered manager, the deputy manager, the administrator, the receptionist, three activities coordinators and the maintenance person. We also spoke with five registered nurses and seven care workers about people's support and treatment. We spoke with the GP, a visiting social worker, a vicar and a representative from the CCG.

We looked at seven people's care records, two staff personnel files and other records about the management of the service. After the inspection, we asked the registered manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

People and relatives provided positive feedback about the safety of care. One person said, "The location layout; it works well for me." The next person told us, "It's got very high standards, clean with good staff." The next person said, "It's comfortable and clean." Other comments included, "I get on well with all the staff", Very good and very caring. They have been extremely attentive to mum and me", "She (the person) has improved very much since she came in", "It's a nice environment. (Care workers) have very good personalities and are very caring", "(Staff) seem to care and understand her (the person's) dislikes. (There is a nice environment)" and "Care from (the carer) is excellent with mum; understanding and patient and always happy."

The service had established safeguarding policies and procedures. Information on how to report safeguarding concerns was displayed in the office on each floor, along with relevant contact numbers for the local safeguarding team. Staff we interviewed confirmed that they had training in safeguarding with regular updates. They were able to provide definitions of different forms of abuse when asked. Staff said they would report any concerns about abuse or neglect to the senior staff member on duty or the manager and most said that it was also necessary to inform the local authority safeguarding team whenever a safeguarding alert was reported.

There was good evidence that the service assessed and managed risks. Each person's care file contained a pre-admission assessment of needs and risks and there were a range of dependency and risk scores for different aspects of care such as the malnutrition universal screening tool, Waterlow scores to assess skin integrity and falls risk scores. These were updated monthly, including weight records and were up-to-date. Any risks associated with medical conditions, physical, environmental or psychological risks were addressed in the relevant care plans and in most cases there was direction on how to manage and mitigate any identified risk. Any allergies were clearly noted at the front of each care file.

We made a recommendation at our last inspection about fire safety. The service had acted on our recommendation. Each care file had a personal evacuation plan and a fire risk assessment which specified levels of mobility and the equipment and staff support that would be required in the event of emergency. This information was clear and well documented. We saw that the service had ensured safety from the premises was properly managed. There was evidence of a Legionella risk assessment, gas safety certificate, safety checks of the hoists, slings and passenger lifts. There was a health and safety checklist completed weekly by the maintenance person and a periodic health and safety audit. The maintenance person was very knowledgeable about how to ensure people's safety .

We asked the service at our last inspection to consider reviewing external access for visitors with mobility impairments. We saw the service had dedicated a parking space at the front door for 'blue badge' holders and had enforced parking measures to ensure visitors could easily enter the building. All other areas of the service were reviewed to ensure wheelchair accessibility. Trips, slips and falls hazards were reviewed and removed to prevent harm to people or visitors.

At our prior inspection, we made a recommendation about safe staffing deployment. We found the service took action to ensure this was acted on. The registered manager explained the method of calculating people's care hours needed. This was regularly reviewed and adjustments to staffing levels were made as needed. During our inspection we found a strong visible presence of staff. People were not left alone or neglected. Call bells were answered promptly. The registered manager explained that there were no staff vacancies, and that the service had not used any agency workers. When we reviewed the rotas, we saw that additional staff worked above the calculated deployment levels. Additional support to people was readily accessible from the three activities coordinators.

Robust recruitment processes remained in place. This included thorough scrutiny and checks of applicants for any role. We found the service ensured the correct information was available in personnel files. This included proof of identity, criminal history checks, and references from prior employers, job histories and health declarations. The service ensured only fit and proper persons were employed to care for people.

Systems were in place that showed people's medicines were managed consistently and safely by the registered nurses. Medicines, including controlled drugs were being obtained, stored, administered and discarded appropriately. We observed registered nurses during the administration of medicines to people, and found their practice was methodical, patient and in line with local and national guidelines. The service was subject to regular audits of the medicines management. We saw both the community pharmacist and provider had checked medicines safety in 2017. Where areas for improvement were identified, these formulated an action plan which was overseen by the deputy manager and registered manager.

All areas of the service were very clean, including communal areas, bathrooms and toilets. There were hand sanitisers and hand gels available throughout the premises in communal areas and appropriate handwashing signage was displayed in toilets and bathrooms. Staff wore personal protective equipment (like gloves and disposable aprons) when they delivered personal care and at meal times. Staff said they received training on infection control and the management team said they conducted regular spot checks to ensure that infection control procedures were being followed correctly. We observed domestic staff using colour-coded cleaning equipment and there were locked cupboards for storing chemicals.

We asked staff about the procedure for reporting accidents and incidents at the service and they were able to explain this along with the forms that were completed in the event of an accident. Body maps in care plans were completed and dated to record any bruises or wounds. Photographs were taken to document any injuries to people. Staff said that there were daily handover meetings on each unit to discuss any concerns or incidents. The management team were able to cascade any shared learning from incidents or accidents. The service had a very low rate of serious injuries, like fractures or pressure ulcers with just four occurrences in a one year period. The registered manager showed us how incidents and accidents were analysed each month. Medical alerts and food safety warnings were obtained and shared with staff.

Good

Is the service effective?

Our findings

People and relatives told us they felt staff were knowledgeable and skilled. One person stated , "They are quite knowledgeable, especially the nurses. All staff are very helpful." Another person told us, "Nurses are (the best). (My) family rate them (staff) quite highly. One or two are exceptional..." A relative told us, "Yes. I can't fault them." Other comments included, "Yes I do (think staff are experienced). They have got to know her (the person) very well and are attentive" and "Yes, she (the person) is doing very well here (and is) very happy."

We reviewed a selection of care plans and found they were easy to navigate and well-ordered, with clear and consistent indexing so that information about people could be easily located by anyone. As this was a new system of care planning, all information was recent with all care plans dated within the prior three months. Assessments were carried out on admission and this information was used to develop comprehensive care plans in consultation with the person and their family members. Care plans were evaluated on a monthly basis with the person or their relatives, to ensure that they remained relevant and up-to-date. There were separate care plans for each aspect of care. Each care plan outlined individual needs, the support required and the desired outcomes or goals for care in each case.

Most care plans we saw were detailed, legible and tailored to each individual with identified risks, and needs clearly recorded. They were dated and signed by registered nurses and care staff. In some cases more information was required by staff after ongoing consultations with people's families. There were clear examples of people's and relatives' input into the care choices. This commenced from the pre-admission phase and continued until the person's end of life. When a person was not capable of making care decisions for themselves, independent advocates assisted them. We saw evidence that an advocate was involved in a person's care choices. People were fully involved in their care planning which ensured effective care from the staff at the service.

Nursing staff carried out assessments for people, developed and updated care plans. Care staff said that they learnt about the needs and progress of people either by talking to nursing staff, to the person themselves or by reading the individual care plans when they had time. Care staff we interviewed demonstrated that they were familiar with the individual needs and characteristics of different people. They were able to explain how to support specific people, along with any medical conditions or risks that they needed to be aware of such as mobility needs, those at risk of choking and those who preferred to talk to staff in their rooms rather than engage in activities.

Staff had access to very good support for their learning and professional development needs. Staff told us that the service provided regular training, delivered face-to-face or online to ensure that skills and knowledge levels were maintained. Examples of recent training included health and safety, fire training, first aid, safeguarding, medication, dementia and mental capacity. Newer staff members outlined the induction process that they completed, including mandatory training modules which followed Care Certificate standards, home induction and shadowing experienced staff. The Care Certificate is a national standard of minimum training topics for staff that are new to adult social care environments.

The service maintained well-documented evidence of staff supervision reviews and appraisals. We reviewed nine separate staff training files and the evidence from 2017. Each file contained a central planner showing records of planned and actual performance reviews throughout the year. This showed that all staff had had supervision reviews at least every two months including one annual appraisal. There were sections for each member of staff in the supervision or performance review, with a separate sheet to record each review, signed by both supervisor and supervisee. There was evidence of objective setting and discussion across a range of topics relevant to the role. Appraisals included self-appraisal forms and personal development along with training needs that had been discussed as relevant. One staff member said, "We're encouraged by the home to undertake extra training, such as a health care practitioner course." Staff interviewed confirmed that they received supervision every two months (or more frequently if needed) and said that they had opportunities to progress within the organisation if they wished and were encouraged to further their training. This ensured a knowledgeable and skilled workforce at Sandown Park Care Home.

Each person's care file had a separate care plan for eating and drinking which covered information on nutritional status with detail on any special dietary requirements such as a diabetic diet, need for pureed or fortified food and any risks such as difficulty with swallowing. There was also a good level of detail on preferences and routines, any food likes and dislikes and any allergies. For example, one person specified that they preferred small portions, while others stated that they wished to have a hot drink before going to bed at night. Any cultural requirements were noted, such as vegetarian food in some cases. There was a dietary notification form in each plan which summarised nutritional and dietary needs with instruction to forward a copy of the form to the kitchen for their records.

People's weight was monitored monthly along with malnutrition scores to indicate nutritional risks and track any weight gain or loss over time. Where weight loss was noted we saw that more frequent weekly weighing of the person was introduced. We saw evidence of referral to dietitians where there were concerns and advice and recommendations were noted in the care plan and in the section of the care file which recorded healthcare professional input. In some cases where it was felt necessary to monitor risk more closely, daily food and fluid charts were introduced in the person's daily folder. We checked a sample of these and they had been well maintained with targets for fluid intake and in one case a calendar to indicate any days where fluid targets had not been met.

We observed plenty of food and drinks for people. There were easy-read menus people could use, but staff plated food up and showed it to people so they could select based on the appearance and their preference. Where one person could not state what they wanted, we saw a care worker say, "How about ice-cream for your pudding? I know you like ice-cream." There were snacks and drinks throughout the day in both communal areas and for people who liked to stay in their rooms.

There was evidence in all care files of liaison and correspondence with other agencies involved in the care and support of people including hospital services, local authority assessments and reviews as well as specialist input from a range of health professionals. Visits from health care professionals were recorded in a separate section of each care file and these were well-documented with details of the date of visit, any relevant comments on advice given or follow up required. We saw good evidence of contacts with opticians, dietitians, dentists, specialist nurses such as tissue viability, and details of hospital appointments and relevant correspondence.

A local GP visited the service every week or as required for consultations with people or to conduct general health or medication reviews. We saw that details of these visits were also recorded in a separate log kept in the staff stations with a note of the date, symptoms and outcome for each person seen. GPs also recorded details of ad-hoc visits in care files. We spoke to the GP whilst they were at the service. They gave very good

feedback about their connection with the service. They told us, "I have nothing but praise for Sandown Park Care Home." The GP described that staff were pre-emptive in their monitoring and decision-making about people's care, which reduced the burden on the doctor's surgery. The GP commented, "They (staff) know the people well." The GP described that together with the service, they had reduced or eliminated the use of sedative medicines for people, replacing this with better management of behaviours that challenge.

Each care file contained a 'care passport' which contained a summary of the needs and risks relating to each person, categorised as 'things you must know about me' and 'things that are important to me'. This could be used if the person was admitted to hospital or transferred to another service.

The service provided a safe and hazard free environment for people to move around freely, with ample space in corridors and communal areas for those with walking aids and wheelchairs. The service was very well-appointed throughout with good quality modern furnishings and flooring in all areas. Bedrooms were personalised with individual possessions and pictures and there were memory boxes with personal items such as photographs and other memorabilia outside rooms on dementia units. Communal areas were decorated and equipped for the needs and comfort of people living there, including those living with dementia. Corridors had been decorated in bright colours with scenic murals and some sensory themed wall hangings. There were separate activity rooms including a reminiscence room that had been decorated in a comfortable and old fashioned style with armchairs, a fireplace and old style magazines and journals. There was good signage throughout the premises with bedrooms, toilets and bathrooms clearly labelled and there were clocks in communal areas for reference. The service had followed the best practise guidelines published by the Kings Fund for older adults and those living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were forms to evidence consent in all the care files reviewed. There was a new comprehensive consent form used covering consent to care and treatment as outlined in the agreed care plan, consent to access documentation as required and consent to photographs. The consent form had a section to indicate whether the person had capacity to consent and if not whether consent had been sought from a power of attorney, if appropriate or if there had been consultation with a relative. There was a section on the form for a signed witness to give verbal consent if the person was unable to physically sign consent. Where there was no capacity or others authorised to consent, there were best interest decision forms relevant to each decision such as use of bedrails, providing personal care or administering medication.

There were mental capacity assessment forms in relevant people's care files and these had been well completed in each case, using the correct two stage test required by the MCA. Where a person lacked capacity there were appropriate forms to document best interest decisions that showed involvement and consent of relatives or others relevant. Where there was a power of attorney in place, this was recorded and we saw evidence of the documents, as well as those from the Office of the Public Guardian. In one case there was a Court of Protection order in place and a copy of this was seen in the care file. There was evidence of DoLS applications and authorisations in care files where relevant and documentation seen was correctly

completed. Staff reported that they had received training in the MCA. All care staff demonstrated good levels of knowledge and understanding of the MCA and the key principles involved. All were able to clearly explain the definition of mental capacity and the implications for care if a person lacked capacity, such as helping people to make decisions and choices as far as possible using suitable language and alternative ways of communicating such as signing, facial expressions or visual aids.

Outstanding ☆

Is the service caring?

Our findings

The service continued to provide outstanding care, formed compassionate relationships with people and supported family members of people who were connected with Sandown Park Care Home. People and relatives told us the service ensured they were treated with kindness and respect. People provided positive feedback. Comments included, "They will bring me anything I ask for", "Staff are kind and caring when they are moving or helping me", "Oh yes, staff are always very pleasant. I know if I needed to complain they would listen", "They do their best", "Helpful and lovely", "They let me do whatever I want. I come back to my room (whenever I want)", They are very good; always attentive and helpful", "They (the staff) have excellent qualities and understanding", "Very attentive and polite at all times", "Kind, caring, friendly happy" and "They are doing their jobs to the best of their abilities. Very polite."

We observed good evidence of gentle and unhurried care throughout our inspection with staff providing appropriate and attentive care to people who used the service. Staff demonstrated that they were familiar with people's needs and routines and knew how to support and communicate with them. In one case we saw a member of staff conversing with a person in a different language. Although the person could speak English, they liked to speak in their native language and staff respected the person's preference. We observed that care staff were attentive and careful when they assisted people to move around the service and were prompt to attend to call bells or other requests for assistance. We observed that people were offered choices about what they wished to do or what they wanted to eat and staff were careful to allow people time to express themselves.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's support plans included extensive information about how to effectively communicate with them. We observed many staff could speak languages other than English. Staff conversed with one person in Italian and another person in Spanish. Throughout the building, there was evidence information in English was translated into several other languages. Staff told us they used the signage to help communicate with people. Staff could recite different food and fluids in other languages. The service ensured that people had access to the information they needed in a way they could understand it and were fully compliant with the Accessible Information Standard.

People and relatives were actively engaged in the day-to-day operation of the service. There were regular 'residents and relatives' meetings and surveys to gain people's opinions about care. One person told us, "I would most certainly recommend the home based on the way they have rallied around my situation." A relative told us, "I have been to one relatives' meeting and have had a written survey." Other comments included "They listen to any views" and "I have been to a relatives' meeting and any issues are dealt with. "I never felt we needed to keep watching." There were no restrictions to visiting hours and people could have small gatherings for special events. The service could provide catering as requested by the person or family, so that memorable events were created. Staff often took photos of people's events (with their consent), so they could reflect back on good times they had enjoyed. Print outs of the photos were provided to people and relatives which could be used for reflection and reminiscence.

Care plans were person-centred and recorded a good level of detail in relation to people's preferences and routines. Consent documentation and care plans showed extensive evidence of consultation and input from people living at the service and their relatives. Each care file contained a section on life history which recorded details of past occupations, family and significant events. They had a good level of detail to add colour and interest to the care plan. There was a form in the care file to record contact with relatives. It was clear from contact sheets in some files that there was regular communication between the home and family members.

We observed that staff checked on people's well-being throughout the day. As people moved about the premises, staff greeted them and asked them how they felt. We noted on several occasions that staff members asked if there was anything a person needed. During times when people did not wish to be disturbed, such as when they were in a bedroom or alcove lounge, staff respected their freedom but maintained a visible presence if the person needed something. We observed that people enjoyed starting conversations with staff and engaging with them. We saw people laughed and smiled when they were talking with staff. This demonstrated people had developed positive relationships with the staff team. We also observed that staff allowed people to perform tasks for themselves, and only offered assistance in the least way possible. This ensured that maximum independence was encouraged and people could remain as active as possible in their own care.

People's privacy and dignity was protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. We observed that people's doors were closed when staff were in the room to provide care. We also noted staff knocked on closed doors before they entered and announced their arrival and asked permission if a person's door was open. Signs were used on the outside of bedrooms doors to indicate that privacy was requested, so that people and staff were not disturbed during intimate personal care activities.

Confidential information about people who used the service and staff was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record keeping. People and staff's confidential information was protected.

Outstanding ☆

Is the service responsive?

Our findings

The service continued to provide outstanding person-centred care. The registered manager and deputy manager led the service by example. They placed people, relatives, visitors and healthcare professionals before themselves. During our inspection, they excused themselves at times to attend to people or engage with relatives they saw, which demonstrated their commitment to a welcoming, attentive service. When we observed the interaction between managers and staff, we saw joined-up working, excellent team thinking and a positive workplace culture. Staff told us they were happy to work at the service and felt connected to people. People and relatives had provided 41 written compliments and positive feedback in one year. People and relatives felt staff extensively knew them and the care requirements. The service's focus on people had ensured care experiences were tailor-made and unique care was provided to each person.

We noted people's apartments were very nicely decorated to their choice. They told us they were able to have their own furniture and belongings, and we observed the room was laid out in accordance with how the person liked it. One person was emphatic that we viewed their bedroom. The room, walls and floor were covered with family photos and celebrities. The person repeatedly remarked on how they were allowed to put up all their photos and cuttings. The person told us they liked that the service had accommodated their request, despite any damage that there may be to the premises by gluing and sticking items down.

People continued to have a very active social life. There was a special focus on people who were less ambulant or were living with dementia. One activities coordinator, a specialist in dementia-friendly activities and reminiscence, was instrumental in putting together the 1940's themed sitting room. This was still well-used by people, who enjoyed the experience. The expansive sensory garden created by the activities team continued to be regularly used, was wheelchair friendly and hosted multiple community get-togethers since our last inspection. There were raised garden beds, tactile stimulating plants, bright coloured displays of flowers and ornaments and areas where scented plants could be touched and used. The registered manager told us that both the garden and the service were nominated for the 2017 national dementia care awards. The service and the garden were demonstrated as having a positive effect on people's physical, emotional and mental wellbeing. We viewed the article about the impact in a journal and via other media. The activities coordinator told us use of the garden would be further expanded in the warmer seasons. This was to include informal dining in a casual sun-loving atmosphere.

One activities coordinator told us they used research and best practise to guide the type of programme that was developed. The service has subscribed to a specialist dementia care magazine, showcased activities that were different, unusual or newly tested. We could see some of the ideas were taken from the magazine and put in place at the service. For example, one alcove in a corridor had been transformed into an indoor garden. Two seats were available for people to sit down and look at, touch and smell the plants. A large mural in the alcove depicted the outside world. We saw many people stop on their way in the hall, and sit down to interact with the garden. One person told us they "liked" the garden alcove as they found it hard to go outside.

Since our last inspection, the complete care documentation system was replaced by more robust and

detailed tools. These provided an even clearer picture or story about each person and how they liked to live their life. Care plans however remained person-centred with information on routines and preferences as well as detail on any cultural, ethnic or religious requirements. Attention was given to activities of living which are often overlooked in older people's care, such as waking and night routines, preferences at the end of life, clothing style and personal care preferences. People's preferred names were clearly noted at the front of the care plan as well as any preferences for the gender of care staff. We observed staff call people by their preferred name throughout our inspection.

People's care documentation was holistic and successfully reflected each aspect of their life. Care files contained a profile of the person with key details at the front of the file, including a photograph, date of birth, admission, preferred name, contact details for relatives and next of kin, preferred GP, medical profile and background, and any allergies. There were individual care plans for personal care, diet and weight, mobility, moving and handling (including a falls 'diary'), memory and orientation, medicines, social contact and recreational activities, eyesight, hearing, oral healthcare, podiatry, communication, skin care and continence. There were monthly evaluations of each care plan carried out by nursing or other senior staff and most were up-to-date, with a good level of detail. More detail would be added as staff became more familiar with the provider's new care documentation.

When we reviewed the Provider Information Return (PIR) before our inspection, we saw the service had an exceptionally low incidence of wounds such as bruising, skin tears and pressure ulcers. We also noted when the service admitted people from nearby hospitals they were often able to completely heal pre-existing chronic wounds and pressure ulcers. Where people had wounds or pressure areas these were documented in separate section of the care file with a realistic wound management plan, wound assessment charts, body maps and details of any specialist input. For example, there was evidence of community healthcare professional advice from the tissue viability nurse that provided advice on cleaning, dressing and bandaging as necessary.

Extensive daily records of people's support and monitoring charts were maintained by care workers. There was a separate folder for each person containing daily charts such as personal care records, food and fluid records (if necessary), re-positioning charts, topical creams records and night checks. These were up-to-date and correctly completed with records of when people had had showers or refused personal care. There was a separate care plan for social contact and activities within the care file which outlined which activities were preferred, level of engagement and in some cases, whether people preferred not to engage in group activities. A separate activities folder was maintained on each floor with a section for each person containing a daily activity log to record their participation in various activities or other social engagement.

People were provided with service guides which contained key information about various aspects of Sandown Park Care Home. This included how to raise a concern or make a complaint. In addition, information was available in the reception area of how to report issues concerning care, accommodation or other matters. We saw the service had a satisfactory complaints policy and we looked at the complaints folder. We saw the registered manager dealt with any recorded concerns or complaints promptly and outcomes and actions were recorded. The registered manager was knowledgeable about their role in complaints management. There was a low rate of complaints about the service or care, and all of the complaints received were resolved.

The service regularly provided end of life care. There was a separate care plan in each file for people's end of life preferences. The level of detail varied depending on individual requirements but resuscitation wishes were correctly recorded and there was information on any funeral arrangements, family contacts, religious or spiritual requirements. We saw the use of the National Institute for Health and Care Excellence (NICE)

guidance was used in palliative care plans. For example, there was an end of life checklist including relevant aspects of care such as maintaining hydration, promoting dignity and anticipatory prescribing of medicines for support and comfort. We saw end of life practice occurred during our inspection, with a vicar visiting and supporting grieving family members and staff. A relative of the person approached us to provide their opinion of the care, despite the difficult circumstances. They wanted us to know how the staff and service had respected the person's and family's wishes, which resulted in a peaceful, pain-free death.

Where a 'do not resuscitate' decision was made in advance with the person and their family, the service ensured the relevant forms were located near the front of care files. We saw they included advice from multidisciplinary healthcare professionals. All were completed on original, legally valid forms and had been completed, authorised and dated by the GP. At the time of the inspection, 95% of people who used the service had made a definitive decision about their resuscitation preferences.

Outstanding ☆

Is the service well-led?

Our findings

The service's management and care team were outstanding. People and relatives described a very well-led service. One person said, "Very good (staff); everyone works well together." Another person described the registered manager. They told us, "On the whole, she (the manager) is marvellous. She takes an interest and helps out when needed. She is very approachable." A further person we asked about the management said, "She (the manager) is very nice. Comes in now and again (to the person's room). Heavens yes, well-run. They all do their best." Other comments we received included, "She (the manager) is polite", "The manager is very approachable. She took time to sit down with me and suggested ways forward. In fact, everyone has been extremely polite and caring", "Let us say manager is on hand and you can go and talk to her. She is visible", "We can't fault it. Everyone works together. There is a good environment. The manager is pretty good; fair but assertive" and "I like the fact that the manager has an 'open door' policy and is always available."

Staff sentiments echoed those of people who used the service and their relatives. One staff member said, "The manager is very helpful." Another staff member told us, "The manager is fantastic, very supportive, always approachable. I can't compliment her enough." Other staff commented, "The management here is very good. They know we work hard and show they appreciate us" and "The manager is very supportive and very flexible with her staff if they need time off in an emergency." Staff stressed that there was very good communication between senior staff and those on individual floors with a prompt response to any concerns or queries raised. One staff member said, "There is very good communication from the manager. She's around all the time and really takes care of her staff." Another nearby staff member approached us and stated, "If anything is wrong the manager's door is always open. She always knows what's going on and is always there to provide help." A national staff recognition scheme had commenced to reward outstanding talent in the workforce. The registered manager described that staff would be nominated based on going above their role expectations for people's needs.

Staff reported that the registered manager and deputy manager were visible and accessible at all times, including out of hours. They told us there were daily 'walkabouts' throughout the service. All staff felt that senior staff were approachable and were confident that they could raise any concerns or issues and receive a sympathetic and considered response. Staff said that there were regular monthly meetings on each floor as well as whole service staff meetings, at which issues concerning the home, queries or concerns could be raised and discussed freely. These were in addition to daily handover meetings where people's progress was discussed and any concerns addressed. Staff told us the deputy manager and registered manager participated in these handovers so they knew the status of people's care. When asked, several staff claimed that they would be happy for a relative to be cared for at the service.

There was a proactive, innovative way of tackling difficult issues at the service. An example was with one person where the care needs were being skewed by an external source. Despite constant criticism and at times upsetting behaviour, the registered manager and deputy manager acted professionally and in the interests of the person. This involved working jointly with a healthcare professional, including participation in legal processes to ensure the person received the best possible care. Another example was the detection and management of one staff member whose behaviour fell well below the professional standards required.

The service ensured safety of all concerned. They sent the staff member home in a taxi, checked people's medicines, made a detailed report of the issue and referred the matter to a professional body. Via our monitoring processes, we could see the wider public were protected from poor care practices by the action the service took in relation to the single incident.

The service repeatedly demonstrated their commitment to quality care. The service had built strong and reliable connections with the local community and multidisciplinary healthcare professionals. Examples included the fortnightly pre-schoolers' visits with people who used the service. We heard that children and people had engaged positively during the 'army wives' visits (a similar earlier project with children). People, relatives and staff told us they "loved" having the children at the service. The children would sit with people and talk to them, participate in activities together and ask questions of each other.

The service continued their commitment to research in the adult social care landscape. Since our last inspection, the service had continued one project called 'care companion'. A unique system, designed in England but piloted only at Sandown Park Care Home, staff used portable handsets to log hourly information about each person. This included indicators such as a person's emotion, pain score, skin integrity, hunger and thirst. The data was analysed by the computer to provide a baseline score of the person's needs, and provide real-time monitoring which could be accessed by relatives from their home computers or personal mobile phones. The intuitive system was able to determine when deterioration of a person's condition was imminent, and send warnings to the staff. Staff could then reassess a person, call the GP for simple advice and prevent avoidable hospital admissions. The clinical commissioning group (CCG) representative told us although the project had ended and the impact for people was extremely beneficial, the service had decided to continue to use 'care companion'.

Another example of research was the probiotic study. Probiotics are natural bacteria that live in a person's stomach and intestines. Only 20 care homes in England and Wales were selected to participate. The trial was to determine whether a daily capsule of probiotics would reduce the rate of chest infections, skin problems, diarrhoea or constipation and mouth disorders. Fourteen people who used the service took part. Staff were trained as 'champions' for the project and taught the remainder of the team the purpose and potential benefits of the study. The staff then ensured adherence to the study protocols and documentation requirements. Although the research was not complete, the results would be used to determine whether there was a benefit for people who took daily probiotics. The information from the study would also be published nationally and internationally for healthcare professionals to use in their own services.

The service had continued to use the CCG's 'hydration project' initiative. There is evidence that people who drink more fluids have a decreased risk or development of urinary tract infections. Staff were appointed as 'champions' to ensure the principles of the hydration project were embedded to benefit people. These included at least seven dedicated drinks rounds per day, frequent encouragement for people to take fluids and additional support for people who needed help with drinks. We consistently saw people enjoying drinks, and drinks offered to people. Some people had their favourite cups, including ones with movie characters on the outside which could hold large volumes of fluids. The 'hydration stations' (fluid trolleys) were brightly coloured and decorated in a Tropicana theme. We saw this included palm trees and flamingos. A large range of drinks was available for people, including fizzy waters and traditional flavours from the 1900's. We saw evidence that people did not develop urinary tract infections and communicated regularly with the CCG to track their progress.

There was an underlying equality policy and procedure which staff were aware of. The provider also clearly displayed this on their website and showed the principles they subscribed to. People were respected by staff regardless of their cultural, religious, or linguistic backgrounds. People's characteristics were protected by

staff and the management team. The registered manager also told us the principles applied to the workforce and we observed this. Staff treated each other with respect and dignity. The kitchen staff had an excellent knowledge of special dietary requirements and staff knew specific end of life regimes for different cultures or religions. The service respected people's and visitors' gender and sexuality choices. Additionally, the service had recently commenced a scheme with a European charity to offer work placements to younger adults with disabilities. The service had thoroughly assessed and implemented the principles of equality, diversity and human rights in the provision of care and its daily operations.

A number of quality audits and checks were used to gauge the safety and quality of care. These were completed according to an audit calendar set by the provider and included assessments from the service's staff and management, regional support team, contractors and community healthcare partners. We saw areas that were audited included the kitchen, laundry, maintenance and repairs, medicines, infection prevention and control, staff training and recruitment, personal care and nursing documentation. The calendar clearly set out who was responsible for each audit, and what month the check was to be completed in. We reviewed some of the audits which were completed. There was a key performance indicator report completed monthly aligned with criteria from the Care Quality Commission's five 'key questions' The report populated an action plan which was required to be completed by the registered manager. We saw any areas identified for improvement were always reviewed, and closed off with a signature of the responsible staff member and the date.

There were times when the service was legally required to notify us of certain events which occurred. When we spoke with the registered manager, they were able to explain the circumstances under which they would send statutory notifications to us. We checked our records prior to the inspection and saw that the service had notified us of relevant events. The service's prior inspection rating was clearly displayed in the reception area and on the provider's website.