Bupa Care Homes (ANS) Limited

St Mark's Care Home

Inspection report

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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

About the service:
• The service is based within the campus of the St Mark's Hospital community precinct, in a residential part of Maidenhead.
• The service is part of the Bupa group, which operates multiple care locations throughout England. Bupa is a 'corporate' provider and the registered services are part of our market oversight scheme.
• The service provided accommodation and personal or nursing care to older adults, in particular those with dementia in four units. People lived in their own bedrooms. Rooms had ensuite bathroom facilities. There were also communal bathroom facilities, lounges and dining rooms.
• The service can accommodate up to 80 people. At the time of our inspection, 74 people used the service and there were 98 staff.

People's experience of using this service:
• St Mark's Care Home provided exceptional care to people.
• People, relatives, staff and community professionals consistently described the service as "excellent", "loving", "special", "very well-led" and a unique place to live. One relative said the service was a "gem".
• People were always protected against avoidable harm, abuse, neglect and discrimination. The care they received was safe.
• People's risks were assessed and strategies put in place to mitigate the risks.
• People experienced positive outcomes regarding their health and wellbeing.
• Staff received good supervision and training, which provided them with the knowledge and skills to perform the roles they were employed to do.
• People and relatives provided consistently positive feedback about the care, staff and management. They provided examples of the outstanding care at the service and how people's lives were enhanced.
• Care was very person-centred and focused on ensuring people with dementia lived rewarding lives. The care was designed to ensure people's maximum independence was encouraged and maintained, especially when there was an ongoing decline during their stay at the service.
• Care planning was centred around and designed by people. End of life care planning, documentation and nursing care were outstanding.
• The management team had embraced continuous learning, positive change, new ways of working and excellence in care techniques and practices.
• There was an excellent workplace culture and staff we spoke with provided glowing feedback about the management team. Staff appeared to be very content were completely committed to ensuring the best care for people and support to their relatives.
• The service met the characteristics for a rating of "outstanding" in three of the five questions we inspected. Therefore, our overall rating for the service after this inspection was "outstanding".
• More information is in our full report at www.cqc.org.uk

Rating at last inspection:
• The service was rated "good".

• Our previous inspection report was published on 31 August 2016.

Why we inspected:
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.
• We inspect services already rated "good" within 30 months of our previously published inspection report.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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.

Details are in our findings below.

Is the service effective?

Good

The service was effective.

Details are in our findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Details are in our findings below.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive.

Details are in our findings below.

Is the service well-led?

Outstanding ☆

The service was exceptionally well-led.

Details are in our findings below.

St Mark's Care Home

Detailed findings

Background to this inspection

The inspection:
• We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was 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.

Inspection team:
• Our inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had knowledge about the support of older adults within residential care settings.

Service and service type:
• St Mark's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement.
• CQC regulates both the premises and the care provided, and both were looked at during this inspection.
• The service is required to have a registered manager. 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, a manager was registered with us.

Notice of inspection:
• Our inspection was unannounced.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House, the Food Standards Agency, fire and rescue service, environmental health and the Information Commissioner's Office.
• We asked the service to complete a Provider Information Return. This is information we require providers

to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with ten people who used the service and six relatives. We observed the care of numerous other people who were not able to speak with us.
• We spoke with the provider's regional director, registered manager and clinical services manager. We also spoke with three registered nurses, ten care workers, the resident experience manager, two maintenance workers, the activities coordinator and the cleaning staff.
• We spoke with the GP and received written feedback from other health and social care professionals.
• We reviewed six people's care records, six staff personnel files, audits and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Safeguarding systems and processes:
• People and relatives told us the service was safe. A relative said, "I can come in here morning, noon or night and I don't have to worry." A person commented to us, "If they [staff] see me trying to walk without my frame I'm in hot water! [The care workers] are walking up and down all the time, checking on me."
• Staff who applied for positions at the service were asked scenario questions about abuse and neglect. This checked what existing information and knowledge the staff member had about safeguarding people.
• Staff were required to undertake safeguarding training during their induction period.
• The provider operated a "speak up" programme which allowed anonymous reporting of any abuse or neglect.
• The 'residents' voice group (also formed of relatives) were able to raise any issues of concern with the management team.

Assessing risk, safety monitoring and management:
• The service received referrals for new people to move in to the care home, and used the information to determine whether the person may be suitable to live there.
• If the person was deemed safe to live at the service, a pre-admission was completed in various settings, such as people's homes or hospitals.
• Information from health and social care professionals was also used to inform decision making.
• Historical information was recorded about the person. This included medical history, social history and background.
• Other risks included eating and drinking, moving and handling, skin integrity and medicines management.
• Premises and equipment were properly maintained. Risks from the premises were assessed and mitigated. We found the fire risk assessment, Legionella risk assessment and lifting equipment checks were satisfactorily completed.
• The Legionella risk assessment showed seven remedial actions were required. There was evidence of an action plan for these and that the risks were mitigated and signed off as complete. People were protected from risks posed by the building.

Staffing and recruitment:
• The service introduced a resident experience manager. This role supported the 'hotel' services (non-clinical) departments, and line managed the heads of the kitchen, laundry and cleaning.
• The role focused on the dining experience of people, the cleanliness of people's rooms and communal areas and the management of people's clothes and linen. The regional director told us the role was to "ensure that people received all aspects of care" in an appropriate manner.
• The service had also introduced hostesses who were responsible for the management of lunch time meals. They managed people's requests for food and the plating of the meals. This allowed the staff to focus on

supporting people and less time was spent on the management of meals.
• A care worker had commenced the care practitioner course. A care practitioner is an advanced role undertaken by care workers. A care practitioner can support registered nurses and be indirectly supervised with more complex care tasks.
• A call bell analysis was completed weekly by the registered manager. These allowed the identification of trends and themes in support requests. For example, the registered manager identified there was an increased number of calls at 4pm each day because activities finished at this time.
• Remedial action to deal with the increase in calls at this time included staggering the end time of the activities.
• The service used dependency scoring to determine safe staffing deployment. The scores were added together to determine the number of care hours each person required each day.
• The staffing deployment tool was effective in ensuring people's safety. Where care needs were more complex, such as in the dementia unit, more staff were deployed to ensure people's risks were well-managed.

Using medicines safely:
• Medicines were safely managed by the registered nurses and care workers.
• Medicines were safely stored away and at the right temperatures.
• There were protocols in place for 'as required' medicines. For example, there were instructions in place for medicines such as cough linctus and paracetamol.
• 'Controlled drugs' (those subject to stringent control) were appropriately managed.
• The service had worked with the clinical commissioning group's care homes medicines optimisation team in November 2018. The pharmacist checked the stores of medicines and that staff were following medicines best practice guidelines.
• Staff who administered medicines were subject to competency checks to ensure their practice was safe. This involved a senior staff member observing the practice of the registered nurse or care worker on up to three separate occasions.

Preventing and controlling infection:
• There was satisfactory access to handwashing points throughout the buildings. There were also reminder signs for handwashing in critical areas such as bathrooms, kitchens and toilets. Alcohol based hand gel was also available in wall-mounted dispensers where needed.
• Staff had access to personal protective equipment to prevent cross infection. This included disposable gloves, aprons and hair nets (for kitchen staff).
• The building was clean and tidy. There were no odours; new bedpan washers were installed to prevent cross infection.

Learning lessons when things go wrong:
• Staff reported incidents and accidents via an electronic system.
• The management team received a notification when an incident was logged by staff. Depending on the circumstances, a formal investigation was triggered. This involved witness statements, reviews of documentation and speaking with people, relatives and staff.
• The regional director also had oversight of the incidents and accidents, including updates made by any registered manager in their patch.
• The registered manager created "lessons learnt" documents when things had gone wrong. These included outcomes from the incidents and what actions were taken or could be used.
• Night checks were completed by the registered manager, or their delegate, to ensure the safety of people at night. The registered manager also completed weekend and night shifts to work alongside staff and observe practice.

• CCTV was installed since our last inspection. This had proven extremely useful when the management investigated accident and injuries and for monitoring care practices within the service.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good and feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's preferences, likes and dislikes were always assessed and recorded in care documentation.
•Staff told us they had contributed, with relatives and people themselves, to assessments of people's needs which were comprehensive, identified expected outcomes, and were regularly reviewed.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.

Staff support: induction, training, skills and experience:
• Staff we spoke with were competent, knowledgeable, and skilled and felt very well supported by managers to develop.
• We saw the service had an induction process that involved areas such as understanding one's role, diversity and inclusion, privacy and dignity, safeguarding, infection control, communication, complaints handling, and fluids and nutrition.
• Managers used an online system called "Grow" which highlighted any training overdue and generated email reminders. This ensured staff training was up to date, as far as possible.
• All staff we spoke with said managers encouraged them to undertake additional training and ensured they had time to study. We saw evidence of additional training in areas such as dysphagia, 'stress and distress', sepsis (severe infections), care planning and 'living well with dementia'.
• Managers had appointed 'dementia champions' who were able to develop additional knowledge about dementia and disseminate it to other staff.
• Several members of staff told us a 'virtual dementia tour' arranged by the provider had helped them understand much better the experience of dementia from a person's own point of view.
• We saw documentation and confirmed with staff that showed us they had regular supervision and annual appraisals, known as 'performance conversations'.

Supporting people to eat and drink enough with choice in a balanced diet:
• People said they had a choice of food. One comment was, "The food is good. It's a bit posh. I can choose. If I don't like the menu they say, 'What can I get you?' I say: 'Can I have bangers and mash?' and chef will cook it. Sometimes I say I want chips and chef will come down with a plate of chips."
• There were appropriate risk assessments and care plans in place for nutrition and hydration.
• Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) were made when necessary.
• People had correctly modified texture diets where there were risks of choking. People's drinks were thickened when needed, to prevent the risk of choking on fluids.
• Snacks were available throughout the building and at any time, to encourage people with dementia to eat

regularly and prevent weight loss.

Staff working with other agencies to provide consistent, effective, timely care:
• The service's connections with the local authority and the clinical commissioning group (CCG) remained strong and effective. This ensured the service always had the latest information and access to best practice to ensure people's lives were the best they could be.
• Local stakeholders and community partners spoke highly of St Mark's Care Home. The service had a good reputation in the local community for facilitating timely admissions and discharges from nearby hospitals.

Adapting service, design, decoration to meet people's needs:
• There was a rolling capital expenditure programme to decorate and redesign aspects of the service. This had occurred with the rehabilitation gym, which changed to a large activities area and a bereavement room was planned.
• There was safe and effective mobility access inside and outside the service. Corridors and door entries were wide, to allow access for hoists, walking equipment and wheelchairs. Surfaces and pathways were even and the service ensured trip free access.
• There was the provision of disabled parking facilities for people's relatives, friends and others.
• The service had decorated communal bathrooms, toilets, bedroom doors and corridors in the right way to support people with dementia. We noted multiple clocks and calendars which aided people to view the time, day, date and weather.

Supporting people to live healthier lives, access healthcare services and support:
• A range of professionals from primary and hospital health services were involved in assessing, planning, implementing and evaluating people's care and treatment. This was clear from the record of appointments in the care documentation.
• Professionals who visited people at the service included GPs, district nurses, dietitians, speech and language therapists (SALTs), podiatrists, physiotherapists and social workers.

Ensuring consent to care and treatment in line with law and guidance:
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions.
• Where people could not make their own decisions, the best interest decision making process was used and appropriate documentation completed.
• DoLS applications for authorisation of restriction of people's liberty were completed by the management team, and renewals submitted to local authorities as needed.
• Where necessary, documentation for enduring or lasting power of attorney was sought and kept on file. This ensured only parties legally authorised to provide consent to care and treatment were involved in such decisions.

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; equality and diversity:
• There was overwhelming praise for how caring the service was. People and relatives or visitors provided numerous examples of the level of the compassion in the care provided.
• Relatives said, "Not once has [my relative] had a problem here. He's had the most excellent care…It's a great relief for me to be able to come in here and find him comfortable. I can go home and not worry", "The staff are absolutely amazing. I don't know how they stay so smiley and positive all the time", "All the girls are marvellous" and "The night staff are excellent; they will bring her [the person] tea and talk to her if she can't sleep.
• People said, "I must say [the care workers] couldn't try harder. They never moan", "I think the care is excellent…The staff are very approachable, very kind, very professional…What more can you ask for?" and "What I like about these carers, I mean, these carers treat me like I was their own mother. They shower me, they dress me, they open up my wardrobe and say: 'What are you going to wear today?' I say: 'You choose' They say: 'No, you choose' – and I do! They're 110%. They really are, all of them."
• There were 52 reviews about St Mark's on a popular internet site for care homes. The comments mirrored those from people and relatives we spoke with at our inspection.
• Community care professionals we spoke with also commented on the excellence of care. We spoke with the GP who described the service as "well organised" and that staff had "good communication".
• In the Windsor unit, five 'destination points' were set up along the corridors. These were used to reduce people's challenging behaviour and had proved to be very effective. Examples of the points included a train station, sports point, "nanny's nursery", ladies dressing table and a beach area.
• Each of the points were decorated with trinkets and equipment which pertained to the themes they recognised. For example, the beach area had a picnic basket with small juice boxes and seaside snacks. This encouraged people to eat small snacks and increase their hydration.
• People were encouraged to leave their rooms. They enjoyed exploring the various 'destination points' and each person was attracted to different themed areas.
• One person who walked about liked the company of children. She was interested in the "nanny's nursery" and took a pram which she could push into the corridor and into her room. She also liked to take care of one of the dolls which represented a child. The person took the pram and doll into their room at night and this had positively affected their sleeping; they had a more effective sleep pattern.
• The service had created a sensory garden outside the Windsor unit. The pathways were made safer, wider and friendlier for wheelchair users.
• Raised garden beds were added and herbs and vegetables were planted. People who used the service were involved in the planning and upkeep of the raised beds.
• We saw evidence of one person who had behaviour that challenged actively involved in watering large

garden beds. The staff explained the positive emotional change the person had experienced. The person who was normally distressed and not interested in other activities had become actively involved in gardening, especially using the watering can.
• One person who had lost his wife before moving into the home, wanted to make a memorial garden. A rose was planted by the person and a plaque, made by the maintenance person, was installed. The person could see the memorial garden from their room. The person had explained to staff that they felt closer to their departed spouse.
• Another person that moved from their home and was very proud of their garden wanted to bring ornaments to remember their house by. Outside their window, a garden was created where the person and their family had placed the gnomes, metal sculptures and a small windmill. Over time, the number of ornaments had increased as the person expressed their memories of home when new items were placed there.
• A former rehabilitation gym had been transformed into a dedicated activities centre. Examples of different approaches included the "active mind" boxes. These were designed to stimulate all five senses of people. For example, essential oils and essences were used in containers to help people remember items such as shoe polish, clean cotton sheets and baby powder.

Supporting people to express their views and be involved in making decisions about their care:
• There was evidence in all the care documentation we viewed that people and their relatives were the decision-makers in the care process. Language used throughout the care plans and daily notes reflected what people told the staff, rather than what staff thought was the best option.
• Staff told us they supported people to make decisions about their care and showed us they knew when people needed help and support from their relatives.
• There was a very positive impact on people's lives because they were engaged in their care planning. One person told us, "[At home] I was throwing in the towel. I didn't want to live anymore and then I came here. It was an eye opener. They are kind and gentle and very understanding. The kind of people I wanted to meet. They had time to listen to me and try to understand what was lacking in my life. I wouldn't want to be spending another day out of here. The day I came in here was the beginning of my life…"
• Engagement of people and relatives in the care journey was constantly promoted by staff. At every possible opportunity, staff asked people and relatives what changes they wanted in their care. Changes in care were not limited to standardised, time limited periods. One relative wrote, "Some of the staff went over and above their role." The person wanted to have fast food on a regular basis instead of the service's meals. The relative went on to state, "One [staff member] in visited [the person] on their days off to take her for a McDonalds."
• Staff showed us they were aware of people's needs, including those related to protected equality characteristics such as age, disability, race and gender, and their choices and preferences were regularly reviewed.
• Technology was widely embraced to provide the best possible care for people. This included the use of large button phones, mobile phones, tablet computers and video links. People could keep in touch with significant others in their life. This reduced their social isolation and prompted social inclusivity. Another person used an alphabet board to communicate with staff and their relatives.

Respecting and promoting people's privacy, dignity and independence:
• People's right to privacy and confidentiality was respected.
• People were afforded choice and control in their day to day lives. Staff were keen to offer people opportunities to spend time as they chose and where they wanted. We observed staff waiting for people to respond when asked a question to ensure they knew the person's choice.
• The service had commenced challenging conversations with people, staff and relatives about sexuality and disabilities. This had raised awareness of quality and diversity. Further communication about human rights was scheduled, to keep this as a continuous point for reflection.

• One relative explained how staff promoted dignified care. They said, "[The person's] been getting excellent care. I can't fault the care."
• Another relative told us about the planned dignity of care for a person if they suffered any deterioration in health. They said, "It [dignity planning] was the first thing they [the service] did when he [the person] came in. Together, we agreed there would be no more hospital admissions. As long as [my relative] is getting the dignified care that he needs, what more can the staff do?"

Outstanding ☆

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

Services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• The service's care and support of people was extremely person-centred.
• The service had taken all of the necessary steps to ensure that people received information in the way they could understand it.
• The care notes documented that the service identified and recorded communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it. For example, people had access to documents in large fonts, there was extensive use of pictures and symbols throughout signage and alternative formats of communication, for example Braille or sign language, were easily available.
• The service operated a "never too late" scheme. This was a programme to allow people to have life wishes they had never fulfilled. A mobile farm visited the service, and a person felt a connection with a guinea pig. They wanted to keep the animal from the mobile farm. The management team organised for the purchase and homing of a guinea pig so the person could have the pet "of their dreams".
• The registered nurses came into the dining rooms at various points to offer their assistance to the care workers and to check people's welfare. They spoke with people and stimulated conversations.
• This led to very good communication between people and staff. Staff attempted to trigger conversations when possible, even if the person was disinterested or distracted.
• The activity coordinator completed case studies of people to understand their social interests and hobbies. These were used to inform the activities programme, as well as explain to staff people's backgrounds. For example, one person mentioned their involvement in the RAF and how they liked to see fighter planes from the war. The activities coordinator and other staff used the information to start conversations with the person and help with their memory. They also ensured the person received information about planes, relevant news and stories or pictures.
• Staff were able to take part in dementia virtual tours. A staff member said , "This makes me feel I know a lot more about dementia" and another said, "It gave me a greater insight into the daily lives and obstacles faced by those living with dementia."
• The service brought six different countries into the service by having themed days. This included having decorations, clothing, food and entertainment from the relevant countries. A professional photo book as produced for each country. People were given passports which were stamped as they 'travelled' to each country. Attention to detail was extensive. People fed back how keen they are for events like these to continue.
• The service used multiple social media websites to promote their activities, changes and communicate relevant information. Relatives and members of the public could access real-time updates on the care, events, news and other activities.
Improving care quality in response to complaints or concerns:

• Staff knew how to provide feedback to the management team about their experiences and told us they were very happy to do so.
• Staff knew how to make complaints should they need to. They told us they believed they would be listened to and acted upon in an open and transparent way by management, who would use any complaints received as an opportunity to improve the service.
• A very good complaints management system was in place. Standard processes ensured the effective acknowledgement, management, investigation and documentation related to concerns. However, the management team took action beyond this level. They used all concerns or formal complaints as learning opportunities to shape practice.
• We saw how the clinical services manager and registered manager reached out to complainants after the outcome of a complaint. This showed the service continually aimed to improve the management of complaints and evaluate how well complaints were dealt with.
• People knew how to raise a complaint. Because concerns were dealt with swiftly, they rarely became a complaint. Staff were accountable and took responsibility if there were errors or mistakes and when things could have been handled in alternative ways.

End of life care and support:
• Care for people at the end of their life was outstanding. Feedback from relatives and others about palliative care was glowing.
• One relative wrote, "When the [staff] first welcomed us, [we] could not have asked for more outstanding care. All [the person's needs] were met with great kindness, patience and professional care. St Mark's became our home for over seven years…we will never be able to thank you all enough." Another relative wrote, "The sadness is still with us, but we can think about the difficulties [the person] went through with gratitude and appreciation of all your care. That is still a beautiful memory!"
• The service used best practice guidelines for palliative care and improving environments. The service used the strategies to embed a person-centred, responsive approach to end of life care.
• People's pain was managed quickly and proactively. Comments included, "Sometimes he [the person] might have pain and I ask them [staff] for paracetamol. Within five minutes he gets them. They certainly wouldn't have him in pain."
• Staff received specialist end of life care training. The clinical services manager completed a course to become a specialist in palliative care. They used their expertise to teach other staff the best practice and methods for providing pain free, dignified deaths in the way people wanted. Two staff members volunteered to become bereavement counsellors.
• The management identified that the environment for the end stages of people's lives could be enhanced to ensure a peaceful and dignified discussion with people and relatives. This included the introduction of a bereavement room. The bereavement room would be used to hold difficult discussions with relatives, talk about end of life wishes and advanced care planning, hold meetings to make best interest decisions during palliative care and provide a space for reflection and quiet contemplation.
• A registered nurse designed a leaflet for relatives about palliative care. This was written in a simple format, without the use of medical terms or jargon, so that the purpose and description of end of life care was easily understandable. Relatives had told the management they found the leaflet helped them prepare for bereavement.
• The service also introduced a monthly drop in opportunity for relatives to speak about end of life care, death and dying. This enabled relatives to have a specific date and time to speak with a staff member experienced in palliative care.
• The service commenced bereavement support with relatives. This included sending cards, flowers, staff attending funerals or cremations and holding an annual candlelight remembrance.
• Subject-focused workshops were planned for staff every six weeks. The topic was flexible and based on items in which it considered staff required refresher information.

Outstanding ☆

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service leadership was exceptional and distinctive. Leaders and the service culture they created drove and improved high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support, and how the provider understands and acts on duty of candour responsibility when things go wrong:
• The service had a core set of principles that were person-centred. This included positive experiences and positive outcomes which encompassed "passion", "care", "openness", "authenticity" and "accountability".
• Staff we spoke with were able to relate to the service's core values and objectives. They could explain what the values meant to them and how they put the service's ethos into everyday practice. For example, one staff member said they liked to ensure that the people they cared for were "Given the best care possible, no matter how trivial the request [was]."
• The service identified that further improvement could be made in the hydration of people, to prevent avoidable illnesses such as urinary tract infections.
• The service researched strategies to increase the hydration of people. They implemented several successful strategies. These included hydration 'stations' – trollies and tables which included a wide variety of flavoured drinks of different types. The hydration stations were both static and mobile; the mobile stations were moved throughout the units with music playing to grab people's attention and encourage them to have a drink.
• The service purchased reusable water bottles which had volumes and times printed on the side. These encouraged people to drink a set amount of fluid every hour. These were portable, for the person to carry with them throughout the day and were refilled as required by the staff. The service measured the amount of fluids people consumed from the specific bottles and this strategy had increased the volume of hydration.
• The service actively measured the number of urinary tract infections. These had decreased as the service had increased the volume of fluids that people consumed. For example, in the first month there were 12 infections, in the following month there were six infections and this eventually reduced to just one infection in successive months.
• In addition to the reduction in urinary tract infections, the service researched whether better hydration led to reduced rates of falls. The project set out the aims, which included reduction of avoidable hospital admissions, reducing falls and the fractures that could result from them.
• In one unit's dining room, people wanted the circular dining tables to be joined together. They asked the management team to move the tables to be adjoined side by side rather than apart in different parts of the room. People felt this would foster positive communication during meal times.
• Relatives told us they trusted the opportunity to speak with managers in an open manner. One told us, "Obviously it comes from the manager bringing the right people in and training them properly"

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Staff told us they felt listened to and supported by managers. One said, "You can ask them anything." Another told us, "The manager is the best I've ever come across."
• The registered manager told us they aspired to "lead by example". They were nominated by ten staff who worked at the service for Bupa's care home manager of the year 2018. The registered manager won the award based on their performance, engagements and management techniques at the service.
• The clinical services manager won the 2018 clinical leader of the year for the entire Bupa group because of the outstanding work they had completed for palliative care and end of life measures. Their contribution to ensuring peaceful, dignified death was demonstrated through case studies.
• "Operational essentials plans" were used to determine how often to measure the service, how to measure the care, where to save the evidence and what the evidence should be used for.
• Evidence from the quality and governance checks was used to drive improvements at the service. Frequent measurement of performance meant the service could make changes to any areas they considered required improvement on a more frequent basis than previously.

Engaging and involving people using the service, the public and staff:
• The service continually engaged with people, staff and the public.
• Involvement of people who used the service was via a 'residents' committee. They met with the registered manager every two months, and in between they communicated ideas with each other on an informal basis.
• The committee involved four relatives and three residents who volunteered to take part. Their role was to visit people and others in the building to gain feedback, provide suggestions and inform staff of any special wishes of people.
• For example, one person's wish was to go fishing again. The service had organised for the person to go fishing with a member of staff so that they could fulfil their dream.
• Other forms of feedback from people and relatives included regular meetings. The service also used the provider's "You said, we did" framework. This was when a suggestion was made, implemented and published so that people knew the idea they submitted was used to improve the service. The latest result was people wanted physical activities to take place in the morning. The activities coordinator changed the yoga, Tai Chi and armchair exercises to 11am.
• The service had implemented their own employee of the month scheme. Nominations were provided by people, staff and relatives and then a vote was completed for the nominees each month. A winner was announced each month and the staff were rewarded with a prize of their choice. The registered manager explained that it had brought a "positive vibe".
• The recognition of staff had a very positive effect at the service. It meant there was a below average turnover rate and the retention of staff was very good. This was evidence d in the Provider Information Return (PIR) we required as part of our inspection.
• The service had established procedures for the withdrawal from the European Union. This included preparedness for staff who required settled status for continued working in the UK. The short notice of the political state for EU nationals meant the service had acted quickly to protect their workforce.

Continuous learning and improving care:
• The service implemented a "clinical excellence" training scheme for staff, to increase their knowledge and skills to an advanced level in particular topics.
• The scheme involved a number of workbooks, face to face meetings and webinars designed to continuously improve the staff members' expertise.
• The service had enrolled the registered manager, clinical services manager and two unit managers in the "clinical excellence" training.
• Part of the scheme required the staff member to complete a research project that related and linked back to the service. One staff member chose to examine falls management within the service.
• Results and learning from the research project were communicated at home managers' meetings within

the region. This enabled other services to take on board the findings and implement changes which also prevented falls and avoidable injuries.

Working in partnership with others:
• The clinical services manager created a staff social group, to increase workplace culture and team building.

• The service had a link with a local secondary school where students visited every fortnight to complete activities with people. In additional, students from a local primary school attended to sing to people and interact with them.
• During the football world cup, a group of people were very engaged in the matches. They stayed up late at night and had drinks to watch the games via a large screen TV projector. After the world cup, people expressed their desire to continue to be involved in football. The service decided to sponsor a local football club. The football players visited the home to speak with the people who enjoyed football. They signed photos and wore their football kit, had chats with the people and answered questions about football.
• The service ran a monthly registered nurse discussion group about clinical topics. They invited other care homes to join in and this had resulted in reciprocal invitations to join in activities and meetings at other care homes.
• The service was partnered with the Alzheimer's Society as "dementia friends", so that staff could receive additional training in dementia and use the principles of best practice care for people with dementia.